CHAPTER 9

Capital, Surplus, Reserves, and Other Financial Matters

ARTICLE 1

General Provisions

**SECTION 38‑9‑10.** Capital and surplus required of stock insurers; delinquency.

 (A)(1) Before licensing a stock insurer, the director or his designee shall require the insurer to be possessed of capital which must be maintained at all times and surplus, twenty‑five percent of which must be maintained at all times, in amounts not less than:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|   | If licensed to write |   | Capital |   |   | Surplus |
|   | (a) life: | $ | 600,000 |   | $ | 600,000 |
|   | (b) accident and health |   | 600,000 |   |   | 600,000 |
|   | (c) life, accident, and health |   | 1,200,000 |   |   | 1,200,000 |
|   | (d) property: |   | 1,200,000 |   |   | 1,200,000 |
|   | (e) casualty: |   | 1,200,000 |   |   | 1,200,000 |
|   | (f) surety: |   | 1,200,000 |   |   | 1,200,000 |
|   | (g) marine: |   | 1,200,000 |   |   | 1,200,000 |
|   | (h) title: |   | 600,000 |   |   | 600,000 |
|   | (i) multiple lines: |   | 1,500,000 |   |   | 1,500,000 |

 (2) The director or his designee may require additional initial capital and surplus based on the type or nature of business transacted, and the initial capital and surplus of the insurer must consist of cash or marketable securities that qualify as admitted assets on the most recent statutory financial statement of the insurer filed with the department pursuant to Section 38‑13‑80.

 (B) If the surplus of a stock insurer is less than twenty‑five percent of the surplus initially required, as set forth in subsection (A), the insurer is considered delinquent, and the director or his designee may begin delinquency proceedings as provided by Chapter 27 of this title.

 (C) If the capital of a stock insurer is impaired, the insurer is delinquent, and the director or his designee shall begin delinquency proceedings.

HISTORY: Former 1976 Code Section 38‑9‑10 [1947 (45) 322; 1952 Code Section 37‑142; 1962 Code Section 37‑142] recodified as Section 38‑55‑10 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑610 [1947 (45) 322; 1952 Code Section 37‑181; 1957 (50) 402; 1962 Code Section 37‑182; 1963 (53) 564; 1971 (57) 311] recodified as Section 38‑9‑10 by 1987 Act No. 155, Section 1; 1988 Act No. 317, Section 1; 1991 Act No. 13, Section 6; 1993 Act No. 181, Section 535; 2012 Act No. 137, Section 2, eff April 2, 2012.

**SECTION 38‑9‑20.** Surplus required of mutual insurers; delinquency.

 (A)(1) Before licensing a mutual insurer, the director or his designee shall require the insurer to be possessed of surplus of not less than:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|   | If licensed to write | Surplus which mustbe possessed attime of licensing |
|   | (a) life: |   | $1,200,000 |   |
|   | (b) accident and health: |   | 1,200,000 |   |
|   | (c) life, accident, and health: |   | 2,400,000 |   |
|   | (d) property: |   | 2,400,000 |   |
|   | (e) casualty: |   | 2,400,000 |   |
|   | (f) surety: |   | 2,400,000 |   |
|   | (g) marine: |   | 2,400,000 |   |
|   | (h) title: |   | 1,200,000 |   |
|   | (i) multiple lines: |   | 3,000,000 |   |

 (2) The director or his designee may require additional initial surplus based on the type or nature of business transacted, and the initial surplus of the insurer must consist of cash or marketable securities that qualify as admitted assets on the most recent statutory financial statement of the insurer filed with the department pursuant to Section 38‑13‑80.

 (B) If the surplus of a licensed mutual insurer is less than the sum of the capital and minimum surplus required to be maintained by a stock insurer licensed to write the same kind or kinds of business, the mutual insurer is considered delinquent, and the director or his designee may begin delinquency proceedings as provided by Chapter 27 of this title.

 (C) If the surplus of a licensed mutual insurer is less than the minimum capital required to be possessed by a stock insurer licensed to write the same kind or kinds of business, the mutual insurer is delinquent, and the director or his designee shall begin delinquency proceedings.

HISTORY: Former 1976 Code Section 38‑9‑20 [1947 (45) 322; 1952 Code Section 37‑141; 1962 Code Section 37‑141] recodified as Section 38‑61‑10 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑620 [1947 (45) 322; 1952 Code Section 37‑182; 1957 (50) 402; 1962 Code Section 37‑182; 1963 (53) 564; 1971 (57) 311] recodified as Section 38‑9‑20 by 1987 Act No. 155, Section 1; 1988 Act No. 317, Section 2; 1991 Act No. 13, Section 7; 1993 Act No. 181, Section 535; 2012 Act No. 137, Section 3, eff April 2, 2012.

**SECTION 38‑9‑30.** Capital and surplus requirements of insurers licensed as of July 1, 1988; delinquency.

 Sections 38‑9‑10 and 38‑9‑20 do not apply to an insurer that is licensed to do business in this State on July 1, 1991, if the insurer continues to remain licensed in this State and continues to maintain at least the following minimum capital and surplus amounts if a stock insurer or minimum surplus if a mutual insurer:

 (1) An insurer, if possessed of capital and surplus amounts on December 31, 1990, that were in compliance with the law at that time, but which are less than the minimums required to be maintained by Section 38‑9‑10, shall maintain not less than the amount of capital stated in its 1990 annual statement and maintain surplus of not less than twenty‑five percent of that amount of capital. If the surplus of the insurer is reduced to less than twenty‑five percent of this minimum amount of required capital, the insurer is considered delinquent, and the director or his designee may begin delinquency proceedings as provided by Chapter 27 of this title. If the minimum capital required to be maintained by this section by the insurer becomes impaired, the insurer is delinquent, and the director or his designee shall begin delinquency proceedings. If the capital is increased to an amount greater than the amount possessed on December 31, 1990, the amount of surplus that must be maintained after the increase is twenty‑five percent of that greater amount of capital, and if this amount is not maintained, the director or his designee may begin delinquency proceedings as provided by Chapter 27 of this title. This increased amount of capital must not be reduced to an amount less than the amount required by Section 38‑9‑10, and if it becomes reduced or impaired, the insurer is delinquent, and the director or his designee shall begin delinquency proceedings.

 (2) A mutual insurer, if possessed of surplus on December 31, 1990, that was in compliance with the law at that time but is less than the minimum required to be maintained by Section 38‑9‑20, shall maintain not less than the amount of surplus stated in its 1990 annual statement. If the surplus of the insurer is reduced to less than eighty percent of the amount shown in its 1990 annual statement, the insurer is considered delinquent, and the director or his designee may begin delinquency proceedings as provided by Chapter 27 of this title. If the surplus of the insurer is increased to an amount greater than the amount possessed on December 31, 1990, eighty percent of that greater amount of surplus, or the minimum amount required to be maintained by Section 38‑9‑20, whichever amount is the lesser, must be maintained after the increase, and if it is not maintained, the insurer is considered delinquent, and the director or his designee may begin delinquency proceedings as provided by Chapter 27 of this title.

 (3) A domestic stock insurer possessed of the minimum capital and surplus required by item (1) or a domestic mutual insurer possessed of the minimum surplus required by item (2), which is the subject of a change of control defined in Chapter 21 of this title, the Insurance Holding Company Regulatory Act, immediately shall increase its minimum capital and surplus if a stock insurer, or its minimum surplus if a mutual insurer, to comply with the minimums in Section 38‑9‑10 or 38‑9‑20, whichever is applicable.

HISTORY: Former 1976 Code Section 38‑9‑30 [1947 (45) 322; 1952 Code Section 37‑143; 1962 Code Section 37‑143] recodified as Section 38‑55‑20 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑630 [1947 (45) 322; 1948 (45) 1734; 1952 Code Section 37‑183; 1962 Code Section 37‑183; 1963 (53) 564; 1971 (57) 311] recodified as Section 38‑9‑30 by 1987 Act No. 155, Section 1; 1988 Act No. 317, Section 3; 1991 Act No. 13, Section 8; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑40.** Director to notify insurers of amounts required; annual schedule.

 The director or his designee shall notify each licensed insurer that does not comply with Section 38‑9‑10 or 38‑9‑20 of the amounts of capital and surplus if a stock insurer, or the amount of surplus if a mutual insurer, the insurer shall maintain in order to continue to remain licensed in this State. A schedule of the amounts required must be maintained by each insurer. This schedule must be revised annually as to those insurers whose minimum capital and surplus requirements are increased periodically as required by Section 38‑9‑30.

HISTORY: Former 1976 Code Section 38‑9‑40 [1947 (45) 322; 1952 Code Section 37‑144; 1962 Code Section 37‑144] recodified as Sections 38‑63‑10, 38‑65‑10, and 38‑69‑10 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑640 [1962 Code Section 37‑183.1; 1963 (53) 564] recodified as Section 38‑9‑40 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 535; 1998 Act No. 411, Section 2.

**SECTION 38‑9‑50.** Restrictions on kinds of insurance that insurers may write.

 An insurer that fails to meet the minimum capital and surplus requirements of this chapter, but which continues to remain licensed by virtue of Section 38‑9‑30, shall confine its business to the kinds of insurance for which it was licensed on July 1, 1988. If the insurer desires to write additional kinds of insurance, it shall comply with the capital and surplus requirements of Section 38‑9‑10 or 38‑9‑20 as applicable.

HISTORY: Former 1976 Code Section 38‑9‑50 [1956 (49) 1814; 1962 Code Section 37‑144.1] recodified as Section 38‑63‑20, Section 38‑65‑20, Section 38‑69‑20, Section 38‑71‑220 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑650 [1962 Code Section 37‑183.2; 1963 (53) 564] recodified as Section 38‑9‑50 by 1987 Act No. 155, Section 1; 1988 Act No. 317, Section 4; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑60.** No limitation on certain license provisions.

 Sections 38‑9‑30 to 38‑9‑50 may not be construed as a limitation of any authority conferred elsewhere by this title upon the director or his designee to deny or revoke or suspend a license of an insurer.

HISTORY: Former 1976 Code Section 38‑9‑60 [1947 (45) 322; 1952 Code Section 37‑145; 1962 Code Section 37‑145] recodified as Section 38‑55‑40 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑660 [1962 Code Section 37‑183.3;1963 (53) 564] recodified as Section 38‑9‑60 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 53.

**SECTION 38‑9‑70.** Insurers may make deposits to do business in other states.

 The director or his designee in his official capacity shall take and hold, in trust, deposits made by domestic insurers for the purpose of complying with the laws of any other state to enable the insurer to do business in that state. The insurer making the deposit is entitled to the income and may with the consent of the director or his designee and when not forbidden by the law under which the deposit is made, change, in whole or in part, the securities which compose the deposit for other solvent securities of equal par value approved by the director or his designee.

HISTORY: Former 1976 Code Section 38‑9‑70 [1947 (45) 322; 1949 (46) 600; 1952 Code Section 37‑146; 1962 Code Section 37‑146; 1980 Act No. 305, Section 1] recodified as Sections 38‑63‑210, 38‑69‑110, and 38‑71‑30 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑670 [1947 (45) 322; 1952 Code Section 37‑1851962 Code Section 37‑185] recodified as Section 38‑9‑70 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑80.** Certificates of deposits or securities required; amounts; factors considered in setting amounts; limits.

 (A) The director or his designee shall require every insurer transacting, or desiring to transact, business in this State to deposit with him certificates of deposit of building and loan associations chartered by South Carolina or federal savings and loan associations located within the State in which deposits are guaranteed by the Federal Savings and Loan Insurance Corporation, not to exceed the amount covered by insurance, or of national banks located within the State or banks chartered by South Carolina in which deposits are guaranteed by the Federal Deposit Insurance Corporation, not to exceed the amount covered by insurance, or other securities which:

 (1) qualify as legal investments under the laws of this State for public sinking funds;

 (2) are not in default as to principal or interest;

 (3) have a current market value of not less than ten thousand nor more than two hundred thousand dollars, as determined by the director or his designee pursuant to the standards promulgated by the department.

 (B) The director or his designee shall prescribe the amount, within the limits of this section, of the securities required, and he subsequently may increase or decrease the amount required.

 (C) Notwithstanding the limitations in this section as to the amount of deposits required, the director or his designee may require an insurer to deposit an amount of securities in excess of the limits based on his consideration of the following:

 (1) adverse findings reported in financial condition and market conduct examination reports;

 (2) the National Association of Insurance Commissioners Insurance Regulatory Information System and its related reports;

 (3) the ratios of commission expense, general insurance expense, policy benefits, and reserve increases as to annual premium and net investment income which could lead to a significant adjustment to an insurer’s capital and surplus;

 (4) whether the insurer’s asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity, or diversity to assure the insurer’s ability to meet its outstanding obligations as they mature;

 (5) whether an insurer had a significant operating loss in the last twelve months or a shorter time;

 (6) whether an affiliate, subsidiary, or a reinsurer is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligations;

 (7) contingent liabilities, pledges, or guaranties which individually or collectively involve a total amount which in the opinion of the director or his designee may affect the solvency of the insurer;

 (8) whether the management of an insurer, including officers, directors, or other persons who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness, and reputation necessary to serve the insurer in that position;

 (9) whether management has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry;

 (10) whether the insurer has grown so rapidly and to an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;

 (11) whether the insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems.

HISTORY: Former 1976 Code Section 38‑9‑80 [1947 (45) 322; 1949 (46) 600; 1952 Code Section 37‑147; 1962 Code Section 37‑147] recodified as Section 38‑55‑50 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑680 [1962 Code Section 37‑185.1; 1962 (52) 2148; 1969 (56) 212; 1975 (58) 279; 1986 Act No. 429, Section 1] recodified as Section 38‑9‑80 by 1987 Act No. 155, Section 1; 1992 Act No. 280, Section 1; 1993 Act No. 181, Section 535; 2000 Act No. 259, Section 4.

**SECTION 38‑9‑90.** Securities or bonds must be held as security for claims.

 The bonds or other securities required by Section 38‑9‑80 must be held as security for the payment of claims against the insurer arising out of its failure to meet obligations incurred in this State. Policyholders ratably and without preference and general creditors ratably, without preference, and subordinate to the claims of policyholders shall have a lien on the bonds or other securities for the amount of their claim.

HISTORY: Former 1976 Code Section 38‑9‑90 [1947 (45) 322; 1952 Code Section 37‑148; 1962 Code Section 37‑148] recodified as Section 38‑55‑60 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑690 [1962 Code Section 37‑185.2;1962 (52) 2148] recodified as Section 38‑9‑90 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 53.

**SECTION 38‑9‑100.** Deposit of securities not necessary when made with other states.

 If a qualified insurer deposits with an officer or official body of another state for the protection of all its policyholders, or all its policyholders and creditors, acceptable securities not in default as to principal or interest and of a current market value of not less than one million dollars, and delivers to the director or his designee a certificate to that effect, authenticated by the appropriate state official holding the deposit, the insurer may be relieved of making the deposit required by Section 38‑9‑80. For the purpose of this section a ‘qualified insurer’ is a licensed stock insurer possessed of at least ten million dollars of capital and surplus or a licensed mutual, fraternal, or reciprocal insurer possessed of at least ten million dollars of surplus, according to its most recent annual statement filed with the director or his designee and, in the discretion of the director or his designee, may include eligible surplus lines insurers which meet these capital and surplus requirements. For the purpose of this section, “acceptable securities” means bonds of the United States or of a state of the United States, or of a municipality or county, upon which is pledged the full faith and credit of the appropriate political division, or bonds or notes secured by mortgages or deeds of trust on otherwise unencumbered real estate of a market value of not less than double the amount loaned, or other securities approved by the director or his designee.

HISTORY: 1969 (56) 212; 1971 (57) 2561; 1986 Act No. 429, Section 2] recodified as Section 38‑9‑100 by 1987 Act No. 155, Section 1; 1988 Act No. 314, Section 2; 1992 Act No. 280, Section 2; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑110.** Voluntary deposits for compliance with laws of other states.

 A domestic company, in order to comply with the laws of any other state or territory of the United States, may make a voluntary deposit with the director or his designee in excess of the amount required by Section 38‑9‑80. This excess deposit is subject to all other applicable provisions of the laws of this State relating to the deposits of insurers, except that the excess deposit must be for the protection of all the company’s policy obligations, ratably and without preference, notwithstanding the provisions of Section 38‑9‑90. However, a domestic company making this voluntary deposit is relieved of making the deposit required by Section 38‑9‑80 if the company meets the definition of a qualified insurer as defined in Section 38‑9‑100 and if the voluntary deposit meets the requirements of Section 38‑9‑100.

HISTORY: Former 1976 Code Section 38‑9‑110 [1947 (45) 322; 1952 Code Section 37‑149; 1962 Code Section 37‑149] recodified as Section 38‑55‑70 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑710 [1962 Code Section 37‑185.4; 1962 (52) 2148; 1974 (58) 2099] recodified as Section 38‑9‑110 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑120.** Exchange of deposited securities.

 A depositing insurer may exchange for the deposited securities, or any of them, other securities eligible for deposit under Sections 38‑9‑80 to 38‑9‑140 if, in the opinion of the director or his designee, the aggregate value of the deposit will not be reduced below the amount required by law.

HISTORY: Former 1976 Code Section 38‑9‑120 [1918 (30) 763; 1919 (31) 133; Civ. C. ‘22 Section 5461; 1932 Code Section 9049; 1934 (38) 1493; 1942 Code Section 9049; 1952 Code Section 37‑149.1; 1952 (47) 1893; 1955 (49) 152; 1962 Code Section 37‑149.1; 1973 (58) 335] has no comparable provisions in 1987 Act No. 155; Former 1976 Code Section 38‑5‑720 [1962 Code Section 37‑185.5; 1962 (52) 2148] recodified as Section 38‑9‑120 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑130.** Interest on deposited securities.

 The director or his designee at the time of receiving any bonds or other securities deposited under Sections 38‑9‑80 to 38‑9‑140 shall give to the company authority to collect the interest thereon for its own use. This authority continues in force until the company fails to pay any of its liabilities for which the deposit is security. In case of that failure the party charged with payment of the interest must be notified that thereafter the interest is payable to the director or his designee to be applied, if necessary, to the payment of those liabilities.

HISTORY: Former 1976 Code Section 38‑9‑130 [1935 (39) 287; 1942 Code Section 9051‑2; 1952 Code Section 37‑149.2; 1962 Code Section 37‑149.2; 1967 (55) 184] has no comparable provisions in 1987 Act No. 155; Former 1976 Code Section 38‑5‑730 [1962 Code Section 37‑185.6; 1962 (52) 2148] recodified as Section 38‑9‑130 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑140.** Principal of deposited securities.

 When the principal of any securities deposited under Sections 38‑9‑80 to 38‑9‑140 is paid to the director or his designee, he shall pay the money so received to the company. However, if the securities were required to be deposited under Section 38‑9‑80 the payment may not be made until the company deposits an equal amount of other securities of the character required for similar deposits. If the company fails to deliver to the director or his designee within thirty days after receiving notice of this requirement the securities necessary to maintain its required deposit, he may invest the money in other securities of the required character and hold the same as he held those which were paid.

HISTORY: Former 1976 Code Section 38‑9‑140 [1956 (49) 2028; 1962 Code Section 37‑149.3; 1980 Act No. 477] recodified as Section 38‑55‑80 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑740 [1962 Code Section 37‑185.7; 1962 (52) 2148] recodified as Section 38‑9‑140 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑150.** Return of deposited securities.

 Upon request of a domestic insurer the director or his designee may return to the insurer the whole or any portion of the securities of the insurer held by him on deposit when he is satisfied that the securities asked to be returned are not subject to any liability and are not required to be held any longer by any provision of law or purpose of the original deposit.

 These deposits made by a foreign insurer must be returned by the director or his designee upon the filing with the director or his designee by the trustee or other authorized representative of the insurer a written request and sworn affidavit stating (a) that the insurer has no contracts of insurance in force and no unsatisfied claims outstanding within this State or (b) that reinsurance of all outstanding contracts and acceptance of all unsatisfied claims within this State have been provided by an insurer or insurers authorized to transact the same kinds of business in this State, filing with the affidavit a certified copy of the reinsurance agreement. Release must be made upon the written order of the director or his designee when he is satisfied that the above requirements have been met. The director or his designee is considered the agent of the foreign insurer for acceptance of service of any legal process in any action or proceeding against the insurer for any claim that might arise before or after the return of its deposits. A person making a false affidavit as required in this section is guilty of a felony and, upon conviction, must be imprisoned not more than five years.

HISTORY: Former 1976 Code Section 38‑9‑150 [1947 (45) 322; 1952 Code Section 37‑150; 1962 Code Section 37‑150] recodified as Section 38‑55‑90 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑750 [1947 (45) 322; 1952 Code Section 37‑186; 1960 (51) 1922; 1962 Code Section 37‑186] recodified as Section 38‑9‑150 by 1987 Act No. 155, Section 1; 1993 Act No. 184, Section 65; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑160.** Enforcement of trust created by deposit.

 An insurer which has made a deposit in this State, pursuant to this title, its trustees or resident managers in the United States, the director or his designee, or any creditor of the insurer may, at any time, bring an action in the Circuit Court for the County of Richland against the State and other parties properly joined to enforce, administer, or terminate the trust created by the deposit. The process in the action must be served on the officer of the State having the deposit, who must appear and answer in behalf of the State and perform any orders and judgments the court may make in the action.

HISTORY: Former 1976 Code Section 38‑9‑160 [1947 (45) 322; 1952 Code Section 37‑151; 1962 Code Section 37‑151] recodified as Section 38‑55‑100 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑760 [1947 (45) 322; 1952 Code Section 37‑187; 1962 Code Section 37‑187] recodified as Section 38‑9‑160 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑170.** Unearned premium reserve.

 (A) An insurer authorized to transact business in this State, except as to risks or policies for which reserves are required under subsections (B) and (C) and Section 38‑9‑180 except for real estate title insurance policies, and subject to specific provisions of this title, shall maintain reserves equal to the unearned portions of the gross premiums charged on unexpired or unterminated risks and policies. Credit for reinsurance is allowed a ceding insurer as a deduction from reserves required by this section only as provided in Section 38‑9‑200 or 38‑9‑210.

 (B)(1) With reference to insurance against loss or damage to property except as provided in item (5) and with reference to all general casualty insurance and surety insurance every insurer shall maintain an unearned premium reserve on all policies in force.

 (2) The director or his designee may require that these reserves are equal to the unearned portions of the gross premiums in force as computed on each respective risk from the policy’s date of issue. If the director or his designee does not so require, the portions of the gross premium in force to be held as premium reserve must be computed according to the following table:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Term for WhichPolicy was Written |   | Reserved forUnearned Premium |
| 1 year or less |   |   |   | 1/2 |   |
| 2 years |   |   | 1st year | 3/4 |   |
|   |   |   | 2nd year | 1/4 |   |
| 3 years |   |   | 1st year | 5/6 |   |
|   |   |   | 2nd year | 1/2 |   |
|   |   |   | 3rd year | 1/6 |   |
| 4 years |   |   | 1st year | 7/8 |   |
|   |   |   | 2nd year | 5/8 |   |
|   |   |   | 3rd year | 3/8 |   |
|   |   |   | 4th year | 1/8 |   |
| 5 years |   |   | 1st year | 9/10 |   |
|   |   |   | 2nd year | 7/10 |   |
|   |   |   | 3rd year | 1/2 |   |
|   |   |   | 4th year | 3/10 |   |
|   |   |   | 5th year | 1/10 |   |
| Over 5 years |   |   | pro rata. |   |   |

 (3) All of these reserves may be computed, at the option of the insurer, on a yearly or more frequent pro rata basis.

 (4) After adopting a method for computing the reserve, an insurer may not change methods without the director’s or his designee’s approval.

 (5) With reference to marine insurance, premiums on trip risks not terminated are considered unearned, and the director or his designee may require the insurer to carry a reserve equal to one hundred percent on trip risks written during the month ended as of the date of statement. For all accident and health policies the insurer shall maintain an active life reserve which places a sound value on its liabilities under these policies and which is not less than the reserve according to standards set forth in regulations issued by the director and not less, in the aggregate, than the pro rata gross unearned premium reserves for these policies.

HISTORY: Former 1976 Code Section 38‑9‑170 [1947 (45) 322; 1952 Code Section 37‑152; 1962 Code Section 37‑152] recodified as Section 38‑55‑110 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑770 [1947 (45) 322; 1948 (45) 1734; 1949 (46) 600; 1952 Code Section 37‑188; 1956 (49) 2022; 1958 (50) 1608; 1960 (51) 1554; 1962 Code Section 37‑188; 1964 (53) 1835; 1969 (56) 210; 1975 (59) 182; 1978 Act No. 601; 1979 Act No. 18; 1982 Act No. 373] recodified as Section 38‑9‑170 by 1987 Act No. 155, Section 1; 1991 Act No. 13, Section 9; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑180.** Standard Valuation Law.

 (A) This section is known as the “Standard Valuation Law”.

 (B) For the purposes of this section, the following definitions shall apply on or after the operative date of the valuation manual:

 (1) “Accident and health insurance” means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

 (2) “Appointed actuary” means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in subsection (D)(5).

 (3) “Company” means an entity which:

 (a) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit‑type contracts in this State and has at least one such policy in force or on claim; or

 (b) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit‑type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit‑type contracts in this State.

 (4) “Deposit‑type contract” means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

 (5) “Life insurance” means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

 (6) “NAIC” means the National Association of Insurance Commissioners.

 (7) “Policyholder behavior” means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this section including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

 (8) “Principle‑based valuation” means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with subsection (O) as specified in the valuation manual.

 (9) “Qualified actuary” means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

 (10) “Tail risk” means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

 (11) “Valuation manual” means the manual of valuation instructions adopted by the NAIC as specified in this section or as subsequently amended.

 (C)(1) The director or his designee annually shall value, or cause to be valued, the reserve liabilities, referred to as reserves, for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing business in this State issued prior to the operative date of the valuation manual. However, for an alien insurer the valuation is limited to their United States business. In calculating the reserves he may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required in this section of a foreign or an alien insurer, he may accept any valuation made, or caused to be made, by the insurance supervisory official of a state or another jurisdiction when the valuation complies with the minimum standard provided in this section.

 (2) The provisions set forth in subsections (E) through (M) apply to all policies and contracts, as appropriate, subject to this section issued on or after March 24, 1960, and prior to the operative date of the valuation manual and the provisions set forth in subsections (N) and (O) must not apply to any such policies and contracts.

 (3) The minimum standard for the valuation of policies and contracts issued prior to March 24, 1960, must be that provided by the laws in effect immediately prior to that date.

 (4) The director or his designee annually shall value, or cause to be valued, the reserve liabilities, hereinafter called reserves, for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit‑type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the director or his designee may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this section.

 (5) The provisions set forth in subsections (M), (N), and (O) apply to all policies and contracts issued on or after the operative date of the valuation manual.

 (D)(1) Every life insurance company doing business in this State annually shall submit to the director or his designee the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the director by regulation are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this State. The director by regulation shall define the specifics of this opinion and add other items necessary to its scope.

 (2)(a) Every life insurance company, except as exempted by or pursuant to regulation, also annually must include in the opinion required in item (1) an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the director by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company’s obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

 (b) The director may provide by regulation for a transition period for establishing higher reserves which the qualified actuary considers necessary in order to render the opinion required by this subsection.

 (3) Each opinion required by item (2) is governed by the following provisions:

 (a) A memorandum, in form and substance acceptable to the director or his designee as specified by regulation, must be prepared to support each actuarial opinion.

 (b) If the insurance company fails to provide a supporting memorandum at the request of the director or his designee within a period specified by regulation or the director or his designee determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the director or his designee, the director or his designee may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare supporting memorandum required by the director or his designee.

 (4) Every opinion is governed by the following provisions:

 (a) The opinion must be submitted with the annual statement reflecting the valuation of reserve liabilities for each year ending after December 30, 1993.

 (b) The opinion must apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the director or his designee as specified by regulation.

 (c) The opinion must be based on standards adopted by the Actuarial Standards Board and on additional standards the director by regulation prescribes.

 (d) For an opinion required to be submitted by a foreign or alien company, the director or his designee may accept the opinion filed by that company with the insurance supervisory official of another state if the director or his designee determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State.

 (e) For the purposes of this subsection, “qualified actuary” means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in regulations.

 (f) Except in cases of fraud or wilful misconduct, the qualified actuary must not be liable for damages to a person, other than the insurance company and the director or his designee, for an act, an error, an omission, a decision, or conduct with respect to the actuary’s opinion.

 (g) Disciplinary action by the director or his designee against the company or the qualified actuary must be defined in regulations by the director.

 (h) A memorandum in support of the opinion and related material provided by the company to the director or his designee must be kept confidential by the director or his designee and must not be made public or subject to subpoena, other than for the purpose of defending an action seeking damages from a person by reason of action required by this subsection or by regulations promulgated under it. However, the memorandum or other material may be released by the director or his designee with the written consent of the company or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the director or his designee for preserving the confidentiality of the memorandum or other material. Once a portion of the confidential memorandum is cited by the company in its marketing, is cited before a governmental agency other than a state insurance department, or is released by the company to the news media all portions of the confidential memorandum are no longer confidential.

 (5)(a) Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit‑type contracts in this State and subject to regulation by the director annually shall submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this State. The valuation manual will prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

 (b) Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit‑type contracts in this State and subject to regulation by the director, except as exempted in the valuation manual, annually shall include in the opinion required by item (5)(a), an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company’s obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

 (c) Each opinion required by this item must be governed by the following provisions:

 (i) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the director or his designee, shall be prepared to support each actuarial opinion.

 (ii) If the insurance company fails to provide a supporting memorandum at the request of the director or his designee within a period specified in the valuation manual or the director or his designee determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the director or his designee, the director or his designee may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the director or his designee.

 (d) Every opinion must be governed by the following provisions:

 (i) The opinion must be in form and substance as specified in the valuation manual and acceptable to the director or his designee.

 (ii) The opinion must be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual.

 (iii) The opinion applies to all policies and contracts subject to item (5)(b), plus other actuarial liabilities as may be specified in the valuation manual.

 (iv) The opinion must be based on standards adopted by the Actuarial Standards Board or its successor, and on additional standards as prescribed in the valuation manual.

 (v) In the case of an opinion required to be submitted by a foreign or alien company, the director or his designee may accept the opinion filed by that company with the insurance supervisory official of another State if the director or his designee determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State.

 (vi) Except in cases of fraud or wilful misconduct, the appointed actuary is not liable for damages to a person, other than the insurance company and the director, for an act, error, omission, decision or conduct with respect to the appointed actuary’s opinion.

 (vii) Disciplinary action by the director against the company or the appointed actuary must be defined in regulations by the director.

 (E)(1) Except as otherwise provided in item (3) and subsection (F), the minimum standard for the valuation of policies and contracts issued before March 24, 1960, is that provided by the laws in effect immediately before that date except the minimum standards for the valuation of annuities and pure endowments purchased under group annuity and pure endowment contracts issued before the effective date is that provided for by the laws in effect immediately before that date but replacing the interest rates as specified in the laws by an interest rate of five percent a year.

 (2) Except as otherwise provided in item (3) and subsection (F), the minimum standard for the valuation of policies and contracts issued after March 23, 1960, is the commissioner’s reserve valuation methods defined in subsections (G), (H), and (K), five percent interest for group annuity and pure endowment contracts and three and one‑half percent interest for all other policies and contracts, or for policies and contracts other than annuity and pure endowment contracts issued after May 25, 1975, four percent interest for policies issued before January 1, 1979, five and one‑half percent interest for single premium life insurance policies, and four and one‑half percent interest for all other policies issued after December 31, 1978, and the following tables:

 (a) for ordinary policies of life insurance issued on the standard basis, excluding disability and accidental death benefits in the policies, the Commissioner’s 1941 Standard Ordinary Mortality Table for the policies issued before the operative date stated in Section 38‑63‑650, the Commissioner’s 1958 Standard Ordinary Mortality Table for the policies issued on or after the operative date of Section 38‑63‑590 of the Standard Nonforfeiture Law for Life Insurance, and before the operative date of Section 38‑63‑590 of the Standard Nonforfeiture Law for Life Insurance, if for any category of policies issued on female risks all modified net premiums and present values referred to in this section may be calculated according to an age not more than three years younger than the actual age of the insured; for policies issued before January 1, 1979, and not more than six years younger than the actual age of the insured or policies issued after December 31, 1978, and before the operative date of Section 38‑63‑600; and for policies issued on or after the operative date of Section 38‑63‑600 of the Standard Nonforfeiture Law for Life Insurance the Commissioner’s 1980 Standard Ordinary Mortality Table, at the election of the company for one or more specified plans of life insurance, the Commissioner’s 1980 Standard Ordinary Mortality Table with Ten‑Year Select Mortality Factors, or any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the director for use in determining the minimum standard of valuation for the policies;

 (b) for industrial life insurance policies issued on the standard basis, excluding disability and accidental death benefits in the policies, the 1941 Standard Industrial Mortality Table for policies issued before the operative date stated in Section 38‑63‑650; for all policies issued on or after operative date, the 1941 Standard Industrial Mortality Table or the Commissioner’s 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the director for use in determining the minimum standard of valuation for policies, according to which of these tables is used to calculate adjusted premiums and present values as specified in Section 38‑63‑580;

 (c) for individual annuity and pure endowment contracts, excluding disability and accidental death benefits in the policies, the 1937 Standard Annuity Mortality Table or, at the option of the company, the Annuity Mortality Table for 1949, Ultimate, or a modification of either of these tables approved by the director or his designee;

 (d) for group annuity and pure endowment contracts, excluding disability and accidental death benefits in the policies, the Group Annuity Mortality Table for 1951, a modification of the table approved by the director or his designee or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

 (e) for total and permanent disability benefits in or supplementary to ordinary policies or contracts, for policies or contracts issued after December 31, 1965, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or tables of disablement rates and termination rates, adopted after 1980 by the National Association of Insurance Commissioners, approved by regulation promulgated by the director, for use in determining the minimum standard of valuation for the policies; for policies or contracts issued after December 31, 1960, and before January 1, 1966, either the tables or, at the option of the company, the Class (3) Disability Table (1926) and for policies issued before January 1, 1961, the Class (3) Disability Table (1926) or other table approved by the director or his designee. The table, for active lives, must be combined with a mortality table permitted for calculating the reserves for life insurance policies;

 (f) for accidental death benefits in or supplementary to policies, for policies issued after December 31, 1965, the 1959 Accidental Death Benefits Table, or any accidental death benefits table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the director for use in determining the minimum standard of valuation for the policies; for policies issued after December 31, 1960, and before January 1, 1966, either the table or, at the option of the company, the Inter‑Company Double Indemnity Mortality Table; and for policies issued before January 1, 1961, the Inter‑Company Double Indemnity Mortality Table, or other table approved by the director or his designee. The table must be combined with a mortality table permitted for calculating the reserves for life insurance policies;

 (g) for extra benefits provided in life or endowment contracts or policies under which there is payable a series of coupons or guaranteed dividends or a series of constant or variable pure endowments maturing either during the term of the contract and the continuation of the life of the insured or maturing as a series after the death of the insured, the table or basis of reserves approved by the director or his designee;

 (h) for group life insurance, life insurance issued on the substandard basis and other special benefits, the tables approved by the director or his designee;

 (3) Except as provided in subsection (F), the minimum standard for the valuation for individual annuity and pure endowment contracts issued on or after the operative date of this item, as defined in this section, and for all annuities and pure endowments purchased on or after the operative date under group annuity and pure endowment contracts, is the commissioner’s reserve valuation methods defined in subsections (G) and (H) and the following tables and interest rates:

 (a) for individual annuity and pure endowment contracts issued before January 1, 1979, excluding disability and accidental death benefits in the contracts, the 1971 Individual Annuity Mortality Table, or a modification of this table approved by the director or his designee, and six percent interest for single premium immediate annuity contracts, and four percent interest for all other individual annuity and pure endowment contracts;

 (b) for individual single premium immediate annuity contracts issued after December 31, 1978, excluding disability and accidental death benefits in the contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the director for use in determining the minimum standard of valuation for the contracts, or a modification of these tables approved by the director or his designee, and seven and one‑half percent interest;

 (c) for individual annuity and pure endowment contracts issued after December 31, 1978, other than single premium immediate annuity contracts, excluding disability and accidental death benefits in the contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the director for use in determining the minimum standard of valuation for the contracts, or a modification of these tables approved by the director or his designee, and five and one‑half percent interest for single premium deferred annuity and pure endowment contracts and four and one‑half percent interest for all other individual annuity and pure endowment contracts;

 (d) for annuities and pure endowments purchased before January 1, 1979, under group annuity and pure endowment contracts, excluding disability and accidental death benefits purchased under the contracts, the 1971 Group Annuity Mortality Table, or a modification of this table approved by the director or his designee, and six percent interest;

 (e) for annuities and pure endowments purchased after December 31, 1978, under group annuity and pure endowment contracts, excluding disability and accidental death benefits purchased under the contracts, the 1971 Group Annuity Mortality Table or a group annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the director for use in determining the minimum standard of valuation for the annuities and pure endowments, or a modification of these tables approved by the director or his designee, and seven and one‑half percent interest.

 After May 26, 1975, an insurer may file with the director or his designee a written notice of its election to comply with this item after a specified date before January 1, 1979, which is the operative date of this item for the insurer. However, an insurer may elect a different effective date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no election, the effective date of this item for the insurer is January 1, 1979.

 (F)(1) The calendar year statutory valuation interest rates as defined in this subsection must be used in determining the minimum standard for the valuation of:

 (a) life insurance policies issued in a particular calendar year, on or after the operative date of Section 38‑63‑600 of the Standard Nonforfeiture Law for Life Insurance;

 (b) individual annuity and pure endowment contracts issued in a particular calendar year after December 31, 1982;

 (c) annuities and pure endowments purchased in a particular calendar year after December 31, 1982, under group annuity and pure endowment contracts;

 (d) the net increase, if any, in a particular calendar year after January 1, 1983, in amounts held under guaranteed interest contracts.

 (2) The calendar year statutory valuation interest rates, I, must be determined as follows and the results rounded to the nearer one‑quarter of one percent:

 (a) for life insurance,

 I = .03 + W (R(1) ‑ .03) + W\* (1/2) \* (R(2) ‑ .09);

 (b) for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

 I = .03 + W (R ‑ .03),

 where R(1) is the lesser of R and .09, R(2) is the greater of R and .09, R is the reference interest rate defined in this subsection, and W is the weighting factor defined in this subsection;

 (c) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subitem (b), the formula for life insurance stated in subitem (a) applies to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in subitem (b) applies to annuities and guaranteed interest contracts with guarantee duration of ten years or less;

 (d) for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subitem (b) applies;

 (e) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subitem (b) applies.

 However, if the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one‑half of one percent, the calendar year statutory valuation interest rate for the life insurance policies must be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year must be determined for 1980, using the reference interest rate defined for 1979, and must be determined for each subsequent calendar year regardless of when Section 38‑63‑600 of the Standard Nonforfeiture Law for Life Insurance becomes operative.

 (3) The weighting factors referred to in the formulas stated in this subsection are given in the following tables:

 (a) weighting Factors for Life Insurance:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|   | Guarantee Duration |   | Weighting |   |
|   | Years |   |   |   |
|   | 10 or Less: |   | .50 |   |
|   | More than 10, but not |   |   |   |
|   | more than 20 |   | .45 |   |
|   | More than 20 |   | .35 |   |

 For life insurance, the guarantee duration is the maximum number of years the life insurance may remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

 (b) weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|   |   |   | Weighting Factors |   |
|   |   |   | .80 |   |

 (c) weighting factors for other annuities and for guaranteed interest contracts, except as stated in subitem (b) of this item are as specified subsubitems (i), (ii), and (iii) according to the rules and definitions in subsubitems (iv), (v), and (vi):

 (i) for annuities and guaranteed interest contracts valued on an issue year basis:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|   | Guarantee Duration |   | Weighting |   |
|   | (Years) |   | for Plan Type |   |
|   |   |   | A | B | C |   |
|   | 5 or less |   | .80 | .60 | .50 |   |
|   | More than five, but not more than 10: |   | .75 | .60 | .50 |   |
|   | More than 10, but not more than 20: |   | .65 | .50 | .45 |   |
|   | More than 20: |   | .45 | .35 | .35 |   |

 (ii) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in subsubitem (i) of this subitem increased by:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|   |   |   | Plan Type |   |
|   |   |   | A | B | C |   |
|   |   |   | .15 | .25 | .05 |   |

 (iii) for annuities and guaranteed interest contracts valued on an issue year basis other than those with no cash settlement options, which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in subsubitem (i) of this subitem or derived in subsubitem (ii) increased by:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|   |   |   | Plan Type |   |
|   |   |   | A | B | C |   |
|   |   |   | .05 | .05 | .05 |   |

 (iv) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

 (d) Plan type as used in the above tables is defined as:

 (i) Plan Type A:

 At any time policyholder may withdraw funds only:

 a. with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer;

 b. without the adjustment but in installments over five years or more;

 c. as an immediate life annuity; or

 d. no withdrawal permitted;

 (ii) Plan Type B:

 Before expiration of the interest rate guarantee, policyholder may withdraw funds only:

 a. with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer;

 b. without the adjustment but in installments over five years or more; or

 c. no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without the adjustment in a single sum or installments over less than five years;

 (iii) Plan Type C:

 Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either:

 a. without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or

 b. subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

 An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this subsection an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

 (4) The Reference Interest Rate referred to in item (2) of this subsection is defined as:

 (a) for life insurance, the lesser of the average over a period of thirty‑six months and the average over a period of twelve months, ending on June thirtieth of the calendar year next preceding the year of issue, of Moody’s Corporate Bond Yield Average—Monthly Average Corporates, as published by Moody’s Investors Service, Inc.;

 (b) for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over twelve months, ending on June thirtieth of the calendar year of issue or year of purchase, of Moody’s Corporate Bond Yield Average—Monthly Average Corporates, as published by Moody’s Investors Service, Inc.;

 (c) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subitem (b) with guarantee duration in excess of ten years, the lesser of the average over thirty‑six months and the average over twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody’s Corporate Bond Yield Average—Monthly Average Corporates, as published by Moody’s Investors Service, Inc.;

 (d) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subitem (b), with guarantee duration of ten years or less, the average over twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody’s Corporate Bond Yield Average—Monthly Average Corporates, as published by Moody’s Investors Service, Inc.;

 (e) for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody’s Corporate Bond Yield Average—Monthly Average Corporates, as published by Moody’s Investors Service, Inc.;

 (f) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in subitem (b), the average over twelve months, ending on June thirtieth of the calendar year of the change in the fund, of Moody’s Corporate Bond Yield Average—Monthly Average Corporates, as published by Moody’s Investors Service, Inc.;

 (5) If Moody’s Corporate Bond Yield Average—Monthly Average Corporates is no longer published by Moody’s Investors Service, Inc., or if the National Association of Insurance Commissioners determines that Moody’s Corporate Bond Yield Average—Monthly Average Corporates as published by Moody’s Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by regulation promulgated by the director, may be substituted.

 (G) Except as otherwise provided in subsections (H) and (K), reserves according to the commissioner’s reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, are the excess, if any, of the present value, at the date of valuation, of future guaranteed benefits provided for by the policies, over the then present value of future modified net premiums. The modified net premiums for the policy are the uniform percentage of the respective contract premiums for the benefits that the present value, at the date of issue of the policy, of the modified net premiums is equal to the sum of the then present value of the benefits provided for by the policy and the excess of item (1) over item (2), as follows:

 (1) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium may not exceed the net level annual premium on the nineteen year premium whole life plan for insurance of the same amount at an age one year higher than the age of issue of the policy.

 (2) A net one year term premium for the benefits provided for in the first policy year. For a life insurance policy issued after December 31, 1985, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination of them in an amount greater than the excess premium, the reserve according to the director’s or his designee’s reserve valuation method as of a policy anniversary occurring on or before the assumed ending date defined in this section as the first policy anniversary on which the sum of an endowment benefit and cash surrender value then available is greater than the excess premium, except as otherwise provided in subsection (K), is the greater of the reserve as of the policy anniversary calculated as described in the preceding paragraph and the reserve as of the policy anniversary calculated as described in that paragraph, but with the value defined in item (1) being reduced by fifteen percent of the amount of the excess first year premium, all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, the policy being assumed to mature on the date as an endowment, and the cash surrender value provided on the date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in subsection (E)(1) and (F) shall be used.

 Reserves according to the commissioner’s reserve valuation method for: life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums, group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer including a partnership or sole proprietorship or by an employee organization, or both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as amended, disability and accidental death benefits in all policies and contracts, and all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, must be calculated by a method consistent with the principles of subsection (F), except extra premiums charged because of impairments or special hazards must be disregarded in the determination of modified net premiums.

 (H) This subsection applies to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer including a partnership or sole proprietorship, or by an employee organization, or both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as amended. Reserves according to the commissioner’s annuity reserve method for benefits under annuity or pure endowment contracts, excluding disability and accidental death benefits in the contracts, is the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by the contracts at the end of each respective contract year, over the present value, at the date of valuation, of future valuation considerations derived from future gross considerations, required by the terms of the contract, that become payable before the end of the respective contract year. The future guaranteed benefits must be determined by using the mortality table, if any, and the interest rate, or rates, specified in the contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

 (I)(1) An insurer’s aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued after March 23, 1960, must not be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (G), (H), (K), and (L) and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for the policies.

 (2) The aggregate reserves for all policies, contracts, and benefits must not be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by subsection (D).

 (J) Reserves for policies and contracts issued before March 24, 1960, may be calculated, at the option of the insurer, according to the standards which produce greater aggregate reserves for all the policies and contracts than the minimum reserves required by the laws in effect immediately before the date. Reserves for a category of policies, contracts, or benefits established by the director or his designee, after March 23, 1960, may be calculated, at the option of the insurer, according to the standards which produce greater aggregate reserves for the category than those calculated according to the minimum standard provided in this section, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, must not be greater than the corresponding rate or rates of interest used in calculating nonforfeiture benefits. An insurer which adopts a standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this section, with the approval of the director or his designee, may adopt a lower standard of valuation, but not lower than the minimum provided in this section. However, for purposes of this subsection, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required by subsection (D) must not be deemed to be the adoption of a higher standard of valuation.

 (K) If in a contract year the gross premium charged by a company on a policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract is the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or contract, or the reserve calculated by the method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this subsection are those standards stated in subsections (E)(1) and (F). For a life insurance policy issued after December 31, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination of them in an amount greater than the excess premium, this subsection must be applied as if the method actually used in calculating the reserve for the policy were the method described in subsection (G), ignoring the second paragraph of subsection (G). The minimum reserve at each policy anniversary of the policy is the greater of the minimum reserve calculated in accordance with subsection (G), including the second paragraph of that subsection, and the minimum reserve calculated in accordance with this subsection.

 (L) For a plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or for a plan of life insurance or annuity which is of a nature so that the minimum reserves cannot be determined by the methods described in subsections (G), (H), and (K), the reserves which are held under the plan must be:

 (1) appropriate in relation to the benefits and the pattern of premiums for that plan;

 (2) computed by a method which is consistent with the principles of this Standard Valuation Law, as determined by regulations promulgated by the director.

 (M) For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (C)(2).

 (N)(1) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (C)(2), except as provided under items (5) or (7).

 (2) The operative date of the valuation manual is January first of the first calendar year following July first as of which all of the following have occurred:

 (a) The valuation manual has been adopted by the NAIC by an affirmative vote of at least forty‑two members, or three‑fourths of the members voting, whichever is greater.

 (b) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy‑five percent of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

 (c) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty‑two of the following fifty‑five jurisdictions: the fifty states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

 (3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January first following the date when the change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

 (a) at least three‑fourths of the members of the NAIC voting, but not less than a majority of the total membership; and

 (b) members of the NAIC representing jurisdictions totaling greater than seventy‑five percent of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subitem (a): life, accident and health annual statements, health annual statements, or fraternal annual statements.

 (4) The valuation manual must specify all of the following:

 (a) minimum valuation standards for and definitions of the policies or contracts subject to subsection (C)(2). These minimum valuation standards must be:

 (i) the commissioner’s reserve valuation method for life insurance contracts, other than annuity contracts, subject to subsection (C)(2);

 (ii) the commissioner’s annuity reserve valuation method for annuity contracts subject to subsection (C)(2); and

 (iii) minimum reserves for all other policies or contracts subject to subsection (C)(2);

 (b) the policies or contracts or types of policies or contracts that are subject to the requirements of a principle‑based valuation in subsection (O)(1) and the minimum valuation standards consistent with those requirements;

 (c) for policies and contracts subject to a principle‑based valuation under subsection (O):

 (i) requirements for the format of reports to the director under subsection (O)(2)(c) and which must include information necessary to determine if the valuation is appropriate and in compliance with this section;

 (ii) assumptions must be prescribed for risks over which the company does not have significant control or influence;

 (iii) procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of the procedures;

 (d) for policies not subject to a principle‑based valuation under subsection (O), the minimum valuation standard must either:

 (i) be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

 (ii) develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring;

 (e) other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls; and

 (f) the data and form of the data required under subsection (O), with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

 (5) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the director or his designee, in compliance with this section, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the director by regulation.

 (6) The director or his designee may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company’s compliance with any requirement set forth in this section. The director or his designee may rely upon the opinion, regarding provisions contained within this section, of a qualified actuary engaged by the commissioner of another state, district, or territory of the United States. As used in this item, the term “engage” includes employment and contracting.

 (7) The director or his designee may require a company to change any assumption or method that, in the opinion of the director or his designee, is necessary in order to comply with the requirements of the valuation manual or this section; and the company shall adjust the reserves as required by the director or his designee. The director or his designee may take other disciplinary action as permitted pursuant to Sections 38‑2‑10 and 38‑5‑120.

 (O)(1) A company must establish reserves using a principle‑based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

 (a) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For polices or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk.

 (b) Incorporate assumptions, risk analysis methods and financial models, and management techniques that are consistent with, but not necessarily identical to, those utilized within the company’s overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

 (c) Incorporate assumptions that are prescribed in the valuation manual or for assumptions that are not prescribed, the assumptions must be established using the company’s available experience, to the extent it is relevant and statistically credible; or to the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

 (d) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty, the larger the margin and resulting reserve.

 (2) A company using a principle‑based valuation for one or more policies or contracts subject to this section as specified in the valuation manual shall:

 (a) establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

 (b) provide to the director and the company’s board of directors an annual certification of the effectiveness of the internal controls with respect to the principle‑based valuation. These controls must be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification must be based on the controls in place as of the end of the preceding calendar year; and

 (c) develop, and file with the director or his designee upon request, a principle‑based valuation report that complies with standards prescribed in the valuation manual.

 (3) A principle‑based valuation may include a prescribed formulaic reserve component.

 (P) A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

 (Q)(1) For purposes of this subsection, “confidential information” means:

 (a) a memorandum in support of an opinion submitted pursuant to subsection (D) and any other documents, materials, and other information, including, but not limited to, all working papers, and copies created, produced or obtained by, or disclosed to the director or any other person in connection with the memorandum;

 (b) all documents, materials, and other information, including, but not limited to, all working papers, and copies, created, produced or obtained by, or disclosed to the director or any other person in the course of an examination made pursuant to subsection (N)(6); provided, however, that if an examination report or other material prepared in connection with an examination made under Section 38‑13‑20 is not held as private and confidential information under Section 38‑13‑10, et seq., an examination report or other material prepared in connection with an examination made under subsection (N)(6) is not “confidential information” to the same extent as if such examination report or other material had been prepared under Section 38‑13‑10, et seq.;

 (c) any reports, documents, materials, and other information developed by a company in support of, or in connection with, an annual certification by the company pursuant to subsection (O)(2)(b) evaluating the effectiveness of the company’s internal controls with respect to a principle‑based valuation and any other documents, materials, and other information, including, but not limited to, all working papers, and copies, created, produced or obtained by, or disclosed to the director or any other person in connection with such reports, documents, materials, and other information;

 (d) any principle‑based valuation report developed under subsection (O)(2)(c) of this section and any other documents, materials, and other information, including, but not limited to, all working papers, and copies of them, created, produced or obtained by, or disclosed to the director or any other person in connection with the report; and

 (e) any documents, materials, data and other information submitted by a company pursuant to subsection (P), collectively, “experience data”, and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies created or produced in connection with the experience data, in each case that includes any potentially company‑identifying or personally identifiable information, that is provided to or obtained by the director or his designee, together with any “experience data”, “experience materials”, and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies, created, produced, or obtained by, or disclosed to the director or any other person in connection with such experience materials.

 (2)(a) Except as provided in this subsection, a company’s confidential information is confidential by law and privileged, is not subject to disclosure pursuant to the Freedom of Information Act, and is not subject to subpoena or discovery or admissible in evidence in any private civil action; provided, however, that the director or his designee is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the director’s or his designee’s official duties.

 (b) Neither the director nor any person who received confidential information while acting under the authority of the director is permitted or required to testify in any private civil action concerning any confidential information.

 (c) In order to assist in the performance of the director’s or his designee’s duties, the director or his designee may share confidential information with other state, federal, and international regulatory agencies and with the NAIC and its affiliates and subsidiaries, and in the case of confidential information specified in item (1)(a) and (d) only, with the Actuarial Board for Counseling and Discipline, or its successor, upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal, and international law enforcement officials, provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data and other information in the same manner and to the same extent as required for the director or his designee.

 (d) The director or his designee may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information.

 (e) The director or his designee may enter into agreements governing sharing and use of information consistent with item (2).

 (f) No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the director or his designee under this section or as a result of sharing as authorized in item (2)(c).

 (g) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this item (2) must be available and enforced in any proceeding in, and in any court of, this State.

 (h) As used in this subsection, “regulatory agency”, “law enforcement agency” and the “NAIC” include, but are not limited to, their employees, agents, consultants and contractors.

 (3) Notwithstanding item (2), any confidential information specified in item (1)(a) and (d):

 (a) may be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under subsection (D) or principle‑based valuation report developed under subsection (O)(2)(c) by reason of an action required by this section or by regulations promulgated under this section;

 (b) may otherwise be released by the director with the written consent of the company; and

 (c) once any portion of a memorandum in support of an opinion submitted under subsection (D) or a principle‑based valuation report developed under subsection (O)(2)(c) is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of the memorandum or report must no longer be confidential.

 (R)(1) The director may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in this State from the requirements of subsection (N) provided:

 (a) the director has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

 (b) the company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the director and promulgated by regulation.

 (2) For any company granted an exemption under this section, subsections (D) through (M) are applicable. With respect to any company applying this exemption, any reference to subsection (N) found in subsections (D) through (M) is not applicable.

 (S)(1) A company that has less than three hundred million dollars of ordinary life premium and that is licensed and doing business in this State and that is subject to the requirements of subsections (N) and (O), may hold reserves based on the mortality tables and interest rates defined by the valuation manual for net premium reserves as defined by the valuation manual and using the methodology defined in subsections (G), (I), (J), (K), and (L) as they apply to ordinary life insurance in lieu of the reserves required by subsections (N) and (O), provided that:

 (a) if the company is a member of a group of life insurers, the group has combined ordinary life premiums of less than six hundred million dollars;

 (b) the company reported total adjusted capital of at least four hundred and fifty percent of authorized control level risk‑based capital in the risk‑based capital report for the prior calendar year;

 (c) the appointed actuary has provided an unqualified opinion on the reserves in accordance with subsection (D) for the prior calendar year; and

 (d) the company has provided a certification by a qualified actuary that any universal life policy with a secondary guarantee issued after the operative date of the valuation manual meets the definition of a nonmaterial secondary guarantee universal life product as defined in the valuation manual.

 (2) For purposes of item (1), ordinary life premiums are measured as direct premium plus reinsurance assumed from an unaffiliated company, as reported in the prior calendar year annual statement.

 (3) A domestic company meeting the requirement of items (1) and (2) may file a statement prior to July first with the director or his designee certifying that these conditions are met for the current calendar year based on premiums and other values from the prior calendar year financial statements. The director or his designee may reject the statement before September first and require a company to comply with the valuation manual requirements for life insurance reserves.

HISTORY: Former 1976 Code Section 38‑9‑180 [1947 (45) 322; 1952 Code Section 37‑153; 1962 Code Section 37‑153] recodified as Section 38‑55‑30 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑770 [1947 (45) 322; 1948 (45) 1734; 1949 (46) 600; 1952 Code Section 37‑188; 1956 (49) 2022; 1958 (50) 1608; 1960 (51) 1554; 1962 Code Section 37‑188; 1964 (53) 1835; 1969 (56) 210; 1975 (59) 182; 1978 Act No. 601; 1979 Act No. 18; 1982 Act No. 373] recodified as Section 38‑9‑180 by 1987 Act No. 155, Section 1; 1987 Act No. 155, Section 1; 1992 Act No. 281, Section 1; 1993 Act No. 181, Section 535; 2016 Act No. 148 (S.850), Section 1, eff April 21, 2016.

Effect of Amendment

2016 Act No. 148, Section 1, rewrote the section, adding (B), and (M) through (S); redesignating former (A) as (C), former (B) through (J) as (D) through (L), and former (K) as (A); and amended (C) though (L).

**SECTION 38‑9‑190.** Loss and claim reserves.

 A company authorized to transact insurance in this State shall maintain reserves in an amount estimated in the aggregate as being sufficient to provide for the payment of all losses or claims arising by the date of an annual or other statement, whether reported or unreported, which are unpaid as of that date and for which the insurer may be liable and also reserves in an amount estimated to provide for the expenses of adjustment or settlement of these claims.

 The reserves for unpaid losses and loss expenses under policies of personal injury liability insurance, employer’s liability insurance, and workers’ compensation insurance must be calculated in accordance with regulations the department prescribes. A company authorized to write these kinds of insurance shall file with its annual statement schedules of its experience in the form the director or designee requires.

 Credit for reinsurance is allowed a ceding insurer as an asset or a deduction from reserves required by this section only as provided in Section 38‑9‑200 or 38‑9‑210.

HISTORY: Former 1976 Code Section 38‑9‑190 [1947 (45) 322; 1948 (45) 1734; 1952 Code Section 37‑154; 1962 Code Section 37‑154] recodified as Section 38‑75‑20 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑780 [1947 (45) 322; 1948 (45) 1734; 1949 (46) 600; 1952 Code Section 37‑189; 1956 (49) 2021; 1958 (50) 1608; 1962 Code Section 37‑189; 1971 (57) 310] recodified as Section 38‑9‑190 by 1987 Act No. 155, Section 1; 1991 Act No. 13, Section 10; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑200.** Reinsurance credits; liability reductions.

 (A) Credit for reinsurance shall be allowed a domestic ceding insurer as an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection (B), (C), (D), (E), or (F). Credit only shall be allowed under subsection (B), (C), or (D) of this section as respects cessions of those kinds or classes of business which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. If meeting the requirements of subsection (D) or (E), the requirements of subsection (G) also shall be met.

 (B) Credit must be allowed when the reinsurance is ceded to an assuming insurer which is licensed to transact insurance or reinsurance in this State, approved as a reinsurer by the director or designee provided by Section 38‑5‑60, or licensed as a captive reinsurance company pursuant to Chapter 90 of this title. It is not the intent of this provision to allow an insurer domiciled outside this State to take credit for reinsurance in its financial statements based on the domestic license, authorization, accreditation, or “substantially similar” status of the captive reinsurance company.

 (C) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer in this State. An accredited reinsurer is one which:

 (1) files with the director or designee evidence of its submission to this state’s jurisdiction;

 (2) submits to this state’s authority to examine its books and records;

 (3) is licensed to transact insurance or reinsurance in at least one state or, for a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance, in at least one state;

 (4) pays an initial submission fee of four hundred dollars and annually pays a four hundred dollar fee by March first;

 (5) files annually with the director or designee a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and:

 (a) maintains a surplus as regards policyholders of not less than twenty million dollars and whose accreditation has not been denied by the director or designee within ninety days of its submission; or

 (b) maintains a surplus as regards policyholders of less than twenty million dollars and whose accreditation has been approved by the director or designee. The accreditation of an assuming insurer with a surplus as regards policyholders of less than twenty million dollars which is licensed in its state of domicile (or, in the case of an alien assuming insurer, in the state through which it is entered and in which it is licensed) to write life, health, annuity insurance, or any combination of those kinds of insurance, shall be approved by the director, and if the assuming insurer, among other criteria:

 (i) maintains a surplus as regards policyholders in an amount in excess of the amounts required by Section 38‑9‑10 and Section 38‑9‑20;

 (ii) maintains total adjusted capital of not less than four times the risk‑based capital authorized control level (determined as of its last filed annual statement); and

 (iii) satisfies the standard for exemption from asset adequacy analysis contained in South Carolina Regulation 69‑52.

No credit is allowed a domestic ceding insurer if the assuming insurer’s accreditation has been revoked by the director or designee after notice and hearing.

 (D)(1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled in, or in the case of a U.S. branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or U.S. branch of an alien assuming insurer:

 (a) maintains a surplus as regards policyholders in an amount not less than twenty million dollars; and

 (b) submits to the authority of this State to examine its books and records.

 (2) The requirement of Section (D)(1)(a) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

 (E)(1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, defined in Section 38‑9‑220(B), for the payment of the valid claims of its United States ceding insurers and their assigns and successors in interest. To enable the director to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the director or his designee information substantially the same as that required to be reported on the National Association of Insurance Commissioners annual statement form by licensed insurers. The assuming insurer shall submit to examination of its books and records by the director and bear the expense of examination.

 (2)(a) Credit for reinsurance shall not be granted under this subsection (E) unless the form of the trust and any amendments to the trust have been approved by:

 (i) the insurance commissioner of the state where the trust is domiciled; or

 (ii) the insurance commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

 (b) The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of a court of competent jurisdiction in the United States. The trust must vest legal title to assets in the trustees of the trust for the benefit of the assuming insurers’ United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the director or his designee.

 (c) The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February twenty‑eighth of each year the trustees of the trust shall report to the director or designee in writing setting forth the balance of the trust and listing the trust’s investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust may not expire before the next following December thirty‑first.

 (3) The following requirements apply to the following categories of assuming insurers:

 (a) The trust fund for a single assuming insurer consists of funds in trust in an amount not less than the assuming insurer’s liabilities attributable to reinsurance ceded by United States ceding insurers, and in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars.

 (b)(i) In the case of a group including incorporated and individual unincorporated underwriters:

 (A) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after August 1, 1995, the trust consists of a trusteed account in an amount not less than the group’s several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group;

 (B) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of this section, the trust consists of a trusteed account in an amount not less than the group’s several insurance and reinsurance liabilities attributable to business written in the United States; and

 (C) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which one hundred million dollars is held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account; and

 (ii) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group’s domiciliary regulator as are the unincorporated members.

 (iii) The group, within ninety days after its financial statements are due to be filed with the group’s domiciliary regulator, shall provide to the director an annual certification by the group’s domiciliary regulator of the solvency of each underwriter member or if a certification is unavailable, financial statements prepared by independent public accountants of each underwriter member of the group.

 (c) In the case of a group of incorporated underwriters under common administration, the group shall:

 (i) have continuously transacted an insurance business outside the United States for at least three years immediately before making application for accreditation;

 (ii) maintain aggregate policyholders’ surplus of at least ten billion dollars;

 (iii) maintain a trust fund in an amount not less than the group’s several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

 (iv) in addition, maintain a joint trusteed surplus of which one hundred million dollars must be held jointly for the benefit of United States domiciled ceding insurers of any member of the group as additional security for these liabilities; and

 (v) within ninety days after its financial statements are due to be filed with the group’s domiciliary regulator, make available to the director an annual certification of each underwriter member’s solvency by the member’s domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

 (F) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection (B), (C), (D), or (E) but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

 (G) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this State, the credit permitted by subsections (D) and (E) shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

 (1) that when the assuming insurer fails to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of a court of competent jurisdiction in a state of the United States, comply with all requirements necessary to give the court jurisdiction, and abide by the final decision of the court or of an appellate court in an appeal;

 (2) to designate the director or designee or a designated attorney as its true and lawful attorney upon whom may be served lawful process in an action, a suit, or a proceeding instituted by or on behalf of the ceding company. This subsection does not conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes if an obligation is created in the agreement.

 (H) If the assuming insurer does not meet the requirements of subsection (B), (C), or (D), the credit permitted by subsection (E) shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

 (1) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by subsection (E)(3), or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

 (2) The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

 (3) If the commissioner with regulatory oversight determines that the assets of the trust fund or any part of them are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part of them shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

 (4) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this provision.

 (I) The director may promulgate regulations to implement the provisions of this section and Section 38‑9‑210.

HISTORY: 1991 Act No. 13, Section 1; 1993 Act No. 181, Section 535; 1994 Act No. 370, Section 1; 1998 Act No. 422, Section 2; 2001 Act No. 58, Section 17, eff May 29, 2001.

**SECTION 38‑9‑210.** Reduction from liability for reinsurance; security.

 An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 38‑9‑200 must be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations, if the security is held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer or, for a trust, held in a qualified United States financial institution, defined in Section 38‑9‑220(B). This security may be in the form of:

 (1) cash;

 (2) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners that qualify as admitted assets on the most recent statutory financial statement filed by the insurer with the department pursuant to Section 38‑13‑80.

 (3) clean, irrevocable, unconditional letters of credit issued or confirmed by a qualified United States financial institution defined in Section 38‑9‑220(A) no later than December thirty‑first of the year for which filing is being made and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation, notwithstanding the issuing or confirming institution’s subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs; or

 (4) other form of security acceptable to the director or designee.

HISTORY: 1991 Act No. 13, Section 1; 1993 Act No. 181, Section 535; 1998 Act No. 422, Section 3; 2012 Act No. 137, Section 4, eff April 2, 2012.

**SECTION 38‑9‑220.** “Qualified United States financial institution” defined.

 (A) For purposes of Section 38‑9‑210, a “qualified United States financial institution” means an institution that:

 (1) is organized or, for a United States office of a foreign banking organization, licensed under the laws of the United States or its state;

 (2) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies;

 (3) has been determined by the director or designee or the Securities Valuation Office of the National Association of Insurance Commissioners to meet standards of financial condition and standing necessary and appropriate to regulate the quality of financial institutions whose letters of credit are acceptable to the director or designee.

 (B) For purposes of those provisions of this law specifying those institutions that are eligible to act as a fiduciary of a trust, a “qualified United States financial institution” means an institution that is:

 (1) organized or, for a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or its state and has been granted authority to operate with fiduciary powers;

 (2) regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

HISTORY: 1991 Act No. 13, Section 1; 1993 Act No. 181, Section 535.

**SECTION 38‑9‑225.** Submission of Statements of Actuarial opinion; Actuarial Opinion Summaries and supporting papers.; liability of Appointed Actuary.

 (A) Each property and casualty insurance company doing business in this State, unless otherwise exempted by the director or his designee, shall submit annually the opinion of an actuary entitled “Statement of Actuarial Opinion”. This opinion must be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions.

 (B)(1) Each property and casualty insurance company domiciled in this State that is required to submit a statement of Actuarial Opinion shall submit annually an Actuarial Opinion Summary, written by the company’s Appointed Actuary. This Actuarial Opinion Summary must be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and must be considered as a document supporting the Actuarial Opinion required in subsection (A).

 (2) A company licensed but not domiciled in this State shall provide the Actuarial Opinion Summary upon request.

 (C)(1) An Actuarial Report and underlying workpapers as required by the appropriate NAIC Property and Casualty Annual Statement Instructions must be prepared to support each Actuarial Opinion.

 (2) If the insurance company fails to provide a supporting Actuarial Report or workpapers, or both, at the request of the director or his designee or the director or his designee determines that the supporting Actuarial Report or workpapers provided by the insurer is otherwise unacceptable to the director or his designee, the director or his designee may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare the supporting Actuarial Report or workpapers, or both.

 (D) The Appointed Actuary is not liable for damages to a person, other than the insurer and the director or his designee, for any act, error, omission, decision, or conduct with respect to the actuary’s opinion, except in cases of fraud or wilful misconduct on the part of the Appointed Actuary.

HISTORY: 2009 Act No. 27, Section 1, eff June 2, 2009.

**SECTION 38‑9‑230.** Confidentiality.

 (A) The Statement of Actuarial Opinion must be provided with the Annual Statement in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and must be treated as a public document.

 (B)(1) Documents, materials, or other information in the possession or control of the department that are considered an Actuarial Report, workpapers, or Actuarial Opinion Summary provided in support of the opinion, and any other material provided by the company to the director or his designee in connection with the Actuarial Report, workpapers, or Actuarial Opinion Summary, are confidential by law and privileged, are exempt from disclosure under applicable law, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action.

 (2) This provision may not be construed to limit the director or his designee’s authority to release the documents to the Actuarial Board for Counseling and Discipline so long as the material is required for the purpose of professional disciplinary proceedings and that the Actuarial Board for Counseling and Discipline establishes procedures satisfactory to the director or his designee for preserving the confidentiality of the documents, nor may this section be construed to limit the director or his designee’s authority to use the documents, materials, or other information in furtherance of a regulatory or legal action brought as part of the director or his designee’s official duties.

 (C) Neither the director nor a person who received documents, materials, or other information while acting under the authority of the director is permitted or required to testify in a private civil action concerning confidential documents, materials, or information subject to subsection (B).

 (D) In order to assist in the performance of the director’s duties, the director may:

 (1) share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (B) with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information and has the legal authority to maintain confidentiality;

 (2) receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

 (3) enter into agreements governing sharing and use of information consistent with subsections (B), (C), and (D).

 (E) A waiver of an applicable privilege or a claim of confidentiality in the documents, materials, or information shall not occur as a result of disclosure to the director under this section or as a result of sharing as authorized in subsection (D).

HISTORY: 2009 Act No. 27, Section 1, eff June 2, 2009.

ARTICLE 3

Risk‑Based Capital

Editor’s Note

2014 Act No. 164, Section 15, effective January 1, 2015, provides as follows:

“SECTION 15. (A) Article 3, Chapter 9, Title 38, designated ‘Risk Based Capital’ is redesignated ‘Risk‑Based Capital’.

“(B) Sections 38‑9‑400, 38‑9‑410, 38‑9‑420, 38‑9‑430, 38‑9‑440, 38‑9‑450, and 38‑9‑460 of the 1976 Code, which are designated as Article 5, Chapter 9, Title 38, are redesignated as part of Article 3, Chapter 9, Title 38, and Article 5, Chapter 9, Title 38 is deleted.”

**SECTION 38‑9‑310.** Definitions.

 In this article, unless the context requires otherwise:

 (1) “Adjusted RBC Report” means a risk based capital report which has been adjusted by the director in accordance with Section 38‑9‑320(F).

 (2) “Capital and surplus” or “capital” except when used in the term “risk‑based capital” or “adjusted capital”, means net worth of a health maintenance organization as defined in Section 38‑33‑100 and, for all other licensees, means surplus to policyholders as defined in Section 38‑1‑20.

 (3) “Corrective order” means an order issued by the director specifying corrective actions which the director has determined are required.

 (4) “Domestic health organization” means any health organization domiciled in this State.

 (5) “Domestic insurer” means an insurer domiciled in this State.

 (6) “Domestic licensee” means and includes a domestic insurer and a domestic health organization.

 (7) “Foreign health organization” means any health organization not domiciled in this State which is licensed in this State.

 (8) “Foreign insurer” means an insurer which is licensed to transact business within this State, but which is not domiciled in this State.

 (9) “Foreign licensee” means and includes a foreign insurer and a foreign health organization.

 (10) “Health organization” means an insurer which is required to use the NAIC’s Annual Statement Blank‑Health pursuant to the NAIC Annual Statement Instructions‑Health and to file it as prescribed by Section 38‑13‑80 or a health maintenance organization, as defined in Section 38‑33‑20, which is required to use the NAIC’s Annual Statement Blank‑Health pursuant to the NAIC Annual Statement Instructions‑Health and to file it as prescribed by Section 38‑33‑90.

 (11) “Licensee” means and includes a life and health insurer, a property and casualty insurer, and a health organization.

 (12) “Life and health insurer” means an insurer licensed to transact life and health insurance in this State and any licensed property and casualty insurer writing only accident and health insurance.

 (13) “NAIC” means the National Association of Insurance Commissioners.

 (14) “Negative trend” means a negative trend over a period of time, as determined in accordance with the Trend Test Calculation included within the NAIC RBC Instructions.

 (15) “Property and casualty insurer” means an insurer licensed to transact property and casualty insurance in this State. A “property and casualty insurer” does not include monoline mortgage guaranty insurers, financial guaranty insurers, or title insurers.

 (16) “RBC” means risk‑based capital.

 (17) “RBC Instructions” means the risk‑based capital report including RBC Instructions adopted and amended by the NAIC.

 (18) “RBC Level” means a licensee’s Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC:

 (a) “Company Action Level RBC” means the product of 2.0 and its Authorized Control Level RBC;

 (b) “Regulatory Action Level RBC” means the Product of 1.5 and its Authorized Control Level RBC;

 (c) “Authorized Control Level RBC” means the number determined by the RBC formula in accordance with the RBC Instructions; and

 (d) “Mandatory Control Level RBC” means the product of .70 and the Authorized Control Level RBC.

 (19) “RBC Plan” means a comprehensive financial plan filed by a licensee containing the elements specified within Section 38‑9‑330(B). If the director rejects the RBC Plan and it is revised by the licensee, with or without the director’s recommendation, then that plan must be called the “Revised RBC Plan”.

 (20) “RBC Report” means the report required by Section 38‑9‑320.

 (21) “Total Adjusted Capital” means the sum of a licensee’s statutory capital and surplus and any other items provided in the RBC Instructions.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 1, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 1, rewrote the section, adding definitions for: “Capital and surplus” or “capital”, “Domestic health organization”, “Domestic licensee”, “Foreign health organization”, “Foreign licensee”, “Health organization”, “Licensee”, “Negative trend”, and “RBC”.

**SECTION 38‑9‑320.** Preparation and submission of RBC (risk based capital) Report; form and content.

 (A) Every domestic licensee must, on or before each March first filing date, prepare and submit to the director an RBC Report of its RBC Levels as of the end of the preceding calendar year. That RBC Report must be filed in a form and must contain such information required by the RBC Instructions. In addition, every domestic licensee must file its RBC Report:

 (1) with the NAIC in accordance with the RBC Instructions; and

 (2) with the chief insurance regulatory officer in a state in which the licensee is authorized to transact business, if that chief insurance regulatory officer has notified the licensee in writing. The licensee must file its RBC Report with that chief insurance regulatory officer no later than fifteen days from its receipt of notice to file or the March first filing date.

 (B)(1) A life and health insurer’s RBC must be determined in accordance with the formula detailed in the RBC Instructions. The formula must be determined in each case by applying the factors in the manner detailed in the RBC Instructions and must take into account, and may adjust for the covariance between:

 (a) risk with respect to assets;

 (b) risk of adverse insurance experience with respect to liabilities and obligations;

 (c) interest rate risk with respect to the insurer’s business; and

 (d) all other business risks and other relevant risks in the RBC Instructions.

 (2) Each risk must be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

 (C)(1) A property and casualty insurer’s RBC must be determined by applying the factors in the manner detailed in the RBC Instructions and must be determined in accordance with the formula detailed in the RBC Instructions. The formula must take into account, and may adjust for the covariance between:

 (a) asset risk;

 (b) credit risk;

 (c) underwriting risk; and

 (d) all other business risks and other relevant risks in the RBC Instructions.

 (2) Each risk must be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

 (D)(1) A health organization’s RBC must be determined by applying the factors in the manner detailed in the RBC Instructions and must be determined in accordance with the formula detailed in the RBC Instructions. The formula must be taken into account, and may adjust for the covariance between:

 (a) asset risk;

 (b) credit risk;

 (c) underwriting risk; and

 (d) all other business risks and other relevant risks in the RBC Instructions.

 (2) Each risk must be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

 (E) An excess of capital over the amount produced by the RBC requirements, formulas, schedules, and instructions contained in this article is desirable. Licensees should seek to maintain capital above the required RBC levels. Additional capital is used and is useful in securing a licensee against various risks inherent in or affecting the business of insurance and not accounted for, or which only may be partially measured, by the RBC requirements contained in this article.

 (F) If a domestic licensee files an RBC Report which, in the judgment of the director, is inaccurate, then the director must adjust the RBC Report to correct the inaccuracy and must notify the domestic licensee in writing of the adjustment. The notice must include the reasons for the adjustment.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 2, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 2, substituted “licensee” for “insurer” throughout; rewrote subsection (C); added subsection (D); redesignated the remaining subsections accordingly; and made other nonsubstantive changes.

**SECTION 38‑9‑330.** Company Action Level Event defined; preparation and submission of RBC (risk based capital) Plan by insurer.

 (A) A “Company Action Level Event” includes any of the following events:

 (1) filing of an RBC Report which indicates that Total Adjusted Capital is greater than, or equal to, Regulatory Action Level RBC, but is less than Company Action Level RBC;

 (2) filing of an RBC Report which indicates that a life and health insurer has Total Adjusted Capital which is greater than, or equal to, its Company Action Level RBC, but is less than the product of its Authorized Control Level RBC and 3.0 and has a negative trend;

 (3) filing of an RBC Report which indicates that a property and casualty insurer has Total Adjusted Capital which is greater than, or equal to, its Company Action Level RBC, but is less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the NAIC Property and Casualty RBC instructions;

 (4) filing of an RBC Report which indicates that a health organization has Total Adjusted Capital which is greater than, or equal to, its Company Action Level RBC, but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the NAIC Health RBC Instructions; or

 (5) issuance of an Adjusted RBC Report that indicates the event in item (1), (2), (3), or (4), provided that the licensee does not challenge the Adjusted RBC Report pursuant to Section 38‑9‑370. If the licensee challenges an Adjusted RBC Report, then the Company Action Level Event occurs upon notification that an administrative law judge has rejected the challenge.

 (B) In the event of a Company Action Level Event, the licensee must prepare and submit to the director an RBC Plan which must:

 (1) identify the conditions which contributed to the Company Action Level Event;

 (2) include proposals for corrective actions which will result in the elimination of the Company Action Level Event;

 (3) provide projections of the licensee’s financial results for the current year and for at least the four succeeding years if the licensee is a life and health insurer or a property and casualty insurer, or at least two succeeding years if the licensee is a health organization. The projections must consider both the absence of proposed corrective actions and the proposed corrective actions. The projections must include projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections both for new and for renewal business may include separate projections for each major line of business and may separately identify each income, expense, and benefit component;

 (4) identify key assumptions impacting upon the projections and detail the sensitivity of the projections to the assumptions; and

 (5) identify the quality of, and any problems associated with, the licensee’s business including, but not limited to, assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

 (C) The RBC Plan must be submitted within forty‑five days of the Company Action Level Event. If the licensee challenges an Adjusted RBC Report pursuant to Section 38‑9‑370, then the RBC Plan must be submitted within forty‑five days after notification that an administrative law judge has rejected the challenge.

 (D) Within sixty days after the submission of an RBC Plan, the director must notify the licensee stating whether the RBC Plan may be implemented or if the RBC Plan is unsatisfactory. If the director determines that the RBC Plan is unsatisfactory, then notification must set forth the reasons for that determination. The notification may set forth proposed revisions which will render the RBC Plan satisfactory. Upon receipt of notification, the licensee must prepare a Revised RBC Plan which may incorporate by reference any revisions proposed by the director. That Revised RBC Plan must be submitted to the director within forty‑five days after the date of notification. If the licensee challenges the notification under Section 38‑9‑370, then the Revised RBC Plan must be submitted within forty‑five days after notification that an administrative law judge has rejected the challenge.

 (E) If the director notifies a licensee that its RBC Plan or its Revised RBC Plan is unsatisfactory, then the director, subject to the licensee’s right to a public hearing pursuant to Section 38‑9‑370, may specify within the notification that it constitutes a Regulatory Action Level Event.

 (F) Every domestic licensee that files an RBC Plan or Revised RBC Plan with the director must also file a copy of the RBC Plan or Revised RBC Plan with the chief insurance regulatory officer in any state in which that licensee is licensed to transact business if that state has RBC provisions substantially similar to Section 38‑9‑380, Section 38‑9‑390, and Section 38‑9‑400, and if that chief insurance regulatory officer has requested the filing in writing. The licensee must file a copy of the RBC Plan or Revised RBC Plan in that state no later than fifteen days after its receipt of the request to file or the date on which the RBC Plan or Revised RBC Plan is filed under Section 38‑9‑330(C) and (D).

HISTORY: 1996 Act No. 254, Section 2; 2009 Act No. 27, Section 3, eff June 2, 2009; 2014 Act No. 164 (S.908), Section 3, eff January 1, 2015; 2016 Act No. 191 (S.978), Section 1, eff January 1, 2017.

Effect of Amendment

2014 Act No. 164, Section 3, substituted “licensee” for “insurer” throughout; added subsection (A)(4); in subsection (A)(5), substituted “(3), or (4)” for “(3) of this subsection”; and rewrote subsection (B)(3).

2016 Act No. 191, Section 1, in (A)(2), substituted “3.0” for “2.5”.

**SECTION 38‑9‑340.** Regulatory Action Level Event defined; duties of director; corrective action.

 (A) A “Regulatory Action Level Event” includes any one of the following events:

 (1) filing of an RBC Report which indicates that Total Adjusted Capital is greater than, or equal to, Authorized Control Level RBC, but is less than Regulatory Action Level RBC;

 (2) issuance of an Adjusted RBC Report that indicates the event in Section 38‑9‑340(A)(1), provided that the licensee does not challenge that Adjusted RBC Report pursuant to Section 38‑9‑370. If the licensee challenges an Adjusted RBC Report, then the Regulatory Action Level Event occurs upon notification that an administrative law judge has rejected the challenge;

 (3) failure to file an RBC Report by the March first filing date, unless the licensee has filed an explanation for this failure that is satisfactory to the director and has cured the failure within ten days after the March first filing date;

 (4) failure to timely submit an RBC Plan or Revised RBC Plan to the director;

 (5) notification that the RBC Plan or Revised RBC Plan is, in the judgment of the director, unsatisfactory and that the notification constitutes a Regulatory Action Level Event, provided that the licensee does not challenge the determination under Section 38‑9‑370. If the licensee challenges a determination, then the Regulatory Action Level Event occurs upon notification that an administrative law judge has rejected the challenge;

 (6) notification by the director that the licensee has failed to adhere to its RBC Plan or its Revised RBC Plan. However, notification must conclude that the failure has had substantial adverse effect upon the ability of the licensee to eliminate the Company Action Level Event in accordance with its RBC Plan or Revised RBC Plan, provided that the licensee has not challenged the determination pursuant to Section 38‑9‑370. If the licensee challenges a determination, then the Regulatory Action Level Event occurs upon notification that an administrative law judge has rejected the challenge.

 (B) In the event of a Regulatory Action Level Event, the director must:

 (1) require the licensee to prepare and submit an RBC Plan or a Revised RBC Plan;

 (2) perform an examination or an analysis of the assets, liabilities, and operations of the licensee, including a review of the licensee’s RBC Plan or its Revised RBC Plan; and

 (3) issue a Corrective Order detailing corrective actions which the director determines are required.

 (C) In determining corrective actions, the director may take into account factors which he considers relevant based upon his examination or analysis. Those factors may include, but must not be limited to, the results of any sensitivity tests undertaken pursuant to the RBC Instructions.

 (D) The RBC Plan or Revised RBC Plan must be submitted within forty‑five days after the occurrence of the Regulatory Action Level Event. If the licensee challenges an Adjusted RBC Report or a Revised RBC Plan pursuant to Section 38‑9‑370, then the RBC Plan or Revised RBC Plan must be submitted within forty‑five days after notification that an administrative law judge has rejected the challenge.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 4, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 4, substituted “licensee” for “insurer” throughout; and made other nonsubstantive changes.

**SECTION 38‑9‑350.** Authorized Control Level Event defined; discretion, rights, powers and duties of director.

 (A) An “Authorized Control Level Event” includes any of the following events:

 (1) filing of an RBC Report which indicates that a licensee’s Total Adjusted Capital is greater than, or equal to, its Mandatory Control Level RBC, but is less than its Authorized Control Level RBC;

 (2) issuance of an Adjusted RBC Report that indicates the event in Section 38‑9‑350(A)(1), provided that the licensee does not challenge that Adjusted RBC Report pursuant to Section 38‑9‑370. If the licensee challenges that Adjusted RBC Report, then the Authorized Control Level Event occurs upon notification that an administrative law judge has rejected the challenge; or

 (3) the failure of a licensee to respond to a Corrective Order in a manner satisfactory to the director, provided the licensee has not challenged the Corrective Order pursuant to Section 38‑9‑370. If the licensee has challenged a Corrective Order and an administrative law judge has rejected the challenge or has modified the Corrective Order, then the Authorized Control Level Event occurs upon the failure of the licensee to respond to that Corrective Order in a manner satisfactory to the director.

 (B) In the event of an Authorized Control Level Event, the director may take action pursuant to Section 38‑9‑340 or, if the director considers it to be in the best interests of the policyholders and creditors of the licensee and of the public, he may take action necessary to place the licensee under regulatory control pursuant to Section 38‑26‑10, et seq., or to Section 38‑27‑10, et seq. The Authorized Control Level Event is sufficient grounds for the director to take that action, and the director has the rights, powers, and duties detailed within those provisions of law. If the director takes action, then the licensee is entitled to the protections that are afforded under those provisions pertaining to summary proceedings.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 5, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 5, substituted “licensee” for “insurer” throughout; and made other nonsubstantive changes.

**SECTION 38‑9‑360.** Mandatory Control Level Event defined; discretion, rights, powers and duties of director.

 (A) A “Mandatory Control Level Event” includes any one of the following events:

 (1) filing of an RBC Report which indicates that the licensee’s Total Adjusted Capital is less than its Mandatory Control Level RBC;

 (2) notification of an Adjusted RBC Report pursuant to Section 38‑9‑360(A)(1), provided the licensee does not challenge that Adjusted RBC Report pursuant to Section 38‑9‑370. If the licensee challenges an Adjusted RBC Report notification, then the Mandatory Control Event Level occurs upon notification that an administrative law judge has rejected the challenge.

 (B) In the event of a Mandatory Control Level Event:

 (1) For a life and health insurer, the director must take action necessary to place the insurer under regulatory control pursuant to Section 38‑26‑10, et seq., or Section 38‑27‑10, et seq. The Mandatory Control Level Event is sufficient grounds for the director to take that action, and the director has the rights, powers, and duties detailed within those provisions of law. If the director takes action, then the insurer is entitled to the protections afforded under those provisions pertaining to summary proceedings. The director, in his discretion, may forego action for up to ninety days after the Mandatory Control Level Event if the director finds that there is a reasonable expectation that the Mandatory Control Level Event will be eliminated within that period.

 (2) For a property and casualty insurer, the director must take action necessary to place the insurer under regulatory control pursuant to Section 38‑26‑10, et seq., or Section 38‑27‑10, et seq. If the insurer is not writing business and is running off its existing business, then the director may allow the insurer to continue its run‑off under his supervision. The Mandatory Control Level Event is sufficient grounds for the director to take either action, and the director has the rights, powers, and duties detailed within those provisions. If the director takes action, then the insurer is entitled to the protections afforded under those provisions pertaining to summary proceedings. The director, in his discretion, may forego action for up to ninety days after the Mandatory Control Level Event if the director finds that there is a reasonable expectation that the Mandatory Control Level Event will be eliminated within that period.

 (3) For a health organization, the director must take action necessary to place the health organization under regulatory control pursuant to Section 38‑26‑10, et seq., or Section 38‑27‑10, et seq. In that event, the Mandatory Control Level Event must be considered an indication of a hazardous financial condition which serves as sufficient grounds for the director to commence delinquency proceedings, and the receiver appointed in conjunction with the proceedings has the rights, powers, and duties with respect to the licensee as are set forth in Section 38‑26‑10, et seq., or Section 38‑27‑10, et seq., or an order of liquidation, rehabilitation, or conservation entered under it. If the director takes action, then the health organization is entitled to the protections afforded under those provisions pertaining to summary proceedings. The director, in his discretion, may forego action for up to ninety days after the Mandatory Control Level Event if the director finds that there is a reasonable expectation that the Mandatory Control Level Event will be eliminated within that period.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 6, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 6, substituted “licensee” for “insurer” throughout; in subsection (A)(2), inserted “Level” following “Control Event”; and added subsection (B)(3).

**SECTION 38‑9‑365.** Discretion of director to retain actuaries, investment experts, and other consultants; fees, costs, and expense.

 The director may retain actuaries, investment experts, attorneys, and other consultants whom he considers necessary to enforce the provisions of this article. The fees, costs, and expenses of those actuaries, experts, attorneys, and other consultants must be borne by the affected licensee or other related or affiliated parties as required by the director.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 7, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 7, substituted “licensee” for “insurer”.

**SECTION 38‑9‑370.** Confidential hearing; notification; time of hearing.

 (A) A licensee has the right to a confidential hearing, on a record before the director, at which the licensee may challenge a determination or action by the director, upon notification to a licensee by the director:

 (1) of an Adjusted RBC Report;

 (2) that the licensee’s RBC Plan or Revised RBC Plan is unsatisfactory, and that this notification constitutes a Regulatory Action Level Event with respect to the licensee;

 (3) that the licensee has failed to adhere to its RBC Plan or Revised RBC Plan and that this failure has a substantial adverse effect on the ability of the licensee to eliminate the Company Action Level Event with respect to the licensee in accordance with its RBC Plan or Revised RBC Plan; or

 (4) of a corrective order with respect to the licensee.

 (B) The licensee shall notify the director of its request for a hearing within five days after the notification by the director pursuant to subsection (A). Upon receipt of the licensee’s request for a hearing, the director shall set a date for the hearing, which must be no less than ten days nor more than thirty days after the date of the licensee’s request.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 8, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 8, rewrote the section.

**SECTION 38‑9‑380.** Confidentiality of reports, plans, and orders.

 (A) All RBC Reports and Adjusted RBC Reports, to the extent the information contained within them is not required to be set forth in a publicly available annual statement schedule; all RBC Plans, including the results or report of an examination or analysis of a licensee performed pursuant to this article; and a Corrective Order issued by the director, including information that will be damaging to a licensee if any of them are made available to the licensee’s competitors, must be kept confidential, by law, must not be made public, and are not subject to subpoena. The director may use these reports, plans, and orders for enforcement actions either pursuant to this article or pursuant to another insurance law of this State.

 (B) Neither the director nor a person who received documents, materials, or other information while acting under the authority of the director can be permitted or required to testify in a private civil action concerning confidential documents, materials, or information subject to subsection (A).

 (C) The director may:

 (1) share documents, materials, or other information, including the confidential and privileged documents, materials or information subject to subsection (A), with other state, federal, and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information;

 (2) receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

 (3) enter into agreements governing sharing and use of information consistent with this subsection.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 9, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 9, redesignated and rewrote the former section as subsection (A), and added subsection (B) and (C).

**SECTION 38‑9‑390.** Prohibited use of information; publication of materially false or inappropriate statement.

 (A) The comparison of a licensee’s Total Adjusted Capital to any of its RBC Levels is a regulatory tool for corrective action. It is not intended as a means to rank licensees. Therefore, except as otherwise specifically required under the provisions of this article, the making, publishing, disseminating, circulating, or placing before the public, or, causing to be directly or indirectly made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over a radio or television station, or in another way, an advertisement, announcement, or statement containing an assertion or representation with regard to the RBC Levels of a licensee or of a component derived in the calculations by a licensee or agent engaged in the business of insurance is considered misleading and is prohibited.

 (B) If a materially false or inappropriate comparison of a licensee’s Total Adjusted Capital to its RBC Levels or any RBC Level is published in any written publication and the licensee is able to demonstrate with substantial proof the falsity or the inappropriateness of the statement to the director, then the licensee may publish an announcement approved by the director in that written publication solely to rebut the materially false or inappropriate statement.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 10, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 10, substituted “licensee” for “insurer” throughout, and made other nonsubstantive changes.

**SECTION 38‑9‑400.** Limitations on use of RBC (risk based capital) Instructions, Reports, and Plans.

 RBC Instructions, RBC Reports, Adjusted RBC Reports, RBC Plans, and Revised RBC Plans are intended only for use by the director in monitoring the solvency of licensees and in monitoring the need for corrective action. They must not be used for ratemaking, considered, or introduced as evidence in a ratemaking proceeding, or used to calculate or to derive an element of an appropriate premium level or rate of return for a line of insurance that a licensee, an affiliated licensee, or a subsidiary insurer underwrites.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 11, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 11, substituted “licensee” for “insurer” throughout; substituted “to derive an element” for “to derive any elements”; and made other nonsubstantive changes.

**SECTION 38‑9‑410.** Other powers or duties of director or designee.

 This article is supplemental to all other laws of this State. It does not preclude or limit any other powers or duties of the director or his designee.

HISTORY: 1996 Act No. 254, Section 2.

**SECTION 38‑9‑420.** Regulatory power of director.

 The director may promulgate regulations necessary for the implementation of this article.

HISTORY: 1996 Act No. 254, Section 2.

**SECTION 38‑9‑430.** Exemptions from application of article.

 The director may exempt from the application of this article:

 (1) a domestic property and casualty insurer that:

 (a) writes direct business only in this State;

 (b) writes direct annual written premiums of two million dollars or less; and

 (c) assumes no reinsurance in excess of five percent of its direct written premium; and

 (2) a domestic health organization that:

 (a) writes direct business only in this State;

 (b) assumes no reinsurance in excess of five percent of direct premium written; and

 (c) writes direct annual premiums of one million dollars or less.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 12, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 12, rewrote the section.

**SECTION 38‑9‑440.** Applicability of RBC (risk based capital) requirements to foreign insurers.

 (A) A foreign licensee, upon written request by the director, must submit an RBC Report as of the end of the preceding calendar year not later than the date that an RBC Report would be required to be filed by a domestic licensee under this article or fifteen days after that request is received by the foreign licensee. In addition, a foreign licensee, upon written request by the director, must promptly submit a copy of an RBC document that has been filed with the chief insurance regulatory officer of another state.

 (B) In the event of a Company Action Level Event, Regulatory Action Level Event, or Authorized Control Level Event by a foreign licensee as determined under the RBC Laws in its state of domicile or, if no RBC Laws are in force in that state, as determined under the provisions of this article, if the chief insurance regulatory officer of the state of domicile of that foreign licensee fails to require the foreign licensee to file an RBC Plan in the manner specified under that state’s RBC Laws or, if no RBC statute is in force in that state, under Section 38‑9‑330, then the director may require the foreign licensee to file an RBC Plan. The failure of the foreign licensee to file an RBC Plan with the director is grounds for the director to order the foreign licensee to cease and desist from writing new insurance business in this State.

 (C) In the event of a Mandatory Control Level Event by a foreign licensee, if no domiciliary receiver has been appointed for the foreign licensee under the rehabilitation and liquidation laws of its state of domicile, then the director may petition the circuit court pursuant to Section 38‑27‑910, et seq., for the liquidation of its property in this State. The occurrence of the Mandatory Control Level Event must be considered grounds for the petition.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 13, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 13, substituted “licensee” for “insurer” throughout, and made other nonsubstantive changes.

**SECTION 38‑9‑450.** Limitation of liability.

 There is no liability on the part of, and no cause of action, shall arise against the director, his designee, the Department of Insurance, or its employees or representatives and agents for any action of any nature taken in the performance of their powers and duties under this article.

HISTORY: 1996 Act No. 254, Section 2.

**SECTION 38‑9‑460.** Notification by director which may result in regulatory action.

 All notices by the director which may result in regulatory action under this article must be transmitted by registered or certified mail. Those notices are effective upon the licensee’s receipt.

HISTORY: 1996 Act No. 254, Section 2; 2014 Act No. 164 (S.908), Section 14, eff January 1, 2015.

Effect of Amendment

2014 Act No. 164, Section 14, substituted “licensee’s” for “insurer’s”.

ARTICLE 5

Report Disclosing Acquisitions and Dispositions of Assets, and Ceded Reinsurance Agreements [Deleted]

Editor’s Note

2014 Act No. 164, Section 15, effective January 1, 2015, provides as follows:

“SECTION 15. (A) Article 3, Chapter 9, Title 38, designated ‘Risk Based Capital’ is redesignated ‘Risk‑Based Capital’.

“(B) Sections 38‑9‑400, 38‑9‑410, 38‑9‑420, 38‑9‑430, 38‑9‑440, 38‑9‑450, and 38‑9‑460 of the 1976 Code, which are designated as Article 5, Chapter 9, Title 38, are redesignated as part of Article 3, Chapter 9, Title 38, and Article 5, Chapter 9, Title 38 is deleted.”