Joint Meeting of the
NAIC Executive (EX) Committee and Plenary

Tuesday, October 11, 2011  
via Conference Call

4:30 p.m. Eastern / 3:30 p.m. Central / 2:30 p.m. Mountain / 1:30 p.m. Pacific / 12:30 p.m. Alaska / 10:30 a.m. Hawaii

AGENDA

1. Call to Order—Commissioner Susan E. Voss (IA)

2. Roll Call—Commissioner Adam Hamm (ND)

3. Consider Motion to Adopt Reports of Executive (EX) Committee Task Forces  
   —Commissioner Susan E. Voss (IA)  
   • AIG Managing (EX) Task Force—Superintendent James J. Wrynn (NY)  
   • Government Relations (EX) Leadership Council—Commissioner Susan E. Voss (IA)  
   • International Insurance Relations (EX) Leadership Group—Commissioner Susan E. Voss (IA)  
   • Producer Licensing (EX) Task Force—Commissioner Roger A. Sevigny (NH)  
   • Professional Health Insurance Advisors (EX) Task Force—Commissioner Kevin M. McCarty (FL)  
   • Solvency Modernization Initiative (EX) Task Force—Director Christina Urias (AZ)  
   • Speed to Market (EX) Task Force—Administrator Teresa D. Miller (OR)  
   • Surplus Lines Implementation (EX) Task Force—Commissioner James J. Donelon (LA)

4. Consider Motion to Disband Long-Term Care Insurance (EX) Task Force and Transfer its Charges to the Senior Issues (B) Task Force—Commissioner Susan E. Voss (IA)

5. Consider Motion to Adopt Minutes of the May 16 and July 12 Jt. Executive (EX) Committee/Plenary Conference Calls—Commissioner Susan E. Voss (IA)

6. Consider Motion to Adopt Report of the Sept. 22 Jt. Executive (EX) Committee/Internal Administration (EX1) Subcommittee Conference Call—Commissioner Susan E. Voss (IA)

7. Consider Motion to Adopt Additional Charge for 2011 for the Financial Condition (E) Committee Regarding the Use of Captives by Insurers to Transfer Third Party Insurance Risks—Commissioner Susan E. Voss (IA) and Superintendent Joseph Torti III (RI)

8. Consider Motion to Adopt the 2012 Executive Committee Proposed Charges—Commissioner Susan E. Voss (IA)

9. Consider Motion to Adopt the Amendments to Bylaws—Commissioner Susan E. Voss (IA)

10. Consider Motion to Adopt by Consent the Committee, Subcommittee and Task Force Minutes of the 2011 Spring National Meeting, March 26-29, 2011, except for items denoted with (*) below. Please Note: Minutes made available April 12 at www.naic.org and synopsis of the meeting distributed to Members on Aug. 17—Commissioner Susan E. Voss (IA)

11. Consider Motion to Adopt the Report of the Life Insurance and Annuities (A) Committee—Commissioner Adam Hamm (ND)

12. Consider Motion to Adopt the Amendments to the Annuity Disclosure Model Regulation (#245)—Commissioner Adam Hamm (ND)

13. Consider Motion to Adopt the Insurer Bulletin on Stranger-Originated Annuity (STOA) Transactions—Commissioner Adam Hamm (ND)

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14. Consider Motion to Adopt the Report of the Health Insurance and Managed Care (B) Committee
   —Commissioner Sandy Praeger (KS) Attachment Nine
15. Consider Motion to Adopt the Report of the Property and Casualty Insurance (C) Committee
   —Commissioner Mike Chaney (MS) Attachment Ten
16. *Consider Motion to Adopt the Earthquake Consumer Guide—Commissioner Mike Chaney (MS)
   Attachment Eleven
17. *Consider Motion to Adopt the Third Party Administrator Act Guideline
   —Commissioner Mike Chaney (MS) Attachment Twelve
18. Consider Motion to Adopt the Title Agent Statistical Data Plan Implementation Guideline
   —Commissioner Mike Chaney (MS) Attachment Thirteen
19. Consider Motion to Adopt the Report of the Market Regulation and Consumer Affairs (D) Committee
   —Commissioner Sharon P. Clark (KY) Attachment Fourteen
20. Consider Motion to Adopt the Report of the Financial Condition (E) Committee
    —Superintendent Joseph Torti III (RI) Attachment Fifteen
21. Consider Motion to Adopt the Report of the Fin. Regulation Standards and Accreditation (F) Committee
    —Commissioner Julie Mix McPeak (TN) Attachment Sixteen
22. Consider Motion to Adopt the Report of the International Insurance Relations (G) Committee
    —Commissioner Kevin M. McCarty (FL) Attachment Seventeen
23. Any Other Matters Brought Before the Committee—Commissioner Susan E. Voss (IA)
24. Adjournment
REPORT OF EXECUTIVE (EX) COMMITTEE TASK FORCES

AIG Managing (EX) Task Force—The AIG Managing (EX) Task Force has met as needed, in regulator-to-regulator sessions, pursuant to the NAIC Policy Statement on Open Meetings, to continue to monitor issues related to American International Group (AIG).

Government Relations (EX) Leadership Council—The Government Relations (EX) Leadership Council meets weekly via conference call to discuss strategy on federal activities, and is the mechanism by which the NAIC determines and approves guidance and positions on key federal activities. Most recently, the Leadership Council has reviewed issues related to the Dodd-Frank Wall Street Reform and Consumer Protection Act and the federal Patient Protection and Affordable Care Act (PPACA).

International Insurance Relations (EX) Leadership Group—The International Insurance Relations (EX) Leadership Group meets weekly via conference call to discuss strategic issues related to the NAIC’s involvement in international activities and receive NAIC staff consultations on emerging international issues impacting state regulation of insurance.


Professional Health Insurance Advisors (EX) Task Force—The Professional Health Insurance Advisors (EX) Task Force has not met since the Executive (EX) Committee/Plenary conference call of July 12. As recommended by the Task Force during that call, the NAIC continues to dialogue with federal officials, particularly the U.S Department of Health and Human Services (HHS), about immediate and long-term solutions regarding the impact of the medical loss ratio provisions of PPACA on the ability of agents to assist consumers with economic decisions surrounding the purchase of health insurance.

Solvency Modernization Initiative (EX) Task Force—The Solvency Modernization Initiative (EX) Task Force adopted its working groups’ reports Sept. 19 via e-mail vote, which included adoption of the proposal for Accreditation Part A: Laws and Regulations Substantially Similar Elements for the revised Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation (#450). The proposal will be sent to the Financial Condition (E) Committee for approval. The Working Groups continue to discuss topics such as the impact study of principle-based reserving, the newly proposed Own Risk and Solvency Assessment (ORSA), the newly proposed group capital requirements and future actions related to corporate governance.

On Aug. 31, the Task Force and the International Insurance Relations (G) Committee adopted comments to submit to the International Association of Insurance Supervisors (IAIS) on the proposed Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame).

In July, the Task Force hosted an Enterprise Risk Management (ERM) Symposium in Jacksonville, FL; the North American Chief Risk Officers (CRO) Council representatives held an educational session; individual insurers presented their ERM processes to regulators in closed sessions; all participants discussed how ERM could benefit U.S. regulators in regulatory surveillance; and regulators met in regulator-to-regulator session to discuss ERM in individual companies.

The Speed to Market (EX) Task Force—The Speed to Market (EX) Task Force met Sept. 26 via conference call. During this meeting, the Task Force adopted minutes from its July 6 conference call, adopted 2012 Proposed Charges, adopted reports of the Operational Efficiencies (EX) Working Group and National Standards (EX) Working Group, and received oral reports from the SERFF Board and NAIC staff regarding SERFF activity. A written report from the IIPRC was received. In addition, the Task Force adopted changes to the Uniform Product Coding Matrix. The Task Force held a discussion on the Rate Review Disclosure Form at the request of America’s Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA), from whom written comments were received expressing concern about the collection of the related...
disclosure forms. The Task Force uniformly agreed that the decision to collect this information, whether only for rate filings exceeding the federally established 10% threshold or for all health rate filings, is a decision to be made by each individual state, not something the Task Force can force upon a state. Ultimately, the Task Force agreed, at the request of AHIP, to have NAIC staff create a summary report of state collection status and information regarding whether the state has sent a notification of intent to insurers.

**Surplus Lines Implementation (EX) Task Force**—The Surplus Lines Implementation (EX) Task Force did not meet at the Summer National Meeting in Philadelphia. In December 2010, the NAIC accepted the Surplus Lines Implementation (EX) Task Force’s recommendation to pursue the Nonadmitted Insurance Multi-State Agreement (NIMA) as the means for implementing the surplus lines provisions of the federal Nonadmitted and Reinsurance Reform Act (NRRA). The Task Force met June 10 (Attachment One-D), May 20 (Attachment One-E), April 21 (Attachment One-F), and October 2010-January 2011 (Attachment One-G) via conference call with regulators and interested parties.

To those ends, the Task Force has pursued a multi-pronged approach to implementation. First, the Task Force adopted a model bulletin (Attachment One-A) for the states to utilize in providing guidance to all stakeholders related to general NRRA implementation. This model bulletin was drafted so that any state could use it, regardless of the approach the state may have taken with respect to joining a multistate premium tax allocation system. So far, more than two-thirds of the states have issued guidance on NRRA implementation. Second, the Task Force created a Clearinghouse Plan of Operation (EX) Subgroup to develop a proposed plan of operation related to the functions of the clearinghouse to be created by NIMA. The Subgroup completed a proposed plan of operation, which the Task Force has adopted (Attachment One-B). Third, the Task Force tasked a group of insurance department attorneys with drafting the template for the agreement to be entered into between the state and the clearinghouse, as contemplated by NIMA. This group completed a model Clearinghouse Access Agreement, which the Task Force has adopted (Attachment One-C). Finally, the Task Force released a request for information (RFI) in order to obtain information and solicit interest from potential clearinghouse vendors. The Task Force heard presentations and received formal written responses from vendors, and this information has proved invaluable to the implementation efforts of those states that have joined NIMA.

Much of the work described above was intended to be preparatory in nature. The Task Force sought to provide a foundation for the states that join NIMA, but these states will need to make the relevant decisions related to implementing NIMA and its clearinghouse. As of Oct. 6, 12 jurisdictions have executed NIMA, with additional states expected to join in the near future.
NONADMITTED INSURANCE REFORM
SAMPLE BULLETIN

TO: All insurers eligible to write nonadmitted insurance in [State], all licensed surplus lines brokers, [all insureds independently procuring nonadmitted insurance and stamping office]

FROM: [Commissioner, Director, Superintendent]

DATE: [Insert Date]

RE: Implementation of federal Nonadmitted and Reinsurance Reform Act in [State]

The purpose of this bulletin is to outline nationwide regulatory changes that will affect the placement of nonadmitted insurance in [State]. The Nonadmitted and Reinsurance Reform Act of 2010 (“NRRA”), 15 U.S.C. § 8201 et seq., provides that only an insured’s “Home State” may require the payment of premium tax for nonadmitted insurance. Moreover, the NRRA subjects the placement of nonadmitted insurance solely to the statutory and regulatory requirements of the insured’s Home State, and provides that only the insured’s Home State may require a surplus lines broker to be licensed to sell, solicit or negotiate nonadmitted insurance with respect to such insured. 15 U.S.C. § 8202(a), (b). “Nonadmitted insurance,” as defined in 15 U.S.C. § 8206(9), applies only to property and casualty insurance (excluding workers’ compensation).

The NRRA becomes effective on July 21, 2011. For nonadmitted insurance business placed on or after July 21, 2011, the following information is provided for the benefit of insurers, brokers, [insureds and stamping offices]:

What is the scope of the NRRA?

The NRRA states that “the placement of nonadmitted insurance is subject to the statutory and regulatory requirements solely of the insured’s home state” and that the NRRA “may not be construed to preempt any State law, rule, or regulation that restricts the placement of workers’ compensation insurance or excess insurance for self-funded workers’ compensation plans with a nonadmitted insurer.” 15 U.S.C. § 8202. The NRRA does not expand the scope of the kinds of insurance that an insurer may write in the nonadmitted insurance market and each state continues to determine which kinds of insurance an insurer may write in that state. Although the NRRA preempts certain state laws with respect to nonadmitted insurance, it does not have any impact on insurance offered by insurers licensed or authorized in this state.

What is the insured’s Home State for purposes of a particular placement?

[State] is the insured’s Home State if the insured maintains its principal place of business here or, in the case of an individual, the individual’s principal residence is here. If [State] is considered the insured’s Home State, only [State’s] requirements regarding the placement of such business will apply. If 100% of the insured risk is located outside of [State], then the insured’s Home State is the state to which the greatest percentage of the insured’s taxable premium for that insurance contract is allocated.

[If the state wishes to provide additional guidance on the interpretation of “principal residence” or “principal place of business,” the state may consider inserting definitions of these terms consistent with the Nonadmitted Insurance Multi-State Agreement.]

If more than one insured from an affiliate group are named insureds on a single nonadmitted insurance placement, [State] will be considered the Home State for that placement if [State] is the Home State of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.
How will these rules be applied?

New and renewal policies with an effective date prior to July 21, 2011 will be subject to the laws and regulations of [State] and other jurisdictions, as applicable, of the policy effective date. The laws and regulations of [State] and other jurisdictions, as applicable, of the effective date of such a policy will also apply to any modification to that policy during the policy period, such as all endorsements (including risk- and premium-bearing endorsements), installment payments and premium audits. New and renewal policies with an effective date on or after July 21, 2011, and any modifications thereto, will be subject only to the laws and regulations of [State] if [State] is the Home State of the insured.

What are the requirements for premium tax allocation and payment in this [State]?

As of July 21, 2011, the NRRA permits only the insured’s Home State to require the payment of premium tax for nonadmitted insurance. Until July 21, 2011, the laws and regulations of [State] and other jurisdictions, as applicable, will continue to apply to premium tax due on multi-state placements.

It is the intent of the Department to issue additional bulletins if and when [State] begins participating in a tax sharing arrangement. Until additional bulletins are issued, the [State] tax rate should be applied to new and renewal policies with an effective date on or after July 21, 2011, when [State] is the insured’s Home State. [Note: If the state intends to apply an alternate formula for computing the premium tax on multistate policies for which it is the Home State, that information should be inserted here.]

What are the license requirements for brokers?

Only the insured’s Home State may require a surplus lines broker to be licensed to sell, solicit or negotiate nonadmitted insurance with respect to a particular placement. If [State] is the insured’s Home State, the surplus lines broker must be licensed in [State]. The NRRA provides that [State] may not collect licensing fees for surplus lines brokers as of July 21, 2012, unless [State] participates in the NAIC’s national insurance producer database or any other equivalent uniform national database. 15 U.S.C. § 8203. [State] participates in the National Insurance Producer Registry (NIPR), which provides such a database. [Note: If the state does not participate in NIPR, the state should describe its broker licensing requirements.]

When are the requirements for a diligent search and when is a diligent search not required?

[Insert general diligent search requirements for state].

On or after July 21, 2011, a surplus lines broker seeking to procure or place nonadmitted insurance on behalf of an “exempt commercial purchaser” is not required to perform a diligent search if: 1) the broker has disclosed to the exempt commercial purchaser that insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and 2) the exempt commercial purchaser has subsequently requested in writing for the broker to procure or place such insurance from a nonadmitted insurer. “Exempt commercial purchaser” is defined in [insert State statute consistent with NRRA definition].

What are the eligibility requirements for nonadmitted insurers?

The NRRA restricts the eligibility requirements a state may impose on nonadmitted insurers. See 15 U.S.C. § 8204. For nonadmitted insurers domiciled in a U.S. jurisdiction, a broker is permitted to place nonadmitted insurance with such insurers provided they are authorized to write such business in their state of domicile and maintain minimum capital and surplus of $15 million [or the minimum capital and surplus amount required in State, whichever is greater]. [Note: If the state maintains a list of eligible insurers, the state may indicate where such information is available and/or how an insurer can be added to such a list.]

For nonadmitted insurers domiciled outside the U.S., a broker may place business with such insurers provided the insurer is listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the NAIC.
What are the key definitions from the NRRA?

The NRRA includes several definitions relevant to [State’s] implementation of its requirements. Key definitions include the following:

- **“Exempt commercial purchaser”**: The term “exempt commercial purchaser” means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:
  
  (A) The person employs or retains a qualified risk manager to negotiate insurance coverage.
  
  (B) The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of $100,000 in the immediately preceding 12 months.
  
  (C) (i) The person meets at least 1 of the following criteria:
   
   (I) The person possesses a net worth in excess of $20,000,000, as such amount is adjusted pursuant to clause (ii).
   
   (II) The person generates annual revenues in excess of $50,000,000, as such amount is adjusted pursuant to clause (ii).
   
   (III) The person employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate.
   
   (IV) The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least $30,000,000, as such amount is adjusted pursuant to clause (ii).
   
   (V) The person is a municipality with a population in excess of 50,000 persons.
  
  (ii) Effective on the fifth January 1 occurring after the date of the enactment of this subtitle and each fifth January 1 occurring thereafter, the amounts in subclauses (I), (II), and (IV) of clause (i) shall be adjusted to reflect the percentage change for such 5-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Department of Labor. 15 U.S.C. § 8206(5).

- **“Home State”**:  
  
  (A) In General.—Except as provided in subparagraph (B), the term “home State” means, with respect to an insured—
  
  (i) the State in which an insured maintains its principal place of business or, in the case of an individual, the individual’s principal residence; or
  
  (ii) if 100 percent of the insured risk is located out of the State referred to in clause (i), the State to which the greatest percentage of the insured’s taxable premium for that insurance contract is allocated.
  
  (B) Affiliated Groups.—If more than 1 insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term “home State” means the home State, as determined pursuant to subparagraph (A), of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract. 15 U.S.C. § 8206(6).

- **“Independently procured insurance”**: The term “independently procured insurance” means insurance procured directly by an insured from a nonadmitted insurer. 15 U.S.C. § 8206(7).

- **“Nonadmitted insurance”**: The term “nonadmitted insurance” means any property and casualty insurance permitted to be placed directly or through a surplus lines broker with a nonadmitted insurer eligible to accept such insurance. 15 U.S.C. § 8206(9).

- **“Nonadmitted insurer”**: The term “nonadmitted insurer”—
  
  (A) means, with respect to a State, an insurer not licensed to engage in the business of insurance in such State; but
  
  (B) does not include a risk retention group, as that term is defined in section 2(a)(4) of the Liability Risk Retention Act of 1986 (15 U.S.C. 3901(a)(4)). 15 U.S.C. § 8206(11).

- **“Premium tax”**: The term “premium tax” means, with respect to surplus lines or independently procured insurance coverage, any tax, fee, assessment, or other charge imposed by a government entity directly or indirectly based on any payment made as consideration for an insurance contract for such insurance, including premium deposits, assessments, registration fees, and any other compensation given in consideration for a contract of insurance. 15 U.S.C. § 8206(12).
- **Qualified risk manager**: The term “qualified risk manager” means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:
  (A) The person is an employee of, or third-party consultant retained by, the commercial policyholder.
  (B) The person provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and purchase of insurance.
  (C) The person—
    (i) has a bachelor’s degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by a State insurance commissioner or other State regulatory official or entity to demonstrate minimum competence in risk management; and
    (II) (aa) has 3 years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance; or
    (bb) has—
      (AA) a designation as a Chartered Property and Casualty Underwriter (in this subparagraph referred to as “CPCU”) issued by the American Institute for CPCU/Insurance Institute of America;
      (BB) a designation as an Associate in Risk Management (ARM) issued by the American Institute for CPCU/Insurance Institute of America;
      (CC) a designation as Certified Risk Manager (CRM) issued by the National Alliance for Insurance Education & Research;
      (DD) a designation as a RIMS Fellow (RF) issued by the Global Risk Management Institute; or
      (EE) any other designation, certification, or license determined by a State insurance commissioner or other State insurance regulatory official or entity to demonstrate minimum competency in risk management; 15 U.S.C. § 8206(13).
  (ii) (I) has at least 7 years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; and
    (II) has any 1 of the designations specified in subitems (AA) through (EE) of clause (i)(II)(bb);
  (iii) has at least 10 years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; or
  (iv) has a graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by a State insurance commissioner or other State regulatory official or entity to demonstrate minimum competence in risk management. 15 U.S.C. § 8206(14).

- **Surplus lines broker**: The term “surplus lines broker” means an individual, firm, or corporation which is licensed in a State to sell, solicit, or negotiate insurance on properties, risks, or exposures located or to be performed in a State with nonadmitted insurers. 15 U.S.C. § 8206(15).

- **State**: The term “State” includes any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands, and American Samoa. 15 U.S.C. § 8206(16).
Outline for Clearinghouse Plan of Operation

I. Account Identification

The Clearinghouse will need to require the entry of information necessary to accurately identify the following according to the listed criteria:

- Agency:
  - Federal Identification Number
  - National Producer Number

- Producer:
  - National Producer Number

- Insurance Company:
  - NAIC Company Code or
  - Alien ID
II. Recordkeeping

A. Tax Filing Records
The Clearinghouse shall maintain, as to each Surplus Lines Licensee or insured who independently procures insurance, complete and auditable records of all nonadmitted insurance premium tax filings received by the Clearinghouse, including all related tax payment, allocation, and disbursement information.

B. Operational Records
The Clearinghouse shall maintain comprehensive, complete, and auditable records of its day-to-day operations.

C. Availability of Records
The Clearinghouse shall make all tax filing and operational records available upon request of any Participating State, and shall be available for audit during normal business hours.

D. Maintenance and Preservation of Records
Tax filing and operational records shall be maintained electronically or optically in digital form, and preserved for a period of ten years from the year of the record’s creation.

E. Confidentiality
The confidentiality of tax filing records with respect to a particular Surplus Lines Licensee or insured who independently procures insurance shall be determined by the laws of Home State with respect to such licensee or insured’s transactions.
Approved by Clearinghouse Plan of Operation (EX) Subgroup and Surplus Lines Implementation (EX) Task Force

III. Required Data Collection

RECOMMENDED DATA FIELDS

A. Name of Insured

B. Address/Home State of Insured
   - Home office/principal place of business or residence for an individual as defined under the NRRA
   - Home State as defined under the NRRA

C. Name of Unauthorized Insurer or Surplus Lines Insurer and NAIC or Alien Insurer Number
   - Due to the number of insurance companies with similar names, to avoid selection errors the NAIC or Alien Insurer number should be included on the pull-down menu next to the carrier name.

D. Policy Number
   - Policy-number input fields should be configured to allow various formats for policy numbers.

E. Type of Coverage

F. Type of Transaction
   - Available selections from this pull-down field should include:
     a) New business
     b) Renewal
     c) Endorsement
     d) Cancellation
     e) Reinstatement
     f) Audit

G. Policy Inception Date

H. Policy Expiration Date

I. Transaction Effective Date

J. Amount of Coverage

K. Gross Premium Charged or Returned
Approved by Clearinghouse Plan of Operation (EX) Subgroup and Surplus Lines Implementation (EX) Task Force

L. Fees Charged to the Insured
   • In some states fees charged to the insured are considered to be premium, and are subject to Surplus Lines taxes.

M. Surplus Lines Tax Charged or Returned

N. Stamping Fee (at Discretion of State Stamping Office)

O. Exempt Commercial Purchaser

P. Clearinghouse Fee

Q. Allocation States & Amount of Risk Attributed to Each
IV. Maintenance of State-Specific Data – Required Functionality of Clearinghouse Software

A. Remote access by state regulators and/or state stamping-office personnel to a module of the software that allows for access to information pertaining to tax rates, stamping-office fees, and determination of refunds and penalties.

B. Ability to take into account, in an automated fashion, the implementation dates of any state-specific changes in tax rates and fees.

C. Ability to calculate and allocate premium taxes and fees derived from the single statewide rate for all participating states in accordance with tax rates/fee structures (including state rules regarding refunds and penalties) entered into the system by state regulators and/or state stamping-office personnel.

D. Ability to calculate and report, at the broker level (or for an insured who independently procures insurance), the amounts of taxes collected and owed.

E. Ability to record the identity of the home state for each transaction and to determine the taxes owed by the home state to other participating states.

F. Ability to retain information pertaining to a state’s tax rates and fees for as long as they are effective and for at least ten years afterward.

G. Ability to receive and export batch data.

H. Ability to support a variety of electronic payment methods such as ACH Debit, ACH Credit, and electronic bank transfers.

I. Level of security sufficient to prevent dissemination of confidential or proprietary data and providing for multiple levels of user access.

J. Established business continuation and disaster recovery plan that provides for system backup in more than one location.

K. Development of procedure for when a policy filed in a previous quarter and for which the premium taxes have already been allocated among the states requires a refund.
V. Accounting Requirements for Clearinghouse

A. Maintenance of Accounts
The Clearinghouse shall maintain its accounts in accordance with Generally Accepted Accounting Principles.

B. Financial Statements
The Clearinghouse shall produce quarterly and year-end financial statements that must minimally include a balance sheet, income statement, statement of cash flows and related notes. The year-end financial statements shall be audited by an independent public accounting firm and include a discussion by management regarding operating results for the year.

C. Auditing
The Clearinghouse shall be subject to audits of its financial reporting process, choice of accounting policies and principles, internal control processes, and hiring and performance of its external auditors. The Clearinghouse may also conduct audits of nonadmitted insurance premium transactions processed through the Clearinghouse at the discretion of the State.
Approved by Clearinghouse Plan of Operation (EX) Subgroup and Surplus Lines Implementation (EX) Task Force

VI. Reporting Requirements for Clearinghouse

The Clearinghouse shall prepare and submit the following reports electronically, in the formats specified below, to Participating States, Surplus Lines Licensees, and insureds who independently procure nonadmitted insurance:

A. Reports to Participating States

1. Monthly Transaction Reports (to be submitted by the 15th of the following month), which shall include:
   a. all information required under Exhibit 1 of NIMA (the “Transaction Data”) for Multi-State risks (and Single-State risks, where applicable) organized by transaction number and including the date that the Clearinghouse received the submission;
   b. any adjustments made to information reported in the prior month’s transaction report; and
   c. the gross amounts received and net amounts of Nonadmitted Insurance premium taxes deposited into each Participating State’s depository account.

2. Quarterly Tax Reports (to be submitted no later than 15 days after the quarterly premium tax filing and payment dates below):

   February 15 for the quarter ending the preceding December 31, May 15 for the quarter ending the preceding March 31, August 15 for the quarter ending the preceding June 30, and November 15 for the quarter ending the preceding September 30.

   Quarterly Tax Reports shall include:

   a. the total amount of Nonadmitted Insurance premium taxes due to each Participating State for the preceding quarter and the breakdown of the total premium taxes that were dispersed to the Participating State in the preceding quarter;
   b. for each transaction during the preceding quarter, a detailed breakdown, by the transaction number, showing the insured’s home state and the Nonadmitted Insurance premium taxes that the Clearinghouse has allocated in accordance with NIMA to the Participating State; and
   c. the total amount of Nonadmitted Insurance premium taxes collected by the Clearinghouse on behalf of the Participating State in the preceding quarter.

3. Quarterly Delinquent Reports (to be submitted no later than 15 days after the quarterly premium tax filing and payment dates below):

   February 15 for the quarter ending the preceding December 31, May 15 for the quarter ending the preceding March 31, August 15 for the quarter ending the preceding June 30, and November 15 for the quarter ending the preceding September 30.

   The Reports shall include:

   a. a list of all the outstanding Nonadmitted Insurance premium taxes due but not collected from Surplus Lines Licensees and insureds who independently procure nonadmitted insurance from prior quarters, including the number of days past due;
   b. as to Surplus Lines Licensees, the Surplus Lines Licensee’s name, license number, address, phone number, email address and the transaction number for each policy as to which Nonadmitted Insurance premium taxes remain outstanding; and
Approved by Clearinghouse Plan of Operation (EX) Subgroup and Surplus Lines Implementation (EX) Task Force

c. as to insureds who independently procure nonadmitted insurance, the name, address, phone number, email address and the transaction number for each policy as to which Nonadmitted Insurance premium taxes remain outstanding.

B. Reports to Surplus Lines Licensees and insureds who independently procure nonadmitted insurance

1. Monthly Transaction Reports (to be submitted by the 15th of the following month), which shall include:
   a. Transaction Data for Multi-State risks (and Single-State risks, where applicable) organized by transaction number and including the date that the Clearinghouse received the submission; and
   b. any adjustments made to information reported in the prior month’s transaction report.

2. Quarterly Tax Reports (to be submitted no later than 15 days after the quarterly premium tax filing and payment dates below:
   - February 15 for the quarter ending the preceding December 31, May 15 for the quarter ending the preceding March 31, August 15 for the quarter ending the preceding June 30, and November 15 for the quarter ending the preceding September 30.
   - The report shall include the amount of Nonadmitted Insurance premium taxes paid in the preceding quarter organized by transaction number.

3. Quarterly Delinquent Reports (to be submitted no later than 15 days after the quarterly premium tax filing and payment dates below:
   - February 15 for the quarter ending the preceding December 31, May 15 for the quarter ending the preceding March 31, August 15 for the quarter ending the preceding June 30, and November 15 for the quarter ending the preceding September 30.
   - The report shall include a list of all the outstanding Nonadmitted Insurance premium taxes due but not collected from the Surplus Lines Licensee or insureds who independently procure nonadmitted insurance from prior quarters, including the number of days past due.

C. The Clearinghouse shall also produce an annual report, including an independent auditor’s report, to account for its use of transaction fees and the general financial operations of the Clearinghouse.

D. Other reports, including transaction, tax, delinquency, and ad hoc reports may be requested by Participating States. States shall have the ability to customize and extract reports from data made available by the Clearinghouse.
VII. Assessment and Receipt of Tax Payments

A. Due Date for Tax Payments
   Unless a Participating State has opted to utilize its stamping office for the initial submission of transaction information, the Clearinghouse will collect, reconcile, and record quarterly tax payments in accordance with the schedule stated in NIMA. The process will include reconciling all payments received, and will also include a report of allocations among Participating States.

   The Clearinghouse will also submit the allocated portion of premium taxes to each Participating State electronically within 15 days of the submission date required by the surplus lines licensees.

   The Clearinghouse will provide Participating States with online access to tax payments received by the Clearinghouse.

B. Stamping Fees
   Where authorized, the Clearinghouse will perform the process collecting the stamping fee in addition to the transaction fee. The stamping fee will be remitted to the stamping office or as otherwise required.

C. Delinquent Payments
   The Clearinghouse will provide each Participating State a detailed report showing payment history, via online access.

D. Reasonable Transaction Fees
   The Clearinghouse will charge the insured who independently procures coverage and the Surplus Lines Licensee a reasonable fee per transaction to cover the cost of operations and activities of the Clearinghouse. Such fees may include the costs of administrative support and, for a limited time period, the cost of initially establishing the Clearinghouse.
VIII. Allocation – Access to States’ Depository Accounts

Based on information submitted by the insured who independently procures coverage and the Surplus Lines Licensee, the Clearinghouse will assess the allocated premium based upon each Participating State’s statewide Nonadmitted Insurance tax rate for each Participating State with exposure. At the end of each reporting period, the Clearinghouse will allocate the amount collected on behalf of the Home State to all other Participating States and net the amounts owed to or from each of the States. The netting of taxes will be based on the actual amount collected.

The appropriate amount will be deposited into each Participating State’s depository account at the financial institution selected by the Participating State. With respect to the depository accounts of the Participating States, the Clearinghouse shall only have the authority to transfer premium taxes collected and on deposit in the Clearinghouse account into the depository account of the Participating States.
NONADMITTED INSURANCE PREMIUM TAX CLEARINGHOUSE ACCESS AGREEMENT

This Nonadmitted Insurance Premium Tax Clearinghouse Access Agreement (“Agreement”) is entered into on this ______ day of ______, 2011, (“Effective Date”) by and between ___________ (“the Clearinghouse”), with its principal offices located at __________ and ________________ (“State”), with its principal offices located at ___________________ (collectively referred to as the “Parties”) for the purposes of carrying out the requirements of the Nonadmitted Insurance Multi-State Agreement (“NIMA”).

RECITALS

A. The Clearinghouse is a [DESCRIBE ENTITY] with its principal office presently at ______; and

B. The State is represented by the state agency or agencies charged with enforcing State laws and regulations relating to Nonadmitted Insurance premium taxes. The State is a Participating State under NIMA.

C. The State is authorized pursuant to _________ to enter into this Agreement.

D. The Clearinghouse provides for the facilitation of the receipt and distribution of Nonadmitted Insurance premium taxes and transaction data.

E. The Clearinghouse and the State desire to enter into this Agreement, whereby the Clearinghouse shall facilitate the receipt and distribution of Nonadmitted Insurance premium taxes and transaction data for all insurance policies insuring Multi-state Risks for which the State is the Home State. The State may opt to utilize the Clearinghouse to perform the same functions for all Single-State Risks and/or non-Property and Casualty Insurance risks.

NOW, THEREFORE, in consideration of the mutual promises and agreements contained herein, it is hereby agreed to as follows:

AGREEMENT

1. DEFINITIONS

Where terms in this Agreement are capitalized, such terms shall have the same meaning as defined in NIMA unless otherwise defined herein.

2. STATE OBLIGATIONS

The State shall follow requirements consistent with the Clearinghouse plan of operation as agreed to by a two-thirds majority of the Participating States.

The State shall require Surplus Lines Licensees and insureds who independently procure insurance to utilize the Clearinghouse to facilitate the receipt and distribution of Nonadmitted Insurance premium taxes and transaction data for all Multi-State Risks for which the State is the Home State. [Optional: The State may also, at its discretion and with adequate notice to the Clearinghouse, require Surplus Lines Licensees and insureds who independently procure insurance to utilize the Clearinghouse to facilitate the receipt and distribution of Nonadmitted Insurance premium taxes for all Single-State Risks and/or non-Property and Casualty Insurance risks.]

The State shall require Surplus Lines Licensees and insureds who independently procure insurance to submit transaction information and data consistent with the Annexes and Exhibits attached to NIMA.

The State shall require quarterly tax filings and payments utilizing the following dates only: February 15 for the quarter ending the preceding December 31; May 15 for the quarter ending the preceding March 31; August 15 for the quarter ending the preceding June 30; and November 15 for the quarter ending the preceding September 30.
The State shall select a financial institution at which to maintain a depository account for receipt of its allocated share of Nonadmitted Insurance premium taxes. The State shall provide the depository account information that is necessary for the Clearinghouse to provide services under this Agreement, and shall promptly inform the Clearinghouse of any material changes to the depository account information.

The State shall give notice to the Clearinghouse of any changes to its statewide Nonadmitted Insurance premium tax rate and any statewide assessments at least 90 days prior to the effective date of such changes.

[For stamping office states: The State shall authorize and require the State’s stamping office to forward relevant transaction data, Nonadmitted Insurance premium taxes, and fees to the Clearinghouse for distribution to other Participating States.]

3. CLEARINGHOUSE OBLIGATIONS

The Clearinghouse shall conduct its operations in accordance with the plan of operation pursuant to NIMA.

The Clearinghouse shall operate and maintain a web-based system to facilitate the receipt and distribution of Nonadmitted Insurance premium taxes and transaction data (“Clearinghouse System” or “System”). The Clearinghouse shall provide a remote hosting environment that shall include the system hardware and software necessary for the implementation, operation and maintenance of the Clearinghouse System. The Clearinghouse warrants that the System’s security protocols shall be sufficient to prevent any dissemination of confidential or proprietary data. Unless otherwise agreed to in writing by the Parties, the Clearinghouse shall provide, at no additional charge, new versions and releases and resolution of errors for the Clearinghouse System.

The Clearinghouse shall back-up all Nonadmitted Insurance premium tax data in more than one location.

The Clearinghouse shall be responsible for preparing and implementing a disaster recovery and back-up plan, a summary of which shall be provided to the State, which includes, but is not limited to, equipment, personnel, facilities, and transportation in order to continue services as specified in this Agreement and all incorporated documents in the event of a disaster.

The Clearinghouse shall calculate the allocated Nonadmitted Insurance premium tax based upon each Participating State’s statewide Nonadmitted Insurance premium tax rate and statewide assessments for each Participating State with exposure. At the end of the reporting period, the Clearinghouse shall allocate the amount it receives and net the amounts owed to or from each of the Participating States. The Clearinghouse shall determine the net Nonadmitted Insurance premium taxes using the actual amount remitted, and the Clearinghouse shall transfer the appropriate amount to the State’s depository account.

The Clearinghouse shall provide quarterly tax reports to the State and each Surplus Lines Licensee and insured who independently procures insurance. [Additional reporting requirements described in the final Plan of Operation may also be included.]

Each quarterly tax report provided to the State shall set forth: (a) the total amount of Nonadmitted Insurance premium taxes due to the State for the preceding quarter; (b) any Nonadmitted Insurance premium taxes due to the State for the preceding quarter that were not paid to the Clearinghouse; (c) the total amount of Nonadmitted Insurance premium taxes collected by the Clearinghouse on behalf of the State in the preceding quarter; (d) the total amount of Nonadmitted Insurance premium taxes transferred to the State’s depository account in the preceding quarter; and (e) the method through which the Nonadmitted Insurance premium taxes were paid to the Clearinghouse.

Each quarterly tax report provided to a Surplus Lines Licensee and to an insured who independently procures insurance shall set forth: (a) the total amount of Nonadmitted Insurance premium taxes paid to the Clearinghouse for each Participating State in the preceding quarter; (b) any Nonadmitted Insurance premium taxes due for the preceding quarter that were not paid; and (c) the method through which the Nonadmitted Insurance premium taxes were paid to the Clearinghouse.

The Clearinghouse shall provide a quarterly tax report to the State and each Surplus Lines Licensee and insured who independently procures insurance on or before: February 1 for the quarter ending the preceding December 31; May 1 for the quarter ending the preceding March 31; August 1 for the quarter ending the preceding June 30; and November 1 for the quarter ending the preceding September 30.
The Clearinghouse shall not take any action, other than to transfer Nonadmitted Insurance premium tax payments from the Clearinghouse account to the State’s depository account, without the State’s prior written authorization.

The Clearinghouse shall send notice of any changes in statewide Nonadmitted Insurance premium tax rates and statewide assessments, of which it is notified, to all Participating States via electronic mail to the designated contact of each Participating State.

4. **FEES**

The State recognizes and agrees that the Clearinghouse may charge reasonable transaction fees ("Transaction Fees") as set out in [Identify Attachment], attached hereto and made a part of this Agreement, payable by the insured directly or through a Surplus Lines Licensee on each transaction processed by the Clearinghouse to cover the costs of the operations and activities of the Clearinghouse System. If the State has a stamping office, the Transaction Fees shall be in addition to the service fee that is received by the stamping office.

5. **WARRANTIES**

The Parties represent and warrant that they have the legal authority to enter into this Agreement for the purposes of fulfilling the requirements of NIMA.

[Further warranties should be consistent with any Scope of Work, RFP or Plan of Operation provisions.]

6. **TERM AND TERMINATION**

The term of this Agreement shall be two years, commencing on the first day after the conclusion of the calendar quarter in which this Agreement is executed. [Possible renegotiation period following initial term]

The State may terminate this Agreement without cause at any time upon 90 days advance written notice to the Clearinghouse; provided, however, that if the State is required to terminate this Agreement pursuant to a statute, regulation, administrative ruling or any other binding court order, the State may terminate this Agreement effective immediately, but shall provide the Clearinghouse written notice within 15 days after termination of the Agreement. The Clearinghouse may terminate this Agreement without cause by providing advance written notice to the State at least 180 days before the expiration of this Agreement.

In the event of termination of this Agreement, the Clearinghouse shall facilitate the prompt transfer of all Nonadmitted Insurance premium tax data to the State’s replacement system. The Parties shall be responsible for their own costs and expenses related to such a transfer.

[OPTIONAL PROVISION FOR AMENDMENT OR MODIFICATION]

[Amendments to this Agreement may be proposed by the Parties. Any proposed amendments, whether proposed by the Clearinghouse or a Participating State, shall be distributed by the Clearinghouse to all Participating States for written comments within 60 days from its receipt of the proposed amendment. All comments received shall be distributed to the other Participating States. The Participating States and the Clearinghouse shall have 60 days following the end of the comment period to approve any proposed amendment. The Amendment must be approved by both the Clearinghouse and a two-thirds majority of Participating States in order to be adopted. Once adopted, the Amendment shall be distributed to the Participating States to be appended to this Agreement.]

[Amendments or modifications to the ordinary business operations of the Clearinghouse required under the Plan of Operation may be mutually agreed upon between the Clearinghouse and a majority of the Participating States, without a mandatory comment period.]

7. **TERMINATION FOR CAUSE**

The State may terminate immediately this Agreement, in whole or in part, if the Clearinghouse fails to perform its obligations under the Agreement in a timely and proper manner. The State shall, by providing a written notice of default to the Clearinghouse, allow the Clearinghouse to cure a failure or breach of the Agreement within at least ten days. The State shall
deliver such notice by certified mail, return receipt requested. If the State allows the Clearinghouse to cure a failure or breach of the Agreement, such action shall not waive the State’s right to immediately terminate the Agreement for the same or different breach, which may occur at a different time.

In the event of termination under this section, the Clearinghouse shall not suspend or terminate the State’s access to the Clearinghouse System for 180 days or until an online system, comparable to the Clearinghouse System that facilitates the receipt, allocation and distribution of Nonadmitted Insurance premium taxes and transaction data, and such other functions specified in the Agreement, is operational and available to the State, whichever occurs first.

The State shall certify that any confidential or proprietary information relating to the Clearinghouse System furnished to the State by the Clearinghouse hereunder has either been returned to the Clearinghouse or destroyed and that, during the term of this Agreement, there have been no unauthorized disclosures or duplications of the Clearinghouse System.

In the event of termination of this Agreement, the Clearinghouse shall facilitate the prompt transfer of all Nonadmitted Insurance premium tax data to the State’s replacement system. The Parties shall be responsible for their own costs and expenses related to such a transfer.

8. **INSURANCE REQUIREMENTS [Alternate heading: FINANCIAL RESPONSIBILITY]**

The Clearinghouse shall maintain professional liability insurance to cover damages to the State caused by an error, omission or negligent act on its part related to the services to be provided under this Agreement. Such coverage shall include losses due to failure of an information technology system. The Clearinghouse shall provide to the State proof of insurance of not less than the following amounts:

- Combined single limit per occurrence:  
- Aggregate limit for all claims per occurrence:  

9. **PERFORMANCE|FIDELITY| BOND**

The Clearinghouse shall supply a bond executed by a corporation authorized to contract surety in the State, payable to the State, which shall be valid for the life of this Agreement to include any renewal or extension periods. The bond shall be in the amount of $_____. The bond shall guarantee that the Clearinghouse shall faithfully perform all requirements, terms and conditions of this Agreement. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. [Optional Fidelity Bond would cover losses resulting from fraudulent or dishonest actions by the Clearinghouse.]

The amount of forfeiture shall be determined by the State based on loss to the State as solely determined by the State, after termination or expiration of the Agreement. Any claim must be filed within __ months following the termination or expiration of the Agreement.

10. **CONFIDENTIAL INFORMATION AND NON-DISCLOSURE:**

The Parties each acknowledge that in the course of this Agreement, the Clearinghouse may acquire confidential information regarding Nonadmitted Insurance premium taxes and transaction data (hereinafter “Confidential Information”). The term “Confidential Information” means any information kept, held, filed, produced, or reproduced by, with, or for the Clearinghouse in any physical form whatsoever regarding the receipt and distribution of Nonadmitted Insurance premium taxes and transaction data that is determined by the State to be of a non-public nature or confidential by law. The Confidential Information shall be used solely for the purpose of the facilitating the receipt and distribution of Nonadmitted Insurance premium taxes and transaction data. The Clearinghouse shall not disclose any of the Confidential Information to anyone other than the State without the State’s prior written consent.

The Clearinghouse agrees that all persons who have or will have access to the Confidential Information shall first be advised of the confidential nature thereof and the requirement that Confidential Information be maintained in the strictest confidence in accordance with this Agreement. The Clearinghouse is responsible for ensuring that its agents, contractors, and employees with access to the Confidential Information are advised of, and adhere to, the confidentiality provisions herein.
The Clearinghouse, using reasonable security measures, shall maintain all Confidential Information under secure conditions, which in any event, shall not be less than the same security measures used by the Clearinghouse for the protection of its own information of a similar kind.

If the Clearinghouse transfers the Nonadmitted Insurance premium tax data to the State’s replacement system pursuant to section 7 of this Agreement, then the Clearinghouse shall subsequently destroy and purge all Confidential Information from the Clearinghouse’s computer drives. Such destruction shall be certified in writing to the State by an authorized Clearinghouse representative supervising such destruction. The Clearinghouse shall not retain any Confidential Information.

If the Clearinghouse is served with a subpoena, order, or other request requiring production of Confidential Information, then the Clearinghouse shall:

(a) immediately, upon receipt of such subpoena, order, or other request, notify the State and afford the State the opportunity to take any action it deems appropriate to protect the Confidential Information;

(b) notify the person who issued the subpoena, order, or other request that the Confidential Information belongs to the State; and

(c) consent to any application by the State to intervene in any action for the purpose of asserting and preserving any privilege(s) or claims of confidentiality with respect to the Confidential Information.

11. **NONASSIGNABILITY**

The Parties agree that neither this Agreement nor any of the rights granted hereunder shall be transferable or assignable to any other person or entity without the express prior written permission of the Parties.

12. **FORCE MAJEURE**

Neither the Clearinghouse nor the State shall be held responsible for, nor deemed to be in default under this Agreement because of any delay or failure in its performance if such delay or failure is the result of causes beyond its reasonable control (provided such causes do not result from the acts or omissions of such party or its agents, contractors, or employees). Such causes shall include (without limitation) acts of God, fire, flood, earthquake, severe weather, transportation disruption, communications failure, failure of electronic or mechanical equipment, telephone or other interconnect problem, Internet problem, unauthorized access, theft, operator error, strike or other labor dispute, war, civil disruption, insurrection, or any other cause beyond the reasonable control of such party (all such causes collectively referred to herein as “Force Majeure”).

The party affected by a Force Majeure shall, upon prompt advance written notice to the other party thereof, be entitled to suspend its performance hereunder on a day-to-day basis to the extent of the prevention, restriction, or interference caused by such Force Majeure, provided, however, that the party affected shall at all times use commercially reasonable efforts to avoid or remove such prevention, restriction, or interference and to minimize the consequences thereof. The party affected shall resume its performance immediately upon elimination or removal of such Force Majeure or its effects. To the extent the party affected by such Force Majeure is entitled to suspend its performance; the party not affected by such Force Majeure shall also be entitled to suspend its performance.

If the Clearinghouse is unable to perform its duties under this Agreement due to a Force Majeure circumstance that continues for a consecutive period of two weeks or more, then the State may give notice to terminate this Agreement for cause pursuant to section 7 of this Agreement.

13. **PUBLICITY**

Each party may assert a proprietary interest in its name and prohibit the other from using the name in connection with marketing or sales.
14. **NO DELEGATION OF STATE REGULATORY AUTHORITY**

Nothing in this Agreement shall be construed as a delegation of state regulatory or legislative authority. The State shall retain final and complete decision-making authority over the receipt, allocation, and distribution of Nonadmitted Insurance premium taxes and transaction data, and all other regulatory matters with respect to the State.

15. **INDEPENDENT RELATIONSHIP**

Neither the Clearinghouse nor any agent, contractor, or employee of the Clearinghouse shall be deemed to be an agent, contractor, or employee of the State. This Agreement shall not be construed as creating a partnership, joint venture, or employment relationship between the Parties, or any other form of legal association that would impose liability on one party for the act or failure to act of the other party. Nothing in this Agreement shall be construed to grant to either party any rights or authority to assume or create any obligation or responsibility, express or implied, for or on behalf of or in the name of the other, or to bind the other in any way or manner whatsoever.

16. **CONFLICTS OF INTEREST**

The Clearinghouse agrees not to engage in lobbying or political activity of any kind, and that it shall not accept gifts or donations that may create an appearance of impropriety or an actual or apparent conflict of interest with respect to its operations or activities on behalf of the State.

17. **GOVERNING LAW AND JURISDICTION**

This Agreement shall be governed by the laws of the State of ________, U.S.A.

18. **NOTICE AND PAYMENTS**

Any and all notices that may be served with respect to this Agreement, including notice of termination, shall be in writing and shall be deemed sufficiently served if mailed by registered mail to the persons specified below.

Clearinghouse:

Name

Title

Mailing Address

City, State, Zip Code

State:

Name

Title

Mailing Address

City, State, Zip Code

The respective Parties may, however, designate in writing such new or other persons or addresses to which such notice shall thereafter be mailed.
19. **WAIVER OF BREACH**

No waiver by either party of a breach of any provision of this Agreement by the other party shall operate as a waiver of any subsequent breach.

20. **SURVIVABILITY**

Sections 5, 8, 9, 10, 13, 17, 18, 19, 20, and 21 shall survive termination of this Agreement.

21. **SEVERABILITY**

If any one or more provisions of this Agreement are held invalid by any court of competent jurisdiction or are voided or nullified for any reason, such provision shall be reformed so as to be effective as nearly as intended by the Parties, and together with the other remaining provisions and paragraphs shall continue in full force and effect and shall be binding upon the Parties so as to carry on the intents and purposes of the Parties as nearly as possible.

22. **ENTIRE AGREEMENT**

This Agreement supersedes all other agreements or representations either oral or written between the Parties regarding the subject matter hereof. No waiver, alteration, or modification of provisions in this Agreement shall be binding unless subsequently made in writing and signed by duly authorized representatives of the Parties.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement on the day and year first above written.

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By: ___________________________ By: ___________________________

Signature: ___________________________ Signature: ___________________________

Printed Name: ___________________________ Printed Name: ___________________________

Title: ___________________________ Title: ___________________________

Date: ___________________________ Date: ___________________________

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The Surplus Lines Implementation (EX) Task Force met via conference call June 10, 2011. The following Task Force members participated: James J. Donelon, Chair, and Tom Travis (LA); Linda S. Hall (AK); Karen Weldin Stewart represented by Ann Fletcher (DE); Kevin M. McCarty represented by Steve Parton (FL); Jack Messmore represented by Jim Rundblom (IL); Stephen W. Robertson represented by Cindy Donovan (IN); Brett J. Barratt represented by Marie Holt and Elena Ahrens (NV); James J. Wrynn represented by Barbara Kluger (NY); John D. Doak represented by Joel Sander (OK); Michael F. Consedine represented by Bob Brackbill (PA); Merle D. Scheiber represented by Wendall Malsam (SD); Mike Geeslin represented by Kimberly Hammer (TX); and Neal T. Gooch represented by Brad Tibbitts (UT).

1. **Adopt Proposed Model Bulletin on State Implementation of Nonadmitted and Reinsurance Reform Act**

John Bauer (NAIC) summarized the changes made from the first draft of the model bulletin. He outlined the changes between drafts of the model bulletin: additional language about the general effect of the federal Nonadmitted and Reinsurance Reform Act (NRRA); a new section on the scope of the NRRA; clarification that the laws and regulations in place on the effective date of a policy will apply to endorsements and modifications; addition of a section on premium tax allocation and payment requirements; clarification of insurer eligibility requirements; and addition of a section on key definitions from the NRRA.

Libby Baney (B&D Consulting, representing National Association of Professional Surplus Lines Offices—NAPSLO) expressed support for the model bulletin and said it would prove helpful to the industry. David Kodama (Property Casualty Insurers Association of America—PCI) offered a series of technical changes that were incorporated into the model bulletin.

Director Hall moved to adopt the model bulletin as amended (Attachment One-A). Mr. Tibbitts seconded. The motion passed.


Director Hall summarized the Outline for Clearinghouse Plan of Operation, which was developed by the Plan of Operation (EX) Subgroup. She noted that the Subgroup discussed governance issues, but decided not to include a governance structure in the Clearinghouse Plan of Operation. Accordingly, the committee structure and voting procedures of the NIMA states will be maintained separately. Director Hall stated that the Subgroup removed licensing verification from the Clearinghouse Plan of Operation such that the clearinghouse is now only responsible for identification of the filing entity. The Subgroup removed references to an audit committee and provided that the clearinghouse is subject to audit of its operations and that the clearinghouse may be given auditing authority over transactions at the discretion of the states. Further, the Subgroup discussed the appropriate deadlines for the clearinghouse’s reports to participating states and other designated stakeholders, and settled on 15 days after each quarterly tax reporting and payment deadline.

Director Hall moved to adopt the outline for the Clearinghouse Plan of Operation (Attachment One-B) and recommend to the NIMA states that they utilize it in establishing a surplus lines tax clearinghouse. Mr. Tibbitts seconded. The motion passed.

3. **Adopt Clearinghouse Access Agreement**

Mr. Travis stated that the legal subgroup completed its task to develop a model Clearinghouse Access Agreement for use by NIMA states and the clearinghouse. Mr. Travis described the subgroup’s resolution of several outstanding issues. Specifically, the subgroup expanded on the optional provision for amendment or modification to clarify that mutually agreeable changes to the scope of work can be made with a simple majority of participating states; retained both insurance and performance bond requirements with a placeholder for a fidelity bond; and removed a strict prohibition on publicity, leaving it to each party’s discretion whether to enjoin use of party names.

Mr. Parton moved to adopt the Clearinghouse Access Agreement (Attachment One-C) for use by the states participating in NIMA. Mr. Tibbitts seconded. The motion passed.

Having no further business, the Surplus Lines Implementation (EX) Task Force adjourned.
The Surplus Lines Implementation (EX) Task Force met via conference call May 20, 2011. The following Task Force members participated: James J. Donelon, Chair (LA); Linda S. Hall (AK); Karen Weldon Stewart represented by Ann Fletcher (DE); Kevin M. McCarty represented by Steve Frederickson (FL); Stephen W. Robertson represented by Cindy Donovan (IN); Brett J. Barratt represented by Gennady Stolyarov and Marie Holt (NV); James J. Wrynn represented by Barbara Kluger and Joana Lucashuk (NY); John D. Doak represented by Kelley Callahan (OK); Merle D. Scheiber represented by Wendall Malsam (SD); and Mike Geeslin represented by Stan Strickland (TX). Also participating were: John Love (KY); and Maureen Motter (OH).

1. **Consider Written Comments on Draft Model Bulletin**

Commissioner Donelon stated that the purpose of the conference call was to receive written comments on the draft model bulletin discussed during the previous conference call of the Task Force. Nicole Allen (The Council of Insurance Agents & Brokers—CIAB) suggested that the bulletin should clarify that endorsements will be subject to the regulatory rules in place as of the effective date of the policy. She added that the bulletin should clarify whether the states have the authority to collect taxes related to non-U.S. exposures.

Sabrina Miesowitz (Lloyd’s America) suggested two minor clarifications to recognize that the alien insurers use alien identification numbers different from NAIC company codes, and that Lloyd’s utilizes a unique market reference identifier that is longer than the typical policy number. Steve Stephan (National Association of Professional Surplus Lines Offices—NAPSLO) opined that the model bulletin should limit its focus to general surplus lines regulatory changes without reference to whether the state intends to enter into a multi-state agreement at a later date. He also noted that issues concerning transitioning to the effective date of the federal Nonadmitted and Reinsurance Reform Act (NRRA) need to be discussed.

Ms. Lucashuk suggested that the model bulletin should include citations to the U.S. code, rules for affiliated groups and additional information about the NRRA. David Kodama (Property Casualty Insurers Association of America—PCI) requested that the model bulletin address certain aspects of the NRRA not necessarily addressed in state surplus lines legislation. Specifically, Mr. Kodama argued that the bulletin should include clearer guidance to surplus lines insurers.

Commissioner Donelon asked if the Task Force believed references to the Nonadmitted Insurance Multi-State Agreement (NIMA) and other multi-state arrangements should be removed from this bulletin and addressed instead in a later bulletin. Mr. Strickland and Ms. Fletcher responded that such references should be removed. Ms. Fletcher added that this bulletin should be one that all of the states could adopt. Mr. Stolyarov opined that there should be a placeholder concerning which multi-state system a state might join later.

Commissioner Donelon noted that interested parties asked for clarification regarding how the states would apply their laws with respect to modifications and endorsements. He pointed out that, if the policy is effective prior to the NRRA’s July 21 effective date and there is an endorsement concerning that policy effective after July 21, it might not be clear which rules will apply to the endorsement. Ms. Motter stated that cancellation issues should also be clarified. Mr. Love asked if the bulletin could clarify these issues. Commissioner Donelon responded that the NRRA is not clear on this point, so it would be good for regulators to attempt to be clear and uniform. There were no objections to stating that laws and regulations in effect as of the effective date of a policy would also apply to any modifications occurring during the policy period.

Commissioner Donelon observed that some commenters proposed attaching the NRRA definitions as an exhibit. Ms. Kluger agreed with doing so, and Ms. Lucashuk stated that U.S. code citations should be included. Wes Bissett (Independent Insurance Agents & Brokers of America—IIABA) opined that the inclusion of key definitions would be helpful for practitioners. Mr. Kodama agreed. There were no objections to including the NRRA definitions in the model bulletin.

Commissioner Donelon requested that John Bauer (NAIC) prepare a second draft of the model bulletin to be considered on a conference call in early June.

Having no further business, the Surplus Lines Implementation (EX) Task Force adjourned.
The Surplus Lines Implementation (EX) Task Force met via conference call April 21, 2011. The following Task Force members participated: James J. Donelon, Chair, and Tom Travis (LA); Linda S. Hall (AK); Karen Weldin Stewart represented by Ann Fletcher (DE); Kevin M. McCarty represented by Steve Parton (FL); Michael T. McRaith represented by Jack Messmore and Bob Wagner (IL); Stephen W. Robertson represented by Cindy Donovan (IN); Brett J. Barratt represented by Gennady Stolyarov and Marie Holt (NV); James J. Wrynn represented by Paul Zuckerman (NY); John D. Doak represented by Joel Sander (OK); Merle D. Scheiber (SD); Mike Geeslin represented by Kathy Wilcox (TX); and Neal T. Gooch represented by Brad Tibbitts (UT).

1. Legislative Update

John Bauer (NAIC) stated that five states approved legislation authorizing the commissioner to enter into the Nonadmitted Insurance Multi-state Agreement (NIMA) or another interstate agreement or compact for surplus lines premium tax allocation. He added that such legislation was awaiting the governor’s signature in six more states and was pending in 11 additional state legislatures. With respect to the Surplus Lines Insurance Multistate Compliance Compact (SLIMPACT), Mr. Bauer stated that two states approved enacting legislation into law and one state adopted legislation authorizing the state to join SLIMPACT. He added that enacting legislation was awaiting the governor’s signature in two more states and was pending in two additional legislatures. Mr. Bauer noted that four states approved legislation to conform state laws with the federal Nonadmitted and Reinsurance Reform Act (NRRA) without providing authority for the commissioner to enter into an interstate agreement and that such legislation remained pending in three additional states.

2. Report from Clearinghouse Plan of Operation (EX) Subgroup

Director Hall noted that the Subgroup was charged with drafting a Clearinghouse Plan of Operation or procedures manual to govern the functions of the clearinghouse. NIMA contemplates that the signatory states will agree on a plan of operation to govern the operations of the clearinghouse. In starting the drafting process, the Subgroup reviewed similar documents from the Interstate Fuel Tax Association and several surplus lines associations. After initial work in February, the focus of the Subgroup shifted to development of a request for proposal (RFP), which itself turned into the request for information (RFI) that was released in March. Director Hall observed that there was a sense that the Subgroup needed the sort of information that might be obtained through an RFI or RFP in order to complete any plan of operation proposal. She added that the Subgroup has not reconvened since the RFI process was completed, but whether the subgroup should do so is a matter for discussion. Ultimately, a plan of operation will be a matter for NIMA states to work out among themselves and with a clearinghouse vendor. Director Hall added that a plan of operation will not be a matter for approval by the NAIC, although the Subgroup’s work is intended to provide NIMA states with a head start in completing a plan of operation.

Mr. Stolyarov indicated that he had no objection to transferring the work to the NIMA states. Commissioner Donelon stated that he would like to see the work transitioned by early May. Ms. Donovan stated that she hoped all of the states would have the opportunity to participate in discussions by the NIMA states. Commissioner Donelon suggested that the Subgroup complete drafting a plan of operation, with the goal of transitioning that work to the NIMA states in the coming weeks.

3. Report Concerning RFI Process

Mr. Wagner noted that the Plan of Operation (EX) Subgroup formed a smaller subgroup in February specifically focused on the development of an RFP. The RFP subgroup, however, developed a RFI as a precursor to the possible development of an RFP. Mr. Wagner offered that, while the RFI process was coordinated by the NAIC, any decisions and recommendations were to be made solely by regulators.

Mr. Wagner stated that the RFI was comprehensive and provided information to the potential vendors regarding the need for a surplus lines tax clearinghouse, the number and type of transactions anticipated, and the specific requirements for the implementation, operation and maintenance of the clearinghouse. As part of the RFI process, interested respondents were given an opportunity to make a presentation to the Task Force and other interested regulators at the Spring National Meeting.

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during a regulator-to-regulator session. These presentations focused on the ability of each vendor to meet the requirements of the clearinghouse.

Mr. Wagner stated that written responses to the RFI were received Friday, April 1. There were two responses: 1) a joint response from the Florida Surplus Lines Service Office and Infinity Software; and 2) a response from the NAIC. Both responses addressed the specific requirements outlined in each section of the RFI and provided additional information regarding their product. In regard to pricing, both respondents identified several options to cover the cost of the transactions processed but could not make a recommendation on the best approach without additional information on specific requirements, number of member states and the volume of transactions. On Friday, April 5, both respondents made a presentation to the Task Force and other interested regulators during a regulator-to-regulator conference call. Each respondent discussed how a transaction would be processed through their system. In addition, each respondent replied to questions from regulators regarding funding of the clearinghouse; development of pricing; implementation of the software and its impact on the states; potential impact of the clearinghouse on agents, brokers and the state insurance departments; cash management and controls; and contractual issues.

Mr. Wagner noted that the information learned during the RFI process can be incorporated into an RFP that the states joining NIMA might decide to issue.

4. Report from Legal Subgroup on Template Agreement

Mr. Travis described the work of the Legal Subgroup, which is charged with creating a draft agreement for each state to execute with the clearinghouse entity. Mr. Travis stated that the current draft reflected efforts to make the draft Clearinghouse Access Agreement consistent with NIMA while setting out the appropriate legal terms and conditions. Mr. Travis added that there are several outstanding issues to address. First, additional terms might need to be defined and should be consistent with the Clearinghouse Plan of Operation that is now under development. Second, it is unknown whether the Clearinghouse Plan of Operation will include a procedure for a state to withdraw from NIMA. Third, it is not clear how the clearinghouse and participating states would propose changes to the scope of work. Finally, Mr. Travis stated that contracting states will have to determine what type of insurance requirements or financial responsibility provisions are appropriate for the agreement. The draft agreement currently contains provisions for an errors or omissions policy and a performance bond. Commissioner Donelon suggested that the subgroup continue its work on the template agreement ahead of transitioning these issues to the NIMA states.

5. Discuss Draft Model Bulletin

Mr. Bauer stated that a draft model bulletin was circulated to regulators and interested parties. The draft bulletin was prepared in response to requests for the states to provide guidance to stakeholders on NRRA implementation and surplus lines regulatory changes. Commissioner Donelon suggested that the model bulletin be exposed for comments from regulators and interested parties.

Director Hall moved, and Ms. Donovan seconded, that the model bulletin be exposed for a three-week comment period. The motion passed

Having no further business, the Surplus Lines Implementation (EX) Task Force adjourned.
The Surplus Lines Implementation (EX) Task Force met via conference call Oct. 26, 2010; Nov. 3, 2010; Nov. 10, 2010; Nov. 16, 2010; Dec. 1, 2010; Dec. 8, 2010; and Jan. 6, 2011. The following Task Force members participated: James J. Donelon, Chair (LA); Linda S. Hall (AK); Karen Weldin Stewart represented by Ann Fletcher and Rourke Moore (DE); Kevin M. McCarty represented by Steve Parton and Susan Dawson (FL); Michael T. McRaith represented by Jack Messmore and Bob Wagner (IL); Stephen W. Robertson represented by Cindy Donovan (IN); Brett J. Barratt, Marie Holt, Elena Ahrens and Gennady Stolyarov (NV); James J. Wrynn represented by Paul Zuckerman, Joana Lucashuk and Barbara Kluger (NY); Robert L. Pratter represented by Steve Johnson (PA); Merle D. Scheiber and Randy Moses (SD); Mike Geeslin represented by Sara Waitt and Stan Strickland (TX); and Alfred W. Gross and Jacqueline K. Cunningham represented by Brian Gaudiose and JoAnne Scott (VA).

During the Task Force’s Oct. 26, 2010, conference call, the following occurred:

- The Task Force debated 1) whether to support the Surplus Lines Insurance Multistate Compliance Compact (SLIMPACT), which was drafted by the National Conference of Insurance Legislators (NCOIL); 2) continue development of the NAIC’s Nonadmitted Insurance Compact; or 3) develop a tax-allocation interstate agreement.
- Mr. Gaudiose moved that the Task Force recommend SLIMPACT as the preferred vehicle for implementing the federal Nonadmitted and Reinsurance Reform Act (NRRA). The motion failed without receiving a second.
- Director Scheiber moved that the Task Force develop a tax-allocation interstate agreement modeled on a draft Surplus Lines Insurance Multi-State Agreement (SLIMA) proposed by Florida. Director Hall seconded the motion. Director Hall also noted that the states would need to make other statutory changes to allow for taxation based on 100% of the gross premiums on a surplus lines placement and to allocate and share taxes with other jurisdictions. The motion passed by a 10-0-1 vote, with Alaska, Delaware, Florida, Illinois, Indiana, Nevada, New York, Pennsylvania, South Dakota and Texas in favor, and with Virginia abstaining.

During the Task Force’s Nov. 3, 2010, conference call, the following occurred:

- The Task Force considered comments on the renamed Nonadmitted Insurance Multi-state Agreement (NIMA).
- Ms. Fletcher expressed concern that NIMA does not cover all of the issues raised by the NRRA. Mr. Parton responded that the Task Force needed to focus on the tax issues and deal with other regulatory issues later.
- Mr. Zuckerman stated that certain areas required clarification, specifically those instances where the principal place of business is not located in the United States, the definition of group insurance, whether the “nerve center” of a business is ascertainable, and a uniform definition of property/casualty insurance.
- Nicole Allen (Council of Insurance Agents and Brokers—CIAB) added that uniformity issues remained important and suggested that the allocation formula be reviewed for consistency and possible redundancy.
- Mr. Johnson noted that the allocation table was based on a document developed out of a SLIMPACT working group several years previously.
- Steve Stephan (National Association of Professional Surplus Lines Offices, Ltd.—NAPSLO) expressed concern about an incremental approach. He opined that the proposed reporting requirements are burdensome, particularly for small brokers. Mr. Stephan added that the discussion about uniformity highlighted the need for a central commission that can impose uniformity. He stated that the current definition of property/casualty insurance might limit the ability of a compact to accept a filing.
- Mr. Zuckerman responded that certain language has been proposed to fill in gaps that were not addressed by the NRRA.
- The Task Force agreed to spend the next conference call working through a list of issues requiring resolution.
During the Task Force’s Nov. 10, 2010, conference call, the following occurred:

- The Task Force considered a list of possible changes to NIMA.
- The Task Force agreed to make changes to the definition of “home state” to account for situations where the insured’s principal residence or principal place of business is located outside the United States, and to tighten the definition of “surplus lines licensee” to account for an “agent of record” under Texas law.
- The Task Force agreed to include language about participating jurisdictions utilizing a plan of operation to govern the operations of the clearinghouse to be established by NIMA.
- Director Hall offered to work with New York to propose changes to the allocation schedule in Annex A of NIMA.
- The Task Force agreed to amend the tax allocation formula in Annex B consistent with changes proposed by Mr. Zuckerman.
- The Task Force agreed to Ms. Dawson’s suggestion that NIMA be amended to clarify that jurisdictions will not be required to impose taxes where the jurisdiction presently has an exemption from taxation.
- Mr. Stephan commented that he was concerned the allocation schedule was becoming too complex.
- James McIntyre (Risk and Insurance Management Society—RIMS) commented that he was concerned about the provisions requiring the payment of a fee by a policyholder.
- Director Hall noted that jurisdictions will need to consider changes to conform their statutes to the NRRA. Mr. Zuckerman added the supplementary legislation will be required to authorize a jurisdiction to enter into NIMA.
- The Task Force agreed to meet by conference call to consider whether additional changes are required.

During the Task Force’s Nov. 16, 2010, conference call, the following occurred:

- Director Hall presented a revised allocation table to be incorporated into Annex A. She stated that the table provides a uniform system for classifying risk and a basis for allocation. There is a relatively straightforward basis of allocating property risk, but the table also intends to standardize casualty risk allocation. Hank Haldeman (The Sullivan Group) stated that brokers would not frequently have a state-by-state breakout for casualty risks and that some information might not be included in the application. Director Hall argued that the NRRA contemplates allocation for multi-state risks and information for allocation should be available. Ms. Donovan suggested that a common reporting methodology would simplify the process in the long run. Mr. Haldeman responded that the detail presently in the table was too granular. Commissioner Donelon stated the Task Force remained open to suggested changes.
- Ms. Fletcher stated that Delaware did not support NIMA, because it does not meet the requirements of the NRRA. She expressed particular concern about procuring a clearinghouse provider, the effects of the definition of “principal place of business” and agreeing on the necessary data elements. Mr. Gaudiose agreed with many of Ms. Fletcher’s concerns.
- Mr. Stolyarov expressed support for NIMA. He added that issues concerning a computer software system would need to be addressed, but noted that the agreement did not preclude states from discussing bylaws prior to execution of NIMA. Mr. Parton agreed with Mr. Stolyarov.
- The Task Force discussed the sub-definition of “principal place of business.” Mr. Wagner suggested the sub-definition could create problems and lead to “gaming the system.” Mr. Zuckerman argued that the term was not defined in the NRRA, making it critical to agree on a uniform interpretation. After discussion, the Task Force agreed to changes to make the clauses within the sub-definition more consistent internally.
- Ms. Allen opined that the sub-definition of “group insurance” potentially created unmanageable tracking issues. Mr. Zuckerman responded that the sub-definition was necessary to avoid the potential for “gaming the system” and was the best way to apply the law.
- The Task Force agreed to meet again by conference call to consider whether to adopt NIMA as its recommended approach for addressing the surplus lines part of the NRRA.

During the Task Force’s Dec. 1, 2010, conference call, the following occurred:

- Commissioner Donelon stated that he believed the Task Force was nearing the point where it could consider adoption of NIMA.
- Ms. Allen voiced concerns about the definition of “home state,” stating the Task Force should stay as close to the NRRA as possible. She argued the sub-definitions of “principal residence” and “principal place of business” were not necessary.
Mr. Stephan stated that provisions of allocation of casualty risk were problematic for small brokers, adding that some brokers allocate casualty risk today and some do not. He also opined that having the non-home state requiring the home state to collect its taxes created enforcement issues under the NRRA. Mr. Zuckerman responded that NIMA provided for only the home state to require the payment of taxes, consistent with the NRRA. Mr. Zuckerman added that New York requires casualty allocation today, so he did not see similar provisions in NIMA as problematic.

Ms. Fletcher proposed a hybrid approach that combined key aspects of NIMA and SLIMPACT. Mr. Parton stated that delegating rulemaking to a central commission would be problematic for Florida. Mr. Zuckerman agreed it would also be problematic for New York. Mr. Fletcher moved that the Task Force adopt the Delaware approach. Mr. Gaudiose seconded. The motion failed 3-8, with Delaware, Indiana and Virginia in favor, and Alaska, Florida, Illinois, Nevada, New York, Pennsylvania, South Dakota and Texas opposed.

Director Scheiber moved that the Task Force recommend the NIMA concept, subject to amendments, to be considered on the next conference call. Mr. Wagner seconded. The motion passed 9-0-2 with Alaska, Florida, Illinois, Indiana, Nevada, New York, Pennsylvania, South Dakota and Texas in favor, and with Delaware and Virginia abstaining.

Commissioner Donelon stated that Task Force would meet again to consider technical amendments, including changes to the ocean marine section of the allocation table.

During the Task Force’s Dec. 8, 2010, conference call, the following occurred:

- The Task Force met to consider technical changes to NIMA. Commissioner Donelon noted that the current draft deleted the definition and exemption for ocean marine insurance.
- Ms. Allen proposed that a provision be added requiring the clearinghouse to facilitate public notice of a jurisdiction’s withdrawal from NIMA. Mr. Johnson moved this change be incorporated into NIMA. Director Scheiber seconded. The motion passed without objection.
- In response to concerns about confidentiality raised by Pamela Young (American Insurance Association—AIA), Mr. Wagner moved that NIMA be amended to include a provision that nothing in the agreement abrogates or supersedes state laws respecting confidential trade secrets and proprietary information. Mr. Stolyarov seconded. The motion passed without objection.
- There was additional discussion about how NIMA’s clearinghouse would operate. Mr. Parton stated that the clearinghouse would not be taking over a state function. Rather, the clearinghouse would be providing a single point of filing for tax collection and disbursement.
- Mr. Zuckerman suggested that a two-thirds vote should be required for adopting a plan of operation. Mr. Johnson moved that this change be incorporated into NIMA. Mr. Zuckerman seconded. The motion passed without objection.
- Mr. Stolyarov moved that the Task Force adopt NIMA as amended (Attachment One-G-1) for recommendation to the NAIC Executive (EX) Committee/Plenary. Director Hall seconded. The motion passed 8-1-2, with Alaska, Florida, Illinois, Indiana Nevada, New York, Pennsylvania and South Dakota in favor, with Delaware opposed, and with Texas and Virginia abstaining.

During the Task Force’s Jan. 6 conference call, the following occurred:

- Commissioner Donelon noted that the NAIC Executive (EX) Committee/Plenary approved NIMA as the NAIC’s recommended approach for implementing the surplus lines tax allocation provisions of the NRRA during a Dec. 16, 2010, conference call.
- Commissioner Donelon suggested there were several areas to consider as preparatory steps to NIMA implementation. He stated that the Task Force should consider developing a model plan of operation as contemplated by NIMA and begin work on the model agreement to be entered into between the participating states and the clearinghouse. Commissioner Donelon added that John Bauer (NAIC) circulated a memorandum on enabling legislation and amendments to underlying surplus lines statutes (Attachment One-G-2). Commissioner Donelon asked whether the Task Force should consider formal action on enabling legislation or changes to the NAIC’s Nonadmitted Insurance Model Act (#870). Mr. Parton stated he believed the clearinghouse requirements should be prioritized. Commissioner Donelon agreed.
- Commissioner Donelon surveyed the Task Force and interested regulators on legislative plans, specifically whether they intended to pursue NIMA, SLIMPACT or another proposal.
The Task Force established a subgroup to begin drafting a clearinghouse plan of operation as contemplated by NIMA. This document would provide a framework to be considered by those jurisdictions that join NIMA. The states volunteering to participate in the subgroup were Alaska, Delaware, Florida, Illinois, Indiana, Nevada, New York, South Dakota, Texas and Utah.

The Task Force tasked a group of small group of insurance department attorneys to work with the NAIC Legal Division to begin drafting a contract template to be entered into by the clearinghouse and jurisdictions that join NIMA. Florida, Louisiana and New York volunteered to participate.

Having no further business, the Surplus Lines Implementation (EX) Task Force adjourned.
NONADMITTED INSURANCE MULTI-STATE AGREEMENT (NIMA)

WHEREAS, the Nonadmitted and Reinsurance Reform Act of 2010 (“NRRA”), which was incorporated into the Dodd-Frank Wall Street Reform and Consumer Protection Act, provides that only an insured’s “Home State” may require a premium tax payment for Nonadmitted Insurance; and

WHEREAS, the NRRA authorizes States to enter into a compact or otherwise establish procedures to allocate among the States the Nonadmitted Insurance premium taxes;

NOW, THEREFORE, in consideration of the foregoing, the Participating States that are signatories hereto, do freely and voluntarily enter into this Agreement under the following terms and conditions:

PART I

Purpose

The purposes of this Agreement, through means of joint and cooperative action among the Participating States, are to:

1. Facilitate the payment and allocation of premium taxes on Nonadmitted Insurance for Multi-State Risks among the Participating States in accordance with the premium tax allocation method and formula contained in the Annexes attached to this Agreement and based on the rates established by each Participating State.

2. Require nationwide uniform requirements, forms and procedures that facilitate the reporting, payment, collection and allocation of premium taxes for Nonadmitted Insurance for Multi-State Risks as contemplated by the NRRA.

3. Coordinate reporting of premium taxes and transaction data on Multi-State Risks among Participating States.

4. Establish a Clearinghouse to facilitate the receipt and distribution of premium taxes and transaction data related to Nonadmitted Insurance of Multi-State Risks.

PART II

Definitions

5. For purposes of this Agreement, the following definitions shall apply:

a. “Agreement” means this Nonadmitted Insurance Multi-State Agreement (NIMA), entered into by the Participating States pursuant to Section 521(b)(1) of the NRRA.

b. "Admitted Insurer" means, with respect to a State, an insurer that is licensed to transact the business of insurance in such State.

c. “Clearinghouse” means the entity established pursuant to this Agreement to facilitate the receipt and distribution of premium taxes and transaction data related to Nonadmitted Insurance.

d. "Home State" means,
(1) In General.—Except as provided in paragraphs (2) through (5), the term ‘‘Home State’’ means, with respect to an insured—

(A) the State in which an insured maintains its principal place of business or, in the case of an individual, the individual’s principal residence; or

(B) if 100 percent of the insured risk is located out of the State referred to in subparagraph (A), the State to which the greatest percentage of the insured’s taxable premium for that insurance contract is allocated.

(2) ‘‘Principal place of business’’ means, with respect to determining the Home State of the insured, (a) the State where the insured maintains its headquarters and where the insured’s high-level officers direct, control and coordinate the business activities; or (b) if the insured’s high-level officers direct, control and coordinate the business activities in more than one State, the State in which the greatest percentage of the insured’s taxable premium for that insurance contract is allocated; or (c) if the insured maintains its headquarters or the insured’s high-level officers direct, control and coordinate the business activities outside any State, the State to which the greatest percentage of the insured’s taxable premium for that insurance contract is allocated.

(3) ‘‘Principal residence’’ means, with respect to determining the Home State of the insured, (a) the State where the insured resides for the greatest number of days during a calendar year; or (b) if the insured’s principal residence is located outside any State, the State to which the greatest percentage of the insured’s taxable premium for that insurance contract is allocated.

(4) Affiliated Groups.—If more than one insured from an affiliated group are named insureds on a single Nonadmitted Insurance contract, the term ‘‘Home State’’ means the Home State, as determined pursuant to subparagraph (A) of paragraph (1) of this subsection, of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.

(5) Group Insurance. When the group policyholder pays 100% of the premium from its own funds, the term ‘‘Home State’’ means the Home State, as determined pursuant to subparagraph (A) of paragraph (1) of this subsection, of the group policyholder. When the group policyholder does not pay 100% of the premium from its own funds, the term ‘‘Home State’’ means the Home State, as determined pursuant to subparagraph (A) of paragraph (1) of this subsection, of the group member.

e. "Independently Procured Insurance" means insurance procured by an insured directly from a Nonadmitted Insurer as permitted by the laws of the Home State.

f. ‘‘Licensed’’ means, with respect to an insurer, authorization to transact the business of insurance by a license, certificate of authority, charter, or otherwise.

g. ‘‘Multi-State Risk’’ means a risk covered by a Nonadmitted Insurer with insured exposures in more than one State.

h. ‘‘Nonadmitted Insurance’’ means any Property and Casualty Insurance permitted in a State to be placed directly or through a Surplus Lines Licensee with a Nonadmitted Insurer eligible to accept such insurance. For purposes of this Agreement, Nonadmitted Insurance includes Independently Procured Insurance and Surplus Lines Insurance.
i. “Nonadmitted Insurer” means, with respect to a State, an insurer not licensed to engage in the business of insurance in such State, but shall not include a risk retention group, as that term is defined in section (2)(a)(4) of the Liability Risk Retention Act of 1986 (15 U.S.C. 3901(a)(4)).

j. “Non-Participating State” means any State that has not executed this Agreement.

k. “Participating State” means any State that has executed this Agreement and that has not withdrawn or defaulted pursuant to Part VII.

l. “Property and Casualty Insurance” means any kind of insurance on property, fidelity and surety insurance, or liability insurance, but does not mean title insurance, workers’ compensation insurance, or any insurance on the life of a person, including life insurance, annuities, accident and health insurance, or disability insurance.

m. “Single-State Risk” means a risk with insured exposures in only one State.

n. “Surplus Lines Insurance” means insurance procured by a Surplus Lines Licensee from a Surplus Lines Insurer as permitted under the law of the Home State; for purposes of this Agreement, “Surplus Lines” shall also mean excess line as may be defined by applicable State law.

o. “Surplus Lines Insurer” means a Nonadmitted Insurer permitted under the law of the Home State to accept business from a Surplus Lines Licensee.

p. “Surplus Lines Licensee” means an individual, firm or corporation that is licensed in a State to sell, solicit or negotiate insurance, including the agent of record on a Nonadmitted Insurance policy, on properties, risks or exposures located or to be performed in a State with Nonadmitted Insurers.

6. In this Agreement, unless otherwise specified, words or expressions used in this Agreement have the same meaning as in the Nonadmitted and Reinsurance Reform Act of 2010.

7. The following are the Annexes that are attached to, and that form an integral part of, this Agreement: Annex A - Nonadmitted Insurance Premium Tax Allocation Schedule; Annex B – Allocation Formula; and Exhibit I – Information Required to be Submitted by the Broker or Insured via the Clearinghouse Web Portal.

PART III

Implementation

8. The Participating State, as signatory herein, represents that it has the legal authority necessary to enter into this Agreement for the purposes stated in the Agreement, including the allocation among the other Participating States of applicable Nonadmitted Insurance premium taxes and the use of the designated Clearinghouse for the facilitation of the payment and distribution of such premium taxes.

9. Pursuant to the terms of this Agreement, each Participating State agrees to:

   a. implement nationwide uniform requirements, forms and procedures that facilitate the reporting, payment, collection and allocation of premium taxes for Nonadmitted Insurance for Multi-State Risks;

   b. allocate among the applicable Participating States the Nonadmitted Insurance premium taxes required by an insured’s Home State as described herein;
c. work collaboratively and in a timely manner towards the imposition of NRRA’s Nonadmitted Insurance premium tax reforms by July 21, 2011; and

d. establish and utilize a Clearinghouse to facilitate the receipt, allocation, and distribution of the payment of Nonadmitted Insurance premium taxes to the Participating States.

PART IV

Collection and Allocation Procedures

10. The Clearinghouse will operate pursuant to a plan of operation, to be agreed upon by two-thirds of the Participating States, to ensure that the Clearinghouse and its computer software system are capable of meeting the requirements of this Agreement.

11. Each Participating State agrees to use the Clearinghouse for all Multi-State Risks for which that state is the Home State. Except as otherwise provided, each Participating State agrees to require Surplus Lines Licensees and insureds who independently procure insurance to utilize the Clearinghouse for the reporting and payment of Nonadmitted Insurance premium taxes for all Multi-State Risks for which that state is the Home State. This Agreement shall not require a State to treat any Property and Casualty Insurance as Nonadmitted Insurance where the laws of the State do not provide such treatment. Further, each Participating State may, at its discretion, agree to use the Clearinghouse for any Single-State Risks or non-Property and Casualty Insurance risks for which that state is the Home State.

12. Each Participating State agrees to contract with the Clearinghouse to provide the services that are the subject of this Agreement. There shall be no material variations in the terms of each Participating State’s contract with the Clearinghouse and each such contract shall include, but not be limited to, terms prohibiting the Clearinghouse from lobbying, accepting gifts or donations, political activity of any kind, or conflicts of interest, and shall include terms requiring confidentiality of information received by or provided to the Clearinghouse.

13. Each Participating State agrees to require the payment of taxes, fees and assessments when the Participating State is the Home State as follows: (a) as determined by the Home State on the portion of the premium allocated to the Home State based on Annex A and Annex B; (b) specified by each Participating State on the portion of the premium allocated to that State based on Annex A and Annex B; and (c) determined by the Home State on any portion of the premium not allocated under subsections (a) and (b) of this section. Each Participating State agrees to establish one tax rate, encompassing any applicable taxes, fees and assessments, that applies to Nonadmitted Insurance; provided, however, that nothing shall require a Participating State to impose a tax on any kind of insurance for which the State presently does not have an obligation to tax or has allowed an exemption; and further provided that, where a Home State utilizes a surplus lines stamping office, the stamping office may, in accordance with the laws of that State, impose stamping fees in addition to the tax.

14. Each Participating State shall give notice to the Clearinghouse of any changes to its statewide Nonadmitted Insurance premium tax rate and any statewide assessments at least 90 days prior to the effective date of such changes. The Clearinghouse will send notice of any changes to all of the Participating States via electronic mail to the designated contact of each Participating State.

15. Each Participating State agrees to authorize the Clearinghouse, when the Participating State is the Home State, to collect a reasonable fee, to be established by contract between the Participating State and the Clearinghouse, payable by the insured directly or through a Surplus Lines Licensee on each transaction processed
through the Clearinghouse to cover the cost of the operations and activities of the Clearinghouse. If the Home State has a stamping office, this fee shall be in addition to the service fee that is received by the stamping office.

16. No Participating State, other than the Home State, may require a Surplus Lines Licensee to submit data, reports or insurance documentation to a stamping office of that State. A Home State with a stamping office may require the initial submission of transaction data, premium taxes and fees with the stamping office of that State provided the State agrees by contract with the Clearinghouse to forward relevant transaction data, premium taxes and fees to the Clearinghouse for distribution to other Participating States.

17. Except as otherwise provided, each Participating State agrees to require, by statute or rule, for those policies of Nonadmitted Insurance where that State is the Home State and for which the payment of Nonadmitted Insurance premium taxes is due, that the Surplus Lines Licensee or insured who independently procures insurance shall forward such payments and related information based on Annex A and Annex B to the Clearinghouse for deposit in the Clearinghouse account. Each Participating State agrees to require that the payment of Nonadmitted Insurance premium taxes will be accompanied by transaction data consistent with Exhibit 1. After the Clearinghouse has collected and reconciled the payments, the appropriate amount will be deposited into each Participating State’s depository account at the banking institution selected by the Participating State. With respect to the depository accounts of the Participating States, the Clearinghouse shall only have the authority to transfer premium taxes collected and on deposit in the Clearinghouse account into the depository account of the Participating States.

18. For those policies of Nonadmitted Insurance where transaction data consistent with Exhibit 1 is submitted prior to the payment of Nonadmitted Insurance premium taxes, each Participating State agrees that the accounting of taxes due will be tracked by the Clearinghouse, and the payment thereof will be handled by the Clearinghouse. Each Participating State agrees to require the Surplus Lines Licensee or insured who independently procures insurance, as applicable, to submit information based on Annex A and Annex B. The Clearinghouse will assess the allocated premium based upon each Participating State’s statewide Nonadmitted Insurance tax rate and statewide assessments for each Participating State with exposure. At the end of the reporting period, the Clearinghouse will allocate the amount collected on behalf of the Home State to all other Participating States and net the amounts owed to or from each of the States. The netting of taxes will be based on the actual amount collected.

19. The Clearinghouse will report to the Participating States, Surplus Lines Licensees and insureds who independently procure insurance, within 15 days of the quarterly premium tax filing and payment dates set forth in section 20 of this Part, all premium taxes owed to each of the Participating States for the preceding quarter, the dates upon which payment of such premium taxes are due, and the method through which they were paid to the Clearinghouse.

20. Each Participating State agrees that, when it is the Home State, it shall require tax filings and payments quarterly utilizing the following dates only: February 15 for the quarter ending the preceding December 31, May 15 for the quarter ending the preceding March 31, August 15 for the quarter ending the preceding June 30, and November 15 for the quarter ending the preceding September 30.

21. The Home State agrees to enforce, if necessary and to the extent allowed by the laws of the Home State, any of the following: unpaid tax; interest due; and applicable penalties. The Home State will follow the calculation of these amounts and the methods of collection governed by the laws of the Home State and the plan of operation adopted pursuant to this Agreement.
PART V
Dispute Resolution

22. Each Participating State agrees to exercise best efforts to reach consensus in respect to disputed issues arising on matters governed by this Agreement.

23. If a dispute arises out of or relates to this Agreement, or the breach thereof, and if the dispute cannot be settled through negotiation, the affected Participating States agree first to try in good faith to settle the dispute by mediation administered by the American Arbitration Association under its Commercial Mediation Procedures before resorting to arbitration, litigation, or some other dispute resolution procedure. A dispute involving one or more Participating States or the Clearinghouse is a dispute arising out of or relating to this Agreement for purposes of this Part.

PART VI
Participating States, Effective Date and Amendment

24. Any State is eligible to become a Participating State. This Agreement shall become effective and binding as of the first day after the conclusion of the calendar quarter in which the Agreement is executed by the duly authorized representative of at least two (2) Participating States. Thereafter, it shall become effective and binding as to any other Participating State as of the first day after the conclusion of the calendar quarter in which such State executes this Agreement.

25. Amendments may be proposed by any of the Participating States under this Agreement. The amendment shall become effective after two-thirds of the Participating States agree in writing to accept the amendment.

PART VII
Withdrawal, Default and Dissolution

26. Withdrawal

a. Once effective, this Agreement shall continue in force and remain binding upon each and every Participating State, provided that a Participating State may withdraw from the Agreement ("Withdrawing State") by providing 60 days’ written notice to the Clearinghouse, which shall provide advance written notice to all Participating States and facilitate public notice of the State’s withdrawal from the Agreement.

b. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal.

27. Default

a. If any Participating State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Agreement, the Defaulting State shall be suspended from the effective date of default. The grounds for default include, but are not limited to, failure of a Participating State to perform its obligations or responsibilities as required by this Agreement.
b. Reinstatement following termination of any Participating State requires renewed execution of the Agreement.

28. Dissolution of Agreement

a. The Agreement dissolves effective upon the date of the withdrawal or default of the Participating State that reduces membership in the Agreement to one Participating State.

b. Upon the dissolution of this Agreement, the Agreement becomes null and void and shall be of no further force or effect.

PART VIII

Severability and Construction

29. The provisions of this Agreement shall be severable and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of this Agreement shall be enforceable.

30. The provisions of this Agreement shall be liberally construed to effectuate its purposes.

31. Throughout this Agreement, the use of the singular shall include the plural and vice-versa. The headings and captions of parts, sections, subsections, paragraphs and sub-paragraphs used in this Agreement are for convenience only and shall be ignored in construing the substantive provisions of this Agreement.

PART IX

Binding Effect of Agreement and Other Laws

32. The terms of this Agreement, and the procedures to be established as amendments to this Agreement, are binding upon the Participating States, except as otherwise may be provided herein.

33. Each Participating State agrees to abide by the applicable laws, regulations, and statutes concerning confidentiality and nondisclosure of information to the extent required or allowed by law. This Agreement neither abrogates nor supersedes applicable Participating State laws respecting confidentiality, trade secrets and proprietary information.

PART X

Miscellaneous

34. This Agreement may be executed in any number of counterparts, each of which will constitute an original and all of which taken together will constitute one and the same instrument. Counterparts may be executed either by hard copy or electronically, or by facsimile, and the Participating States shall accept any signatures received by electronic mail or facsimile as original signatures of the Participating State. The Participating State will promptly forward to the other Participating States and the Clearinghouse a signed copy of this Agreement.
35. By entering into this Agreement, a Participating State is not deemed to surrender or abandon any of the powers, rights, privileges or authorities vested in it under its State constitution, statutes, acts, or otherwise, or to impair any of such powers, rights, privileges or authorities.

36. This Agreement, including all Annexes and the Exhibit attached, constitutes the entire agreement between the Participating States with respect to the subject matter of this Agreement and supersedes all prior agreements and understandings between the Participating States with respect to that subject matter.

37. After execution of this Agreement, each Participating State will do, or cause to be done, all acts as the other Participating States may reasonably require from time to time for the purpose of giving effect to this Agreement and each Participating State will use reasonable efforts, and take all steps as may be reasonably within that Participating State’s power, to implement to its full extent the provisions of this Agreement.

_____________________________________

[Signature of State Official]
ANNEX A
Nonadmitted Insurance Premium Tax Allocation Schedule

This Annex to the Agreement sets forth the provisions governing the method of tax allocation for Multi-State Risks, as specified in Part III. If the allocation schedule does not identify a classification appropriate to the property or risk being insured, then the Surplus Lines Licensee, or an insured who independently procures insurance, consistently shall use an alternative method of equitable allocation across similar types of insurance policies and contracts, and shall maintain for at least five years, documented evidence of the bases and other criteria used by the Surplus Lines Licensee or insured who independently procures insurance in order to substantiate the method.
## EXPOSURE ALLOCATION METHODOLOGY

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<th>MAJOR COVERAGE</th>
<th>COVERAGE TYPE</th>
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<th>*ALLOCATION BASIS BY STATE</th>
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<td>OTHER SURETY BONDS</td>
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<td>TOTAL BOND VALUE OF CONTRACTS IN STATE</td>
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</table>

* U.S. PREMIUM ONLY
ANNEX B
Allocation Formula

For the purposes of this Annex and subject to Parts III, IV, and VII, the Nonadmitted Insurance premium tax revenue for a calendar tax year or for a sub-period of a calendar tax year, as the case may be, is the amount determined by the formula:

Tax Allocation = \( \frac{\text{Net tax due to each State}}{\text{net tax due to all States}} \times \text{Amount collected} \)

Home State Net Taxes = \( \text{Taxes collected for the Home State} + \text{Taxes due from other Participating States} \) – Taxes owed to other Participating States

Total Premium Tax to be Collected on Each Multi-State Policy = \( \text{Home State’s tax rate} \times \text{Portion of premium allocated to Home State} \) + \( \text{Home State’s tax rate} \times \text{Premium allocated to Non-Participating State if insurer is nonadmitted in that State} \) + \( \text{Participating States’ tax rate} \times \text{Premium allocated to each Participating State if insurer is nonadmitted in that state} \)
Exhibit 1

Information Required to be Submitted
By the Broker or Insured via the Clearinghouse Web Portal

A. Submission Contact
Name
Address
Phone Number
E-mail address
Independently procured policy? (Y/N)

B. Agency/Brokerage Firm Data
State
License Number
Name
Address
Phone Number

C. Agent/Sublicensee or Individual Licensee Data
State
License Number
Name
Office Address
Mailing Address
Phone Number
E-mail Address
D. **Billing Contact**

Name

Address

E-mail Address

Phone Number

E. **Policy Data**

Policy Number/Binder Number if Policy Number is not available

Effective Date

Expiration Date

Insured Name

Home State of Insured

F. **Transaction Data**

NAIC Insurer Code Number(s)

Insurer Name(s)

Total Policy Premium by Insurer(s)

Coverage Code

Tax Status

Transaction Type (New, Renewal or Endorsement)

Allocation among States:

  Allocation Method

  Premiums Allocated to Each State
MEMORANDUM

To: States considering joining the Nonadmitted Insurance Multi-State Agreement and updating laws and regulations to conform to the Nonadmitted and Reinsurance Reform Act of 2010

From: NAIC Legal Division

Date: 1 December 2010

Re: NRRA Implementation Considerations

NRRA Implementation Considerations

The Surplus Lines Implementation (EX) Task Force is nearing completion of its work on the Nonadmitted Insurance Multi-State Agreement (NIMA) as the recommended approach for implementing the surplus lines provisions of the Nonadmitted and Reinsurance Reform Act of 2010 (NRRA). While NIMA provides one means of implementing those NRRA provisions concerning surplus lines premium tax collection, allocation and distribution, states should also consider the extent to which they need to amend their laws to allow for full participation in NIMA and to otherwise conform to the NRRA.

This memorandum is prepared for the purpose of assisting states in identifying those areas of their surplus lines laws that may need to be amended or updated. States should conduct a thorough review of their surplus lines laws in the event there are state-specific issues that need to be addressed. This memorandum is divided into two parts: (1) those changes that may be necessary to participate in NIMA, and (2) those changes that may be necessary otherwise to conform state law to the NRRA. In those places where the memorandum provides examples of statutory language, states will need to adapt any such language to the existing format and convention of their insurance codes. The examples included herein are provided for illustrative purposes only.

Statutory changes that may be considered to enter into and implement NIMA

1. Enabling language to permit the state to enter into NIMA

Because participation in NIMA requires states to share tax revenues they are authorized to collect under the NRRA as the home state on a nonadmitted insurance placement, states will likely require statutory authorization to enter into NIMA and participate fully in NIMA. Statutory language similar to that enacted by Texas to authorize its comptroller to enter into an interstate agreement or compact for surplus lines tax collection is one option:

The comptroller may enter into a cooperative agreement, reciprocal agreement, or compact with another state to provide for the collection of taxes imposed by this state and the other states on insurances taxes that may be due the states and this state based on a standardized premium allocation adopted by the states under the agreement. The comptroller may also enter into other cooperative agreements with surplus lines stamping offices located in this state and other states in the reporting and capturing of related tax information. In addition, the comptroller may enter into cooperative agreements with processing entities located in this state or other states related to the capturing and processing of insurance premium and tax data. Tex. Ins. Code Ann. § 229.002.

Another approach may be the following:

For the purposes of carrying out the Nonadmitted and Reinsurance Reform Act of 2010, the commissioner [or other state official] is authorized to enter the Nonadmitted Insurance Multi-State Agreement in order to facilitate the collection, allocation and disbursement of premium taxes attributable to the placement of nonadmitted insurance; provide for uniform methods of allocation and reporting among nonadmitted insurance risk classifications; and share information among states relating to nonadmitted insurance premium taxes.
2. **Add definition of “home state” to surplus lines law**

States may consider codifying the definition of “home state” that is ultimately included within NIMA. Codifying a commonly accepted definition of “home state” will help to ensure states are operating from a mutual understanding of which state will be the “home state” for a nonadmitted insurance placement and reduces the potential for conflicts among states as to which jurisdiction is the home state in a transaction.

3. **Statutory authorization to collect and disburse taxes based on a single home state rate as well as the rates of other states.**

The below language is a modified version of Section 5.F.(1) of the NAIC Nonadmitted Insurance Model Act, which concerns surplus lines taxes. (A related section concerning taxes on independently-procured insurance follows. States may also need to consider whether additional sections requiring the payment of taxes should be similarly modified.) Possible modifications to Section 5.F.(1) are highlighted. The modifications are intended to (a) provide for the payment of surplus lines taxes on 100% of the gross premiums of a surplus lines policy, (b) compute the sum of taxes to be paid based on a formula that incorporates the home state’s tax rate as well as the tax rates of other states where a portion of the risk or exposure on the policy is located, (c) authorize participation in the clearinghouse established by NIMA for the purpose of collecting, allocating and disbursing taxes to other participating states, and (d) provide for the reversion to the home state of any taxes that otherwise would be allocated to a state that does not participate in NIMA.

**Based on Section 5.F.(1) of Nonadmitted Insurance Model Act:**

In addition to the full amount of gross premiums charged by the insurer for the insurance, every person licensed pursuant to Section 5H of this Act shall collect and pay to the commissioner [or other state official] a sum based on the total gross premiums charged, less any return premiums, for surplus lines insurance provided by the licensee pursuant to the license. Where the insurance covers properties, risks or exposures located or to be performed both in and out of this state, the sum payable shall be computed based on (a) an amount equal to [insert number] percent on that portion of the gross premiums allocated to this state pursuant to Paragraph (4) of this subsection, plus (b) an amount equal to the portion of the premiums allocated to other states or territories on the basis of the tax rates and fees applicable to properties, risks or exposures located or to be performed outside of this state pursuant to Paragraph (4) of this subsection, less (c) the amount of gross premiums allocated to this state and returned to the insured. The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the surplus lines licensee or through the producing broker, if any. The surplus lines licensee is prohibited from rebating, for any reason, any part of the tax.

The commissioner [or other state official] is authorized to participate in the clearinghouse established through the Nonadmitted Insurance Multi-State Agreement for the purpose of collecting and disbursing to reciprocal states any funds collected pursuant to clause (b) above applicable to properties, risks or exposures located or to be performed outside of this state. To the extent that other states where portions of the properties, risks or exposures reside have failed to enter into a compact or reciprocal allocation procedure with this state, the net premium tax collected shall be retained by this state.

4. **Statutory authorization to collect and disburse taxes based on a single home state rate as well as the rates of other states for independently-procured insurance.**

The below language, which is based on Section 6.B of the Nonadmitted Insurance Model Act, is intended to bring taxation for independently-procured insurance in conformity with the above-suggested changes for surplus lines taxes. Possible modifications to the existing model law language are highlighted in yellow.

**Based on Section 6.B of Nonadmitted Insurance Model Act:**

Gross premiums charged for the insurance, less any return premiums, are subject to a tax at the rate of [insert number] percent. At the time of filing the report required in Subsection A of this section, the insured shall pay the tax to the commissioner, who shall transmit the same for distribution as provided in this Act. Where the insurance covers properties, risks or exposures located or to be performed both in and out of this state, the sum payable shall be computed based on (a) an amount equal to [insert number] percent on that
portion of the gross premiums allocated to this state pursuant to Section 5F(4), plus (b) an amount equal to the portion of the premiums allocated to other states or territories on the basis of the tax rates and fees applicable to properties, risks or exposures located or to be performed outside of this state pursuant to Section 5F(4).

The commissioner [or other state official] is authorized to participate in the Nonadmitted Insurance Multi-State Agreement for the purpose of collecting and disbursing to reciprocal states any funds collected pursuant to clause (b) above applicable to other properties, risks or exposures located to be performed outside of this state. To the extent that other states where portions of the properties, risks or exposures reside have failed to enter into compact or reciprocal allocation procedure with this state, the net premium tax collected shall be retained by this state.

5. Authorization to establish blended tax rate to participate in NIMA

Participation in NIMA requires the state to establish a single rate applicable to all lines of nonadmitted insurance and encompassing all applicable taxes, fees and assessments. The purpose of this requirement is not to impose or require new taxes but is to ensure that the person submitting relevant transaction information will benefit from the ease of applying a single rate to risk located in a state. States participating in NIMA will likely need to establish the rate of taxation through which the state can be “made whole” in moving from a system of differing rates across lines of business and differing levels of state and local assessments. It is not clear whether states presently have the authority to combine existing taxes, fees and assessments into a single rate applicable to that state. In order to establish the authority to set a single blended rate, states may consider language similar to the following:

In order to participate in the Nonadmitted Insurance Multi-State Agreement, the commissioner [or other state official] is authorized to establish a uniform, statewide rate of taxation applicable to lines of nonadmitted insurance subject to the Agreement. This rate shall encompass all existing rates of taxation, fees and assessments imposed by this State and any political subdivision hereof, and the commissioner [or other state official] shall document the method by which the statewide rate is calculated. The commissioner [or other state official] is authorized to receive any monies obtained through the clearinghouse established through the Agreement for the collection and disbursement of such funds on behalf of any agency or political subdivision of this State and shall transfer monies to any agency or political subdivision in proportion to the inclusion of any rate of taxation, fee or assessment in the statewide rate.

6. Authorization to adopt the Allocation Schedule to be utilized in implementing NIMA

There may be some states for which adoption of a common allocation schedule is subject to legislative approval or administrative procedures. Moreover, Section 5.F.(4) of the Nonadmitted Insurance Model Act currently presumes that a state receives only those taxes attributable to risk located in that state and that the allocation schedules attached to the model regulation will be utilized. The following language is intended to provide the authorization to utilize NIMA’s Allocation Schedule. States may consider the extent to which this or similar language may replace or amend statutes based on Section 5.F.(4).

The commissioner [or other state official] is authorized to utilize [or adopt] the Allocation Schedule included in the Nonadmitted Insurance Multistate Agreement for the purpose of allocating risk and computing the tax due on the portion of premium attributable to each risk classification and to each state where properties, risks or exposures are located.

Statutory and administrative changes that may be considered to bring state law in conformity with provisions of NRRA unrelated to subject matter of NIMA

While NIMA is focused on preserving the existing system of premium tax allocation, the NRRA makes other changes affecting surplus lines regulation. Similar to issues associated with premium tax allocation, the NRRA establishes certain regulatory requirements that will apply to surplus lines insurance. Some of these requirements will go into effect regardless of whether states take uniform nationwide action. States should review the following areas of their surplus lines laws in order to determine whether to amend such laws to be consistent with the NRRA. In the event states choose not to amend their statutes, inconsistent state laws may be subject to preemption pursuant to the NRRA.
1. Regulatory authority

The NRRA establishes the principle of home state deference with respect to surplus lines regulation and taxation. While the NRRA permits states to agree on a nationwide system for premium tax allocation and otherwise work together to achieve uniformity in certain areas, Section 522 enshrines home state deference into federal law. Pursuant to Section 522(a), the placement of business “shall be subject to the statutory and regulatory requirements solely of the insured’s home State.” Additionally, Section 522(c) provides that, with respect to certain provisions of the NRRA, state laws or measures that “appl[y] or purport[] to apply to nonadmitted insurance sold to, solicited by, or negotiated with an insured whose home State is another State shall be preempted with respect to such application.”

This memorandum has already described certain provisions of state laws that will need to be revised to participate in NIMA. The Nonadmitted Insurance Model Act does not include a general section on the scope of the law. For those states where the surplus lines law includes a statement of the law’s scope, states may consider modifying their statute to clarify that such law will only apply to those placements of nonadmitted insurance where that state is the home state of the insured. Concurrent enactment of NIMA’s definition of “home state” may further assist in providing nationwide clarity about the determination of an insured’s home state on a given placement.

2. Insurer eligibility requirements

Without the establishment of uniform nationwide nonadmitted insurer eligibility requirements, Section 524(1) of the NRRA requires states to adhere to Sections 5.A.(2) and 5.C.(2)(a) of the NAIC Nonadmitted Insurance Model Act relating to eligibility requirements for nonadmitted insurers domiciled in other U.S. jurisdictions. Section 524(2) prevents states from prohibiting surplus lines brokers from placing business with non-U.S. carriers included on the NAIC’s Quarterly Listing of Alien Insurers. Therefore, state requirements that differ from the limitations of the NRRA may be subject to preemption. In the absence of amending state law to enact presently-undeveloped uniform nationwide requirements or choosing not to enforce requirements that would be subject to preemption, states may consider amending the appropriate statutes or regulations to conform to Section 524 of the NRRA. The following language is based on Section 5.C of the Nonadmitted Insurance Model Act, with possible changes highlighted. Included is proposed language authorizing the commissioner to participate in a multi-state initiative to establish nationwide, uniform eligibility requirements for U.S.-based carriers:

*Based on Sections 5.A and 5.C of Nonadmitted Insurance Model Act:*

A. Surplus lines insurance may be placed by a surplus lines licensee if:

(2) Each insurer is authorized to write the type of insurance in its domiciliary jurisdiction; . . .

C. A surplus lines licensee shall not place coverage with a nonadmitted insurer, unless, at the time of placement, the surplus lines licensee has determined that the nonadmitted insurer:

(1) Has established satisfactory evidence of good repute and financial integrity; and

(2) Qualifies under one of the following subparagraphs:

(a) Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

(i) The minimum capital and surplus requirements under the law of this state; or

(II) $15,000,000;

(ii) The requirements of Subparagraph (a)(i) may be satisfied by an insurer’s possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and
reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the nonadmitted insurer’s capital and surplus is less than $4,500,000;

(3) For an insurer not domiciled in the United States or its territories, the insurer is listed on the Quarterly Listing of Alien Insurers maintained by the NAIC International Insurers Department.

(4) [Insert state-specific requirements for non-US insurers not on IID quarterly listing]

D. The commissioner [or other state official] is authorized to enter into a cooperative agreement or interstate agreement or compact to establish additional and alternative nationwide uniform eligibility requirements that shall be applicable to nonadmitted insurers domiciled in another state or territory of the United States.

3. National insurer producer database

Section 523 of the NRRA provides that participation in the national insurance producer database of the NAIC for the licensure of surplus lines brokers and renewal of their licenses will be required to collect licensing fees for surplus lines brokers as of July 21, 2012. The National Insurance Producer Registry presently serves as such a database. In the event states require statutory authorization to participate in this database, states may consider the following enabling language:

For the purposes of carrying out the provisions of the Nonadmitted and Reinsurance Reform Act of 2010, the commissioner [or other state official] is authorized to utilize the national insurance producer database of the NAIC, or any other equivalent uniform national database, for the licensure of an individual or an entity as a surplus lines producer and for renewal of such license.

Alternatively, Section 7.G of the NAIC Producer Licensing Model Act includes language that may provide an existing basis for participation in NIPR and may be adopted by states that have not done so:

G. In order to assist in the performance of the insurance commissioner’s duties, the insurance commissioner may contract with non-governmental entities, including the National Association of Insurance Commissioner (NAIC) or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including the collection of fees, related to producer licensing that the insurance commissioner and the non-governmental entity may deem appropriate.

4. Home state broker licensing requirements

Section 522(b) of the NRRA provides that only the insured’s home state may require a surplus lines broker to be licensed to sell, solicit or negotiate nonadmitted insurance with respect to that insured. This paragraph does affect the requirement that states extend reciprocity to non-resident surplus lines brokers pursuant to the NARAB provisions of the Gramm-Leach-Bliley Act. Section 522(b), however, will affect requirements that a broker be licensed in every state where a portion of the risk is located in a multi-state placement. Accordingly, states may consider amending provisions in their surplus lines laws to clarify that licensure is required only where the state is the home state of the insured. The following language is based on Section 5.H.(1) of the Nonadmitted Insurance Model Act, with proposed additions highlighted:

Based on Section 5.H.(1) of Nonadmitted Insurance Model Act:

H. Surplus Lines Licenses

(1) For insureds whose Home State is this state, a person shall not procure a contract of surplus lines insurance with a nonadmitted insurer unless the person possesses a current surplus lines insurance license issued by the commissioner.
5. Exempt commercial purchasers

Section 525 of the NRRA provides that surplus lines brokers seeking to procure or place nonadmitted insurance on behalf of an “exempt commercial purchaser” are not required to satisfy any diligent search requirements where certain conditions are present. Section 527(5) defines those “exempt commercial purchasers” to which this provision would apply. Section 5.A.(3) of the NAIC Nonadmitted Insurance Model Act includes a requirement that a diligent search of admitted carriers be performed. State laws vary with respect to establishing the requirement of the diligent search and any required number of declinations before the coverage may be placed with a nonadmitted insurer. Therefore, states seeking to conform their diligent search laws to NRRA’s exempt commercial purchaser provision will need to tailor relevant statutory language to the specific provisions in their surplus lines law. In developing state-specific language, states may consider the following:

A. A surplus lines broker is not required to make a due diligence search to determine whether the full amount or type of insurance can be obtained from admitted insurers when the broker is seeking to procure or place nonadmitted insurance for an exempt commercial purchaser provided:

(1) The broker procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

(2) The exempt commercial purchaser has subsequently requested in writing for the broker to procure or place such insurance from a nonadmitted insurer.

B. The term ‘exempt commercial purchaser’ means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(1) The person employs or retains a qualified risk manager to negotiate insurance coverage.

(2) The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of $100,000 in the immediately preceding 12 months.

(3) The person meets at least one of the following criteria:

(i) The person possesses a net worth in excess of $20,000,000, as such amount is adjusted pursuant to clause (b).

(ii) The person generates annual revenues in excess of $50,000,000, as such amount is adjusted pursuant to clause (b).

(iii) The person employs more than 500 full time or full time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate.

(iv) The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least $30,000,000, as such amount is adjusted pursuant to clause (b).

(v) The person is a municipality with a population in excess of 50,000 persons.

(b) Effective on January 1, 2015 and every five years thereafter, the amounts in subclauses (i), (ii) and (iv) of clause (a) shall be adjusted to reflect the percentage change for such 5-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Department of Labor.
The Joint Executive (EX) Committee/Plenary met via conference call May 16, 2011. The following members participated:

Susan E. Voss, Chair (IA); Kevin M. McCarty, Vice Chair (FL); James J. Donelon, Vice President (LA); Michael T. McRaith, Secretary-Treasurer, represented by Jack Messmore (IL); Jane L. Cline, Immediate Past President (WV); Linda S. Hall (AK); Jim L. Ridling (AL); Jay Bradford represented by Lenita Blasingame (AR); Christina Urias (AZ); Dave Jones (CA); John Postolowski (CO); Thomas B. Leonardi (CT); Karen Weldin Stewart (DE); Ralph T. Hudgens represented by Justin Durrance (GA); Gordon L. Ito (HI); William W. Deal represented by Shad Priest (ID); Stephen W. Robertson (IN); Sandy Praeger (KS); Sharon P. Clark represented by Ray Perry (KY); Joseph G. Murphy (MA); Elizabeth Sammis (MD); Mila Kofman (ME); Ken Ross (MI); Mike Rothman (MN); John M. Huff (MO); Mike Chaney (MS); Monica J. Lindeen (MT); Wayne Goodwin (NC); Adam Hamm (ND); Bruce R. Range (NE); Roger A. Sevigny (NH); Thomas B. Considine (NJ); John G. Franchini (NM); Brett J. Barratt (NV); James J. Wrynn (NY); Mary Taylor represented by Cathy Geyer (OH); John D. Doak (OK); Teresa D. Miller (OR); Michael F. Consedine represented by Randy Rohrbaugh (PA); Ramón Cruz-Colón represented by Yvette M. Domenech (PR); Joseph Torti III (RI); David Black (SC); Merle D. Scheiber (SD); Julie Mix McPeak (TN); Mike Geeslin represented by Sara Waitt (TX); Neal T. Gooch represented by Silmara Charlesworth (UT); Jacqueline K. Cunningham (VA); Gregory R. Francis represented by John McDonald (VI); Steve Kimbell represented by Susan Donegan (VT); Mike Kreidler represented by Beth Berendt (WA); Ted Nickel (WI); and Ken Vines (WY).

1. **NAIC Secretary-Treasurer Interim Election**

Michael T. McRaith resigned effective May 31, 2011, as NAIC Secretary-Treasurer and Illinois Director of Insurance. The Joint Executive (EX) Committee/Plenary conducted an interim election May 16 to replace the position. The NAIC members elected Commissioner Hamm as Secretary-Treasurer to serve from June 1, 2011 to Dec. 31, 2011.

Having no further business, the Joint Executive (EX) Committee/Plenary adjourned.
The Joint Executive (EX) Committee/Plenary met via conference call July 12, 2011. The following members participated:

Susan E. Voss, Chair (IA); Kevin M. McCarty, Vice Chair (FL); James J. Donelon, Vice President represented by Tom Travis (LA); Adam Hamm, Secretary-Treasurer (ND); Roger A. Sevigny, Immediate Past President (NH); Linda S. Hall (AK); Jay Bradford represented by Lenita Blasingame (AR); Dave Jones (CA); John Postolowski represented by Jim Riesburg (CO); Thomas B. Leonard (CT); William P. White represented by Cherie Ashcroft (DC); Karen Weldin Stewart (DE); Ralph T. Hudgens (GA); Artemio B. Ilagan (GU); Gordon I. Ito (HI); William W. Deal (ID); Jack Messmore (IL); Sandy Praeger (KS); Sharon P. Clark (KY); Joseph G. Murphy represented by Elizabeth Brodeur (MA); Therese M. Goldsmith represented by Elizabeth Sammis (MD); Mike Rothman (MN); John M. Huff (MO); Mike Chaney (MS); Monica J. Lindeen (MT); Wayne Goodwin represented by Christy Neighbors (NE); Thomas B. Considine represented by Peter Hart (NJ); Brett J. Barratt (NV); James J. Wrynn represented by Joseph Fritsch (NY); Mary Taylor represented by Carrie Haughawout (OH); John D. Doak represented by Michael Rhoads (OK); Teresa D. Miller represented by Gayle Woods (OR); Michael F. Consedine (PA); Ramón Cruz-Colón (PR); Joseph Torti III represented by Elizabeth Dwyer (RI); David Black (SC); Merle D. Scheiber (SD); Julie Mix McPeak represented by Vickie Trice (TN); Mike Geeslin represented by Sara Waitt (TX); Neal T. Gooch (UT); Jacqueline K. Cunningham represented by Van Tompkins (VA); Gregory R. Francis represented by John McDonald (VI); Steve Kimbell (VT); Mike Kreidler (WA); Ted Nickel (WI); Michael D. Riley (WV); and Ken Vines (WY).

1. **Adopted the Report of the Health Insurance and Managed Care (B) Committee**

Commissioner Praeger reported that in order to assist states electing to establish a Health Benefit Exchange, as provided for in the federal Patient Protection and Affordable Care Act (PPACA), the Health Insurance Exchanges (B) Subgroup developed a series of white papers to highlight issues states should consider when establishing an exchange.

Commissioner Praeger made a motion, seconded by Commissioner Lindeen, to adopt the three NAIC white papers: *The Comparative Roles of Navigators and Producers in an Exchange: What are the Issues?; Health Insurance Exchanges under the Affordable Care Act: Governance Options and Issues; and Adverse Selection Issues and Health Insurance Exchanges under the Affordable Care Act* (Attachments Two-A, Two-B and Two-C). The motion passed.

2. **Update from the Professional Health Insurance Advisors (EX) Task Force**

Commissioner McCarty reported the Professional Health Insurance Advisors (EX) Task Force held a public hearing on March 27 to discuss the impact of the Medical Loss Ratio provisions of PPACA on the ability of agents to assist consumers with the economic decisions surrounding the purchase of health insurance. Following the hearing, data and available options were solicited from the Health Insurance and Managed Care (B) Committee. A report was sent to the Task Force and exposed for public comment. The Task Force met on June 30 to consider a recommendation that the NAIC support HR 1206 *Access to Professional Health Advisors Act of 2011* which would amend the PPACA to treat agents’ commissions the same as taxes for the MLR calculation. The Task Force voted to support the federal legislation. As additional alternatives are being discussed, the Task Force recommends the NAIC continue a dialogue with federal officials, particularly the U.S Department of Health and Human Services (HHS) to discuss more immediate and long term solutions to the issue.

Commissioner Voss agreed the NAIC should continue discussions with HHS and with the insurance industry concerning the issue.

3. **Adopted the Report of the NAIC Audit Committee**

Commissioner Hamm reported the Audit Committee met on May 20th and considered: 1) recommended changes to NAIC investment policy statements from the NAIC’s investment adviser; 2) member requests for additional NAIC grant funds; 3) the NAIC’s SAS 70 review; 4) revisions to the Audit Committee Charter; and 5) plans for the Dec. 31, 2011 audit and Feb. 1, 2012 SAS 70 review.

The Audit Committee received a report of investment performance from the NAIC’s investment advisers, Prairie Capital Management, for both the long-term investment portfolio and the defined benefit plan investment portfolio. The Audit
Committee adopted revisions to the NAIC long-term investment policy statement to protect against inflation and rising bond rates in the near term by diversifying 5% of the portfolio into the non-investment grade bond asset class and 5% into the master limited partnership asset class.

The Audit Committee also adopted revisions to the NAIC defined benefit plan investment policy statement to replace three equity asset managers and diversify 5% of the portfolio into Treasury Inflation-Protected Securities. The Audit Committee considered 21 Grant Fund requests and approved $304,467 in NAIC Grant Funds in 2011.

The Audit Committee received a report from the NAIC’s independent auditors, Mayer Hoffman McCann (MHM), regarding the NAIC’s SAS 70 review for the period Aug. 1, 2010 to Jan. 31, 2011. As a supplemental review to the NAIC’s annual financial audit, the SAS 70 review was designed to identify and validate the NAIC’s internal control structures. The report indicated no significant deficiencies or concerns in the internal controls included within the scope of the SAS 70 review.

The Audit Committee approved the engagement of MHM for the NAIC’s Dec. 31, 2011 financial statement audit and the NAIC’s SAS 70 review for the period Feb. 1, 2011 to Jan. 31, 2012. In compliance with the NAIC policy of a five-year rotation of audit firms, the Audit Committee agreed to proceed with a request for proposal for the 2012 financial audit and SAS 70 review.

On July 1, the Audit Committee received the May 31 financial statements which indicated that operational revenues performed above budget $251,139 (0.61%) and operating expenses yielded savings of $378,228 (1.21%). The operating margin is currently above budget by $629,367. Investment activity has produced net investment gains of $3,800,172 compared to a budget of $522,839 for a positive investment income variance of $3,277,333. The NAIC’s 2011 projections have been updated based on actual results through May 31 which indicate that operating revenues may exceed budget by $721,043 and operating expenses may exceed budget by $313,025, for a $408,018 net positive impact on the 2011 operating margin.

Commissioner Hamm made a motion, seconded by Director Huff, to adopt the report of the Audit Committee (Attachments Two-D and Two-E). The motion passed.

Having no further business, the Joint Executive (EX) Committee/Plenary adjourned.
JOINT MEETING OF THE
EXECUTIVE (EX) COMMITTEE AND
INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE
September 22, 2011
Conference Call

Meeting Summary

The Executive (EX) Committee and Internal Administration (EX1) Subcommittee met in joint regulator-to-regulator session Sept. 22 in accordance with the exceptions contained in the NAIC Policy Statement on Open Meetings (i.e., internal or administrative matters of the NAIC, as well as consultations with NAIC staff members).

During the joint meeting, the Committee and Subcommittee:

1. Adopted the minutes of its April 21 and March 26 meetings. During these meetings, the Committee and Subcommittee:
   • Approved a 2011 line of credit for IIPRC in the amount of $400,000.
   • Authorized the signing of a memorandum of understanding with the U.S. Department of Labor (DOL) to facilitate information-sharing between the DOL, the NAIC and the state insurance regulators concerning multiple-employer welfare arrangement (MEWA) scams and bad actors.
   • Selected BlackRock Solutions and PIMCO to model residential and commercial mortgage-backed securities (RMBS and CMBS) for the 2011 year-end reporting period.

2. Adopted the report of the Audit Committee, which included a report on the financial results and the investment performance through July 31, 2011.


4. Approved a report from the consulting firm hired to review the NAIC’s operating reserves, which included a recommendation to revise the NAIC’s liquid operating reserve from a flat 80% target of the next year’s budgeted expenses, to a target range of 80% to 91%. This change is the result of analyzing current and future risks and comparisons to comparable organizations.

5. Approved an information-sharing agreement between the NAIC and the U.S. Department of Health and Human Services (HHS) for access to insurance company financial data.

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2012 PROPOSED CHARGES
EXECUTIVE (EX) COMMITTEE

The mission of the Executive (EX) Committee is to manage the affairs of the NAIC in a manner consistent with the Articles of Incorporation and Bylaws.

Ongoing Support of NAIC Programs, Products, or Services:

1. Based on input of the membership, identify goals and priorities of the organization and make recommendations to achieve such goals and priorities. Make recommendations by 2012 Commissioners’ Conference.—Essential

2. Create/terminate task force(s) and/or executive working groups to address special issues and monitor the work of these groups. Create necessary task forces and/or executive working groups throughout 2012 as necessary.—Essential

3. Submit reports and recommendations to NAIC members concerning the activities of its subcommittee and the standing committees. Submit report at each national meeting.—Essential

4. Consider requests from NAIC members for friend-of-the-court briefs.—Essential

5. Establish and allocate functions and responsibilities to be performed by each zone.—Essential

6. Pursuant to the Bylaws, oversee the NAIC offices to assist the organization and the individual members in achieving the goals of the organization.—Essential

7. Conduct strategic planning on an ongoing basis.—Essential

8. Plan, implement and coordinate communications and activities with the Federal Insurance Office (FIO).—Essential

9. Plan, implement and coordinate communications and activities with other state, federal, local, and international government organizations to advance the goals of the NAIC and promote understanding of state insurance regulation.—Essential

10. Review all requests for development of model laws and give approval of those requests if it is determined the mandated criteria has been satisfied. Reporting at each national meeting is required on model laws approved for development.—Essential

Staff Support: Therese M. Vaughan/Andrew J. Beal/Kay Noonan

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BYLAWS OF THE
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

ARTICLE I

Name, Organization and Location

The name of this corporation is NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC). The NAIC is organized under the General Corporation Law of the State of Delaware. The NAIC may have one (1) or more office locations within or without the State of Delaware as the Executive Committee may from time to time determine.

ARTICLE II

Membership

The Membership of the NAIC shall be comprised of those persons designated as members in the Certificate of Incorporation. Each member of the NAIC shall have the power to vote and otherwise participate in the affairs of the NAIC as set forth herein or as required by applicable law. This power may be exercised through a duly authorized representative who shall be a person officially affiliated with the member’s department and who is wholly or principally employed by said department.

The organization may charge members an annual assessment, the amount of which shall be determined by the Executive Committee. Members failing to pay all NAIC assessments on a timely basis shall be placed in an inactive status. Members in an inactive status shall not have any voting rights and shall be denied membership on NAIC committees and task forces, access to mailings and services of the NAIC Offices, as well as access to zone examination processes and other benefits of membership in the NAIC.

The NAIC’s receipt of full payment from the inactive member of all current and past due assessments shall serve to immediately remove them from inactive status.

The Executive Committee is empowered to reinstate, in part or in whole, an inactive member’s participation on the committees and task forces, access to mailings and services of the NAIC Offices and satellite offices, as well as access to zone examination processes, and other benefits of membership in the NAIC upon good cause shown as determined by the Executive Committee.
ARTICLE III

Officers

The officers of the NAIC shall be a President, a President-Elect, a Vice President, and a Secretary-Treasurer. Annual officer elections shall be held at the last regular National Meeting of each calendar year or at such other plenary session as agreed to by the members. The voting membership, by secret ballot, shall elect officers as provided in these Bylaws. Officers’ terms shall be for one year, beginning on January 1 following their election. The officers shall hold office until their death, resignation, removal or the election and qualification of their successors, whichever occurs first. Any Officer may resign at any time by giving notice thereof in writing to the President of the NAIC. Any such resignation will take effect upon delivery if no date is specified, or as of its date, unless some other date is specified therein, in which event it will be effective as of that date. The acceptance of that resignation will not be necessary to make it effective.

If an interim vacancy occurs in the office of President, the President-Elect shall cease to hold his or her office effective immediately and shall assume the office of President. If an interim vacancy occurs in any one or more of the other officer positions, an interim election shall be held to fill the vacancy. No member may hold any office for more than two consecutive years. Notwithstanding the foregoing, at no time shall more than two officer positions be filled by members of the same Zone during the same term. Any officer may be removed from office by the affirmative vote of two-thirds (2/3) of the members, but only after a resolution for removal is adopted by two-thirds (2/3) of the Executive Committee whenever, in their judgment, the best interests of the NAIC would be served thereby.

The President shall be the chief officer of the NAIC, shall serve as Chairman of the Executive Committee and shall preside at all special and regular meetings of the members. The President shall serve as the leader of the organization and its principal spokesperson. The President shall work closely with the Executive Committee to establish and achieve the strategic, business and operational goals of the organization; ensure appropriate policies and procedures for the organization are implemented and followed; and protect the integrity as well as the resources of the organization. After a member completes his or her term or terms as President, he or she shall not be able to hold another officer position for a period of twelve (12) months from the date such member completes his or her term or terms as President, which shall be referred to as a "waiting period"; provided however, the Executive Committee may waive the twelve month waiting period if warranted by exigent circumstances.

The President-Elect shall serve as Vice-Chairman of the Executive Committee. In the absence of the President at a duly convened meeting of the Executive Committee or at a regular or special meeting of the members, the President-Elect shall preside over such meeting to the extent of the President’s absence. The President-Elect shall perform such other duties and tasks as may be assigned by the President. Where the President does not run for re-election, the President-Elect shall become President at the conclusion of the President’s term of office.
The Vice President, in the absence of the President and President-Elect at a duly convened meeting of the Executive Committee or at a regular or special meeting of the members, shall preside over such meeting to the extent of the President’s and the President-Elect’s absence; and shall perform such other duties as may be assigned by the President or President-Elect, or in the absence thereof, by the Executive Committee.

The Secretary-Treasurer shall assist the President and, as applicable, the President-Elect or the Vice President in the conduct of meetings of the Executive Committee and members. For member meetings, the Secretary-Treasurer shall call the roll of the membership and certify the presence of a quorum and shall receive, validate and maintain all proxies for elections held at member meetings. The Secretary-Treasurer shall also recommend to the Executive Committee such policies and procedures to maintain the history and continuity of the NAIC. The Secretary-Treasurer shall also assist the President and President-Elect in all matters relating to the budget, accounting, expenditure and revenue practices of the NAIC; including, but not limited to reviewing the financial information of the organization and consulting with NAIC management, independent auditors, and other necessary parties regarding the financial operations and condition of the organization.

**ARTICLE IV**

**Executive Committee**

The business and affairs of the NAIC shall be managed by and under the direction of the Executive Committee. The Executive Committee shall be made up entirely of members of the NAIC. The Executive Committee shall consist of the following members: the officers of the NAIC; the most immediate past presidents; the twelve (12) members of the zones as provided for in Article V of these Bylaws; The members of the Executive Committee shall be subject to a conflict of interest policy as adopted by the members. Any Executive Committee member may resign at any time by giving notice thereof in writing to the members of the NAIC. Resignation as an Executive Committee member also operates as resignation as a Zone officer. Any such resignation will take effect upon delivery if no date is specified, or as of its date, unless some other date is specified therein, in which event it will be effective as of that date. The acceptance of that resignation will not be necessary to make it effective.

1. The Executive Committee shall have the authority and responsibility to:

   (a) manage the affairs of the NAIC in a manner consistent with the Certificate of Incorporation and Bylaws;

   (b) make recommendations to achieve the goals of the NAIC based upon either its own initiative or the recommendations of the Standing Committees or Subcommittees reporting to it, for consideration and action by the members at any NAIC Plenary Session;
(c) create and terminate one or more Task Forces reporting to it to the extent needed and appropriate;

(d) establish and allocate, from time to time, functions and responsibilities to be performed by each Zone;

(e) to the extent needed and appropriate, oversee NAIC Offices to assist the NAIC and the individual members in achieving the goals of the NAIC;

(f) submit to the NAIC at each National Meeting, during which a Plenary Session is held, its report and recommendations concerning the reports of the Standing Committees. All Standing Committee reports shall be included as part of the Executive Committee report;

(g) plan, implement and coordinate communications and activities with other state, federal and local government organizations in order to advance the goals of the NAIC and promote understanding of state insurance regulation.

2. Duties and Operations of the Executive Committee.

(a) The Executive Committee shall hold at least two (2) regular meetings annually at a designated time and place. Special meetings may be held when called by the President, or by at least three (3) members of the Executive Committee in writing. At least five (5) days notice shall be given of all regular and special meetings. Meetings may be held in person or by means of conference telephone or other communication equipment by means of which all persons participating in the meeting can hear each other, and such participation in a meeting shall constitute presence in person at such meeting in accordance with applicable laws. The presiding member of the Executive Committee shall only cast his or her vote in order to break a tie vote. In addition, the Executive Committee may act by written consent as provided by law.

(b) The Executive Committee may, with the concurrence of two-thirds of the members of the Executive Committee, establish rules for its conduct that shall not conflict with the Certificate of Incorporation and Bylaws. Such rules may be changed only by a concurrence of two-thirds of the members of the Executive Committee after twenty-four (24) hours notice to all members of the Executive Committee.

(c) Any action required or permitted to be taken at any meeting of the Executive Committee or any committee thereof may be taken without a meeting if all members of the Executive Committee or such committee, as the case may be, consent thereto in writing in accordance with applicable law.

(d) The Executive Committee shall cause to be kept minutes of its meeting and have information of any action of a general character taken by it published to members qualified to vote.

(e) NAIC OFFICES
(i) The Executive Committee shall oversee an Executive Office and a Central Office with management and staff personnel and appropriate resources for performance of duties and assigned responsibilities. Additional satellite offices may be established as needed. The Executive Committee shall have the authority to select, employ and terminate a Chief Executive Officer who shall not be a member of the NAIC and who shall have the primary responsibility for the internal management and functioning of the NAIC Offices within the direction of the Executive Committee, as well as other duties assigned by the Executive Committee through execution of an Employment Agreement or other authorization. The Chief Executive Officer appointed by the Executive Committee pursuant to this section shall not be considered an officer for purposes of Article III hereof and shall not be a member of the Executive Committee. The Executive Committee, through the Internal Administration (EX1) Subcommittee, shall provide oversight and direction to the Chief Executive Officer regarding Office operations.

(ii) Consistent with the purposes of the NAIC, the role of the NAIC Offices is to: (1) provide services to the NAIC through support to the NAIC Committees, Subcommittees, Task Forces or otherwise; (2) provide services to individual State insurance departments, and (3) develop recommendations for consideration as to NAIC policy and administrative decisions of the NAIC.

(iii) In performing its role, subject to the oversight and direction specified in (paragraph i) the NAIC Offices may engage in a variety of functions including but not limited to the following: research; analysis; information gathering and dissemination; library services; data collection; database building and maintenance; report generation and dissemination; government liaison; non-regulatory liaison; securities valuation; administration; litigation; legislative and regulatory drafting; and educational development.

(iv) The Chief Executive Officer shall prepare an annual budget, related to the priorities of the NAIC, for the NAIC Offices to be submitted through the EX1 Subcommittee to the Executive Committee, which shall make its recommendations to the members of the NAIC for action at the next Plenary Session of the NAIC.

3. Internal Administration (EX1) Subcommittee

The Internal Administration (EX1) Subcommittee shall be a Subcommittee reporting to the Executive Committee. Appointments of the Chair and Vice Chair of the Executive Subcommittee and members other than those specifically designated herein shall be made by the President and President-Elect:

This Subcommittee shall be comprised of the President, President-Elect, Vice President, the Secretary-Treasurer, the most immediate past President, and three (3) other members of the Executive Committee. The presiding member of the Subcommittee shall only cast his or her vote in order to break a tie vote.

The Internal Administration (EX1) Subcommittee shall:
(a) Exercise such powers and authority as may be delegated to it by the Executive Committee.

(b) Generally oversee the NAIC Offices including, without limitation: (i) periodically monitor operations of the NAIC Offices, (ii) review and revise the budget of the NAIC hold an annual hearing to receive public comments on the budget of the NAIC and submit the revised budget to the Executive Committee, (iii) approve emergency expenditures which vary from the adopted budget and promptly certify its action in writing to the Executive Committee, (iv) evaluate the Chief Executive Officer and make appropriate recommendations to the Executive Committee, (v) assist the Chief Executive Officer in resolving competing demands for NAIC resources, (vi) review compensation of all senior management and (vii) quarterly prepare a report containing the current budget and expenditures which the Secretary-Treasurer shall present to the Executive Committee.

4. Audit Committee

The President, with the advice and consent of the Executive Committee shall appoint an Audit Committee made up of at least four (4) members of the NAIC, including at least one member from each zone, in addition to the NAIC Secretary-Treasurer. The NAIC Secretary-Treasurer shall chair the Audit Committee. The Audit Committee shall report to the Executive Committee without any NAIC employees being present. The Audit Committee shall be directly responsible for the appointment, compensation, and oversight of the independent certified public accountant employed to conduct the audit. The Audit Committee shall also have the power, to the extent permitted by law, to (i) initiate or review the results of an audit or investigation into the business affairs of the NAIC; (ii) review the NAIC’s financial accounts and reports; (iii) conduct pre-audit and post-audit reviews with NAIC staff, members and independent auditors; and (iv) exercise such other powers and authority as delegated to it by the Executive Committee.

ARTICLE V

Zones

To accomplish the purposes of the NAIC in a timely and efficient manner, the United States, its territories and insular possessions shall be divided into four Zones. Each Zone shall consist of a group of at least eight States, located in the same geographical area, with each State being contiguous to at least one other State in the group so far as practicable, plus any territory or insular possession that may be deemed expedient, all as determined by majority of the Executive Committee. Members of each Zone shall annually elect a Chairman, a Vice Chairman and a Secretary from among themselves prior to or during the last regular National Meeting of each calendar year or at such time as agreed to by the Zone members. The Chairman, Vice Chairman and Secretary of each Zone shall be members of the Executive Committee with terms of office corresponding to that of the officers. Each Zone shall perform such functions as are designated by the Executive Committee of the NAIC or by the members of the NAIC as a whole or by the members of the Zone. Each Zone may hold Zone Meetings for such purposes as may be deemed appropriate by members of the Zone.
ARTICLE VI

Standing Committees and Task Forces

1. General

The Standing Committees shall not be subcommittees of the Executive Committee and shall have no power or authority for the management of the business and affairs of the NAIC. Each Standing Committee shall be composed of not more than 13 members appointed by the President and President-Elect. Standing Committees shall meet at least twice a year at National Meetings and may meet more often at the call of the Chair as required to complete its assignments from the Executive Committee in a timely manner.

The Executive Committee shall make all assignments of subject matter to the Standing Committees and shall require coordination between Committees and Task Forces of the subject matter if more than one Committee or Task Force is affected. The format of the Committee reports shall be prescribed by the Executive Committee. All appointments or elections of members of the NAIC to any office or Committee of the NAIC shall be deemed the appointment or election of a particular member and shall not automatically pass to a successor in office.

2. Specific Duties

The Standing Committees of the NAIC, their duties, powers, and responsibilities shall be as follows:

(a) Life Insurance and Annuities (A) Committee: This Standing Committee shall consider issues relating to life insurance and annuities.

(b) Health Insurance and Managed Care (B) Committee: This Standing Committee shall consider issues relating to health and accident insurance and managed care.

(c) Property and Casualty Insurance (C) Committee: This Standing Committee shall consider issues relating to personal and commercial lines of property and casualty insurance, worker’s compensation insurance, statistical information, surplus lines, and casualty actuarial matters.

(d) Market Regulation and Consumer Affairs (D) Committee: This Standing Committee shall consider issues involving market conduct in the insurance industry; competition in insurance markets; the qualifications and conduct of agents and brokers; market conduct examination practices; the control and management of insurance institutions; consumer services of State insurance departments; and consumer participation in NAIC activities.

(e) Financial Condition (E) Committee: This Standing Committee shall consider both administrative and substantive issues as they relate to accounting practices and procedures;
blanks; valuation of securities; the Insurance Regulatory Information System (IRIS), as it relates to solvency and profitability; the call, monitoring and concluding report of Zone Examinations; and financial examinations and examiner training.

(f) Financial Regulation Standards and Accreditation (F) Committee: This Standing Committee shall consider both administrative and substantive issues as they relate to administration and enforcement of the NAIC Accreditation Program, including without limitation, consideration of standards and revisions of standards for accreditation, interpretation of standards, evaluation and interpretation of states’ laws and regulations, and departments’ practices, procedures and organizations as they relate to compliance with standards, examination of members for compliance with standards, development and oversight of procedures for examination of members for compliance with standards, qualification and selection of individuals to perform the examination of members for compliance with standards, and decisions regarding whether to accredit members.

(g) International Insurance Relations (G) Committee. This Standing Committee shall have the responsibility for issues relating to international insurance.

3. Task Forces

The Executive Committee, its Subcommittee and the Standing Committees may establish one or more Task Forces, subject to approval of the Executive Committee. Except as provided herein, a Task Force shall automatically terminate at the end of the last regular National Meeting of each year, unless the Executive Committee at that Meeting adopts the recommendation of the parent Committee or Subcommittee to continue the Task Force. The parent Committee or Subcommittee, subject to approval of the Executive Committee, may vote to discontinue a Task Force once its charge has been completed, until the last regular National Meeting of the next calendar year. The President and President-Elect shall appoint members of Task Forces by January 30 following such meeting.

Vacancies in the positions of Chair or Vice Chair of any Task Force shall be filled by the parent Committee or Subcommittee from within or outside the present Task Force membership; provided, however, that the chief insurance regulatory official of the state of the former Chair or Vice Chair shall become a member of the Task Force. A vacancy in the position of member shall be filled by the chief insurance regulatory official of the vacating member’s state.

If an existing Task Force is dealing with insurance problems issues that require continuing study, the Executive Committee may adopt the recommendation of the parent Committee or Subcommittee that the Task Force be designated a Standing Task Force. Such designation shall relieve the parent Committee or Subcommittee of its annual duty to recommend that the Task Force be continued. A Standing Task Force shall continue in effect until terminated by the Executive Committee.
ARTICLE VII

Meetings of the Membership

1. Regular Meetings.

The NAIC shall hold at least two (2) regular meetings of the members (“National Meetings”) each calendar year. Notice, stating the place, day and hour and any special purposes of the National Meeting, shall be delivered by the Executive Committee not less than ten (10) calendar days nor more than sixty (60) calendar days before the date on which the National Meeting is to be held, either personally, by mail or by other lawful means, to each member entitled to be present and vote at such meeting.

2. Special Meetings.

Special meetings of the members may be called by any five (5) members of the Executive Committee by giving all members notice of such meeting at least ten (10) but not more than sixty (60) days prior thereto, or by any twenty (20) members of the NAIC by giving all members notice of such meeting at least thirty (30) but not more than sixty (60) days prior thereto. Notice of the special meeting shall state the place, day and hour of the special meeting and the purpose or purposes for which the special meeting is called, and shall be delivered by the persons calling the meeting within the applicable time period set forth herein, either personally, by mail or by other lawful means, to each member entitled to be present and vote at such meeting.

3. Waiver of Notice; Postponement.

Member meetings may be held without notice if all members entitled to notice are present (except when members entitled to notice attend the meeting for the express purpose of objecting, at the beginning of the meeting, because the meeting is allegedly not lawfully called or convened), or if notice is waived by those not present. Any previously scheduled meeting of the members may be postponed by the Executive Committee (or members calling a special meeting, as the case may be) upon notice to members, in person or writing, given at least two (2) days prior to the date previously scheduled for such meeting.

4. Quorum.

Except as otherwise provided by law or by the Certificate of Incorporation, the presence, by person or proxy, of a majority of the members shall constitute a quorum at a member meeting, a meeting of a Standing Committee, Task Force or a working group. The chairman of the meeting may adjourn the meeting from time to time, whether or not there is such a quorum. The members present at a duly called member meeting at which a quorum is present may continue to transact business until adjournment, notwithstanding the withdrawal of enough members to leave less than a quorum.

5. Any meeting of the NAIC may be held in executive session as defined in the NAIC policy on open meetings. Any member may attend and participate in any meeting of the
NAIC or any meeting of a Standing Committee or Task Force whether or not such member has the right to vote. All National Meetings shall provide for a Plenary Session of the NAIC as a whole in order to consider and take action upon the matters submitted to the NAIC.

**ARTICLE VIII**

**Elections**

1. The election of officers of the NAIC shall be scheduled for the plenary session of the last National Meeting of the calendar year or at such other plenary session as agreed to by the members.

2. At the beginning of such Plenary Session, the Secretary-Treasurer shall ascertain and announce the presence of a quorum.

3. Upon the determination of a quorum, the chair shall briefly review the provisions of the Certificate of Incorporation and Bylaws in regard to voting.

4. The President shall ask for and announce all proxies. Proxies shall be held by the Secretary-Treasurer or a designee throughout the election session. Proxies shall be valid, subject to their term, until superseded by the member and shall be governed by ARTICLE IX of the Bylaws.

5. Every individual voting by proxy must meet the requirements of Article II of the Bylaws of the NAIC which requires that such a person be “...officially affiliated with the member’s (the member delegating authority to vote) department, and is wholly or principally employed by said department.”

6. Prior to opening the nominations for office, the Chair shall appoint three (3) members of the NAIC to act as voting inspectors. The voting inspectors shall distribute, collect and count and/or verify ballots, and report their findings to the Secretary-Treasurer. If a voting inspector is nominated for an office and does not withdraw as a candidate, he or she shall not be a voting inspector for the election of the office to which he or she is nominated and the chair shall appoint another voting inspector in his or her place.

7. The Chair shall announce the opening of nominations for offices in the following order:

   (a) President. Provided, however, where the President does not run for re-election, the President-Elect shall become President at the conclusion of the President’s term of office. In those cases where the President runs for re-election or where a vacancy exists because the President–Elect fails or is otherwise unable to assume the Presidency, this office will be subject to an election.

   (b) President-Elect
(c) Vice President

(d) Secretary-Treasurer.

8. Only members or duly authorized proxyholders may make nominations.

9. One nominating speech, not to exceed three (3) minutes in duration, shall be allowed for each nominee.

10. After nominations are closed for each office, each nominee must indicate whether he or she accepts the nomination and, if he or she accepts, shall be permitted to address the membership for a period of up to seven (7) minutes. Such addresses shall be given in the order by which the nominations were made.

11. The Secretary-Treasurer shall provide the ballots.

11. The votes of members, in person or by proxy, constituting a majority of the quorum present at the meeting shall be necessary for election to such office. If no candidate receives a majority, the two candidates with the most votes will participate in a run-off election. The candidate with the most votes in the run-off election shall win such election.

12. Voting need not be by written ballot, unless otherwise required by these Bylaws, the Certificate of Incorporation, or applicable law.
ARTICLE IX

Proxies; Waiver of Notice

Where the delegation of power to vote or participate in the membership of the NAIC is required by ARTICLE II of these Bylaws to be in writing, such delegation must be effected by proxy. All proxies must be dated, give specific authority to a named individual who meets the requirements of ARTICLE II for duly authorized representatives, and meet any other applicable legal requirement. Documents such as electronic transmission, telegrams, mailgrams, etc. are acceptable as proxies if they otherwise meet the requirements contained herein and applicable law. Proxies should be maintained by NAIC Central Office staff. Notwithstanding the foregoing, a member of the Executive Committee may not vote by proxy in a meeting of the Executive Committee or its subcommittees.

Whenever any notice is required to be given to any member (for a meeting of members or the Executive Committee) under the provisions of the Certificate of Incorporation, these Bylaws or applicable law, a written waiver, signed by the person entitled to notice, or a waiver by electronic transmission by person entitled to notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice. Neither the business to be transacted at, nor the purpose of, any annual or special meeting of the members or any committee, subcommittee or task force need be specified in any waiver of notice of such meeting.

Unless otherwise restricted by the Certificate of Incorporation or these Bylaws, Members may participate in a meeting by means of conference telephone or by any means by which all persons participating in the meeting are able to communicate with one another, and such participation shall constitute presence in person at the meeting.

Any notice required under these Bylaws may be provided by mail, facsimile, or electronic transmission.

ARTICLE X

Procedures; Books and Records

The Executive Committee shall adopt policies and procedures for the conduct of meetings. In the event such policies and procedures conflict with the NAIC’s Certificate of Incorporation or Bylaws, the Certificate of Incorporation and Bylaws shall govern.

The books and records of the NAIC may be kept outside the State of Delaware at such place or places as may from time to time be designated by the Internal Administration Subcommittee (EX1) of the Executive Committee.

ARTICLE XI
Amendments

These Bylaws may be altered or repealed and new Bylaws may be adopted at any regular or special meeting of the members by an affirmative vote, in person or by proxy, of a majority of the members entitled to vote at such meeting; provided, however, that any proposed alteration (except to correct typographical or grammatical errors or article, section or paragraph cross-references caused by other alterations, repeals, or adoptions) or repeal of, or the adoption of any Bylaw inconsistent with, Article II [Membership], Article VII, Paragraph 2 [Special Meetings of Members] and Paragraph 4 [Quorum], Article VIII [Elections], or this Article XI [Amendments] of these Bylaws (the “Supermajority Bylaws”) by the members shall require the affirmative vote, in person or by proxy, of at least two-thirds (2/3) of the members entitled to vote at such meeting and provided, further, that in the case of any such member action at a special meeting of members, notice of the proposed alteration, repeal or adoption of the new Bylaw or Bylaws must be contained in the notice of such special meeting. Corrections for typographical or grammatical errors or to article, section or paragraph cross-references caused by other alterations, repeals or adoption, shall only be made if approved by the affirmative vote of at least two-thirds (2/3) of the Executive Committee.

Adopted October 1999, see 1999 Proc., Third Quarter page 7
Amended November 2002, see 2002 Proc., Fourth Quarter page 25
Amended June 2003, see 2003 Proc., Second Quarter page 28
Amended March 2004, see 2004 Proc., First Quarter page 119
Amended December 2004, see 2004 Proc., Fourth Quarter page 58
Amended March 2009, see 2009 Proc., First Quarter page 3-67
Amended September 2009, see 2009 Proc., Third Quarter
Report of the
Life Insurance and Annuities (A) Committee

The Life Insurance and Annuities (A) Committee met via conference call Sept. 23, 2011. During this meeting, the Committee:

1. Adopted its Aug. 3 conference call minutes, which included the adoption of revisions to the *Annuity Disclosure Model Regulation* (#245), which is before the Jt. Executive (EX) Committee/Plenary today:
   
   a. **Revisions to the Annuity Disclosure Model Regulation (#245):** The revisions make a number of changes to the model. The most significant of those changes is a new section that establishes guidelines for annuity illustrations.

2. Discussed a referral from the Life Actuarial (A) Task Force concerning contingent annuities. The Committee plans to continue discussions on this topic at the Fall National Meeting.

3. Adopted the report of the Life Actuarial (A) Task Force, which included adopting its 2012 Proposed Charges and a model law development request to amend the *Model Regulation for Recognizing a New Annuity Mortality Table for Use in Determining Reserve Liabilities for Annuities* (#821) to include the new payout annuity table.
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Section 1. Purpose

The purpose of this regulation is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and foster consumer education. The regulation specifies the minimum information which must be disclosed and, the method for disclosing it and the use and content of illustrations, if used, in connection with the sale of annuity contracts. The goal of this regulation is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.

Section 2. Authority

This regulation is issued based upon the authority granted the commissioner under Section [cite any enabling legislation and state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

Section 3. Applicability and Scope

This regulation applies to all group and individual annuity contracts and certificates except:

A. Registered or non-registered variable annuities or other registered products;

B. Immediate and deferred annuities that contain no non-guaranteed elements;

C. Annuities used to fund:

   (a) An employee pension plan which is covered by the Employee Retirement Income Security Act (ERISA);

   (b) A plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

   (c) A governmental or church plan defined in Section 414 or a deferred compensation plan of a state or local government or a tax exempt organization under Section 457 of the Internal Revenue Code; or

   (d) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(2) Notwithstanding Paragraph (1), the regulation shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make whether on a pre-tax or
after-tax basis, and where the insurance company has been notified that plan participants may choose from among two (2) or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subsection, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement;

C. Non-registered variable annuities issued exclusively to an accredited investor or qualified purchaser as those terms are defined by the Securities Act of 1933 (15 U.S.C. Section 77a et seq.), the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), or the regulations promulgated under either of those acts, and offered for sale and sold in a transaction that is exempt from registration under the Securities Act of 1933 (15 U.S.C. Section 77a et seq.).

Drafting Note: States that regulate charitable gift annuities should exempt them from the requirements of this regulation. States that recognize or regulate funding agreements as annuities should exempt them from the requirements of this regulation.

D. (1) Transactions involving variable annuities and other registered products in compliance with Securities and Exchange Commission (SEC) rules and Financial Industry Regulatory Authority (FINRA) rules relating to disclosures and illustrations, provided that compliance with Section 5 shall be required after January 1, 2014, unless, or until such time as, the SEC has adopted a summary prospectus rule or FINRA has approved for use a simplified disclosure form applicable to variable annuities or other registered products.

(2) Notwithstanding Subsection D(1), the delivery of the Buyer’s Guide is required in sales of variable annuities, and when appropriate, in sales of other registered products.

(3) Nothing in this subsection shall limit the commissioner's ability to enforce the provisions of this regulation or to require additional disclosure.

DE. Structured settlement annuities; EF. [Charitable gift annuities; and] FG. [Funding agreements].

Drafting Note: States that regulate charitable gift annuities should exempt them from the requirements of this regulation. States that recognize or regulate funding agreements as annuities should exempt them from the requirements of this regulation.

Section 4. Definitions

For the purposes of this regulation:

A. “Buyer’s Guide” means the National Association of Insurance Commissioner’s approved Annuity Buyer’s Guide.

AB. [“Charitable gift annuity” means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes, but does not include a charitable remainder trust or a charitable lead trust or other similar arrangement where the charitable organization does not issue an annuity and incur a financial obligation to guarantee annuity payments.]

BC. “Contract owner” means the owner named in the annuity contract or certificate holder in the case of a group annuity contract.

CD. “Determinable elements” means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if
it was calculated from underlying determinable elements only, or from both determinable and guaranteed elements.

DE.  [“Funding agreement” means an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.]

EF.  “Generic name” means a short title descriptive of the annuity contract being applied for or illustrated such as “single premium deferred annuity.”

FG.  “Guaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are guaranteed and determined or have determinable elements at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

H.  “Illustration” means a personalized presentation or depiction prepared for and provided to an individual consumer that includes non-guaranteed elements of an annuity contract over a period of years.

I.  “Market Value Adjustment” or “MVA” feature is a positive or negative adjustment that may be applied to the account value and/or cash value of the annuity upon withdrawal, surrender, contract annuitization or death benefit payment based on either the movement of an external index or on the company’s current guaranteed interest rate being offered on new premiums or new rates for renewal periods, if that withdrawal, surrender, contract annuitization or death benefit payment occurs at a time other than on a specified guaranteed benefit date.

GI.  “Non-guaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, dividends, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

HK.  “Structured settlement annuity” means a “qualified funding asset” as defined in section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

Section 5. Standards for the Disclosure Document and Buyer’s Guide

A.  (1)  Where the application for an annuity contract is taken in a face-to-face meeting, the applicant shall at or before the time of application be given both the disclosure document described in Subsection B and the Buyer’s Guide contained in Appendix A, if any.

(2)  Where the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the Buyer’s Guide no later than five (5) business days after the completed application is received by the insurer.

(a)  With respect to an application received as a result of a direct solicitation through the mail:

(i)  Providing a Buyer’s Guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that the Buyer’s Guide be provided no later than five (5) business days after receipt of the application.

(ii)  Providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.

(b)  With respect to an application received via the Internet:

(i)  Taking reasonable steps to make the Buyer’s Guide available for viewing and printing on the insurer’s website shall be deemed to satisfy the requirement that the
Buyer’s Guide be provided no later than five (5) business day of receipt of the application.

(ii) Taking reasonable steps to make the disclosure document available for viewing and printing on the insurer’s website shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.

(c) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the insurance department of the state for a free annuity Buyer’s Guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free annuity Buyer’s Guide.

(3d) Where the Buyer’s Guide and disclosure document are not provided at or before the time of application, a free look period of no less than fifteen (15) days shall be provided for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look provided under state law or regulation.

B. At a minimum, the following information shall be included in the disclosure document required to be provided under this regulation:

(1) The generic name of the contract, the company product name, if different, and form number, and the fact that it is an annuity;

(2) The insurer’s legal name, and physical address, website address and telephone number;

(3) A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate:

   (a) The guaranteed, and non-guaranteed and determinable elements of the contract, and their limitations, if any, including for fixed indexed annuities, the elements used to determine the index-based interest, such as the participation rates, caps or spread, and an explanation of how they operate;

   (b) An explanation of the initial crediting rate, or for fixed indexed annuities, an explanation of how the index-based interest is determined, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

   (c) Periodic income options both on a guaranteed and non-guaranteed basis;

   (d) Any value reductions caused by withdrawals from or surrender of the contract;

   (e) How values in the contract can be accessed;

   (f) The death benefit, if available and how it will be calculated;

   (g) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

   (h) Impact of any rider, such as including, but not limited to, a guaranteed living benefit or long-term care rider.

(4) Specific dollar amount or percentage charges and fees shall be listed with an explanation of how they apply; and

(5) Information about the current guaranteed rate or indexed crediting rate formula, if applicable, for new contracts that contains a clear notice that the rate is subject to change.
C. Insurers shall define terms used in the disclosure statement in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure statement is directed.

Section 6. Standards for Annuity Illustrations

A. An insurer or producer may elect to provide a consumer an illustration at any time, provided that the illustration is in compliance with this section and:

(1) Clearly labeled as an illustration;

(2) Includes a statement referring consumers to the disclosure document and Buyer’s Guide provided to them at time of purchase for additional information about their annuity; and

(3) Is prepared by the insurer or third party using software that is authorized by the insurer prior to its use, provided that the insurer maintains a system of control over the use of illustrations.

B. An illustration furnished an applicant for a group annuity contract or contracts issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

C. The illustration shall not be provided unless accompanied by the disclosure document referenced in Section 5.

D. When using an illustration, the illustration shall not:

(1) Describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

(2) State or imply that the payment or amount of non-guaranteed elements is guaranteed; or

(3) Be incomplete.

E. Costs and fees of any type shall be individually noted and explained.

F. An illustration shall conform to the following requirements:

(1) The illustration shall be labeled with the date on which it was prepared;

(2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled “page 4 of 7 pages”);

(3) The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;

(4) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the contract is assumed to have been in force;

(5) The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;

(6) Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement indicating the nature of the rider benefits or the contract features, and whether or not they are included in the illustration;

(7) Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled guaranteed.
(8) The non-guaranteed elements underlying the non-guaranteed illustrated values shall be no more favorable than current non-guaranteed elements and shall not include any assumed future improvement of such elements. Additionally, non-guaranteed elements used in calculating non-guaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period.

(9) In determining the non-guaranteed illustrated values for a fixed indexed annuity, the index-based interest rate and account value shall be calculated for three different scenarios: one to reflect historical performance of the index for the most recent ten (10) calendar years; one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the least index value growth (the “low scenario”); one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the most index value growth (the “high scenario”). The following requirements apply:

(a) The most recent ten (10) calendar years and the last twenty (20) calendar years are defined to end on the prior December 31, except for illustrations prepared during the first three (3) months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year.

(b) If any index utilized in determination of an account value has not been in existence for at least ten (10) calendar years, indexed returns for that index shall not be illustrated. If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of those indexes has not been in existence for at least ten (10) calendar years, the allocation to such indexed account(s) shall be assumed to be zero;

(c) If any index utilized in determination of an account value has been in existence for at least ten (10) calendar years but less than twenty (20) calendar years, the ten (10) calendar year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;

(d) The non-guaranteed element(s), such as caps, spreads, participation rates or other interest crediting adjustments, used in calculating the non-guaranteed index-based interest rate shall be no more favorable than the corresponding current element(s);

(e) If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:

(i) The allocation used in the illustration shall be the same for all three scenarios; and

(ii) The ten (10) calendar year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account option.

(f) The geometric mean annual effective rate of the account value growth over the ten (10) calendar year period shall be shown for each scenario;

(g) If the most recent ten (10) calendar year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of subsection H, the most recent ten (10) calendar year historical period experience of the index shall be used for each subsequent ten (10) calendar year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;

(h) The low and high scenarios: (i) need not show surrender values (if different than account values); (ii) shall not extend beyond ten (10) calendar years (and therefore are not subject to the requirements of subsection H beyond subsection H(1)(a)); and (iii) may be shown
on a separate page. A graphical presentation shall also be included comparing the movement of the account value over the ten (10) calendar year period for the low scenario, the high scenario and the most recent ten (10) calendar year scenario; and

(i) The low and high scenarios should reflect the irregular nature of the index performance and should trigger every type of adjustment to the index-based interest rate under the contract. The effect of the adjustments should be clear; for example, additional columns showing how the adjustment applied may be included. If an adjustment to the index-based interest rate is not triggered in the illustration (because no historical values of the index in the required illustration range would have triggered it), the illustration shall so state;

(10) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., "see page 1 for guaranteed elements");

(11) The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;

(12) The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest and application of any market value adjustment, as applicable;

(13) Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;

(14) Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

(a) The benefits and values are not guaranteed;

(b) The assumptions on which they are based are subject to change by the insurer; and

(c) Actual results may be higher or lower;

(15) Illustrations based on non-guaranteed credited interest and non-guaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and non-guaranteed participation rates, caps or spreads for fixed indexed annuities;

(16) The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are in fact more favorable;

(17) Illustrations shall be concise and easy to read;

(18) Key terms shall be defined and then used consistently throughout the illustration;

(19) Illustrations shall not depict values beyond the maximum annuitization age or date;

(20) Annuity benefits shall be based on contract values that reflect surrender charges or any other adjustments, if applicable; and

(21) Illustrations shall show both annuity income rates per $1000.00 and the dollar amounts of the periodic income payable.

G. An annuity illustration shall include a narrative summary that includes the following unless provided at the same time in a disclosure document:
(1) A brief description of any contract features, riders or options, guaranteed and/or nonguaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the contract;

(2) A brief description of any other optional benefits or features that are selected, but not shown in the illustration and the impact they have on the benefits and values of the contract;

(3) Identification and a brief definition of column headings and key terms used in the illustration;

(4) A statement containing in substance the following:

   (a) For other than fixed indexed annuities:

   This illustration assumes the annuity’s current nonguaranteed elements will not change. It is likely that they will change and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

   The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer’s Guide provided with your Annuity Contract for more detailed information.

   (b) For fixed indexed annuities:

   This illustration assumes the index will repeat historical performance and that the annuity’s current non-guaranteed elements, such as caps, spreads, participation rates or other interest crediting adjustments, will not change. It is likely that the index will not repeat historical performance, the non-guaranteed elements will change, and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

   The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer’s Guide provided with your Annuity Contract for more detailed information; and

(5) Additional explanations as follows:

   (a) Minimum guarantees shall be clearly explained;

   (b) The effect on contract values of contract surrender prior to maturity shall be explained;

   (c) Any conditions on the payment of bonuses shall be explained;

   (d) For annuities sold as an IRA, qualified plan or in another arrangement subject to the required minimum distribution (RMD) requirements of the Internal Revenue Code, the effect of RMDs on the contract values shall be explained;

   (e) For annuities with recurring surrender charge schedules, a clear and concise explanation of what circumstances will cause the surrender charge to recur; and

   (f) A brief description of the types of annuity income options available shall be explained, including:

      (i) The earliest or only maturity date for annuitization (as the term is defined in the contract);

      (ii) For contracts with an optional maturity date, the periodic income amount for at least one of the annuity income options available based on the guaranteed rates in the contract, at the later of age seventy (70) or ten (10) years after issue, but in no case later than the maximum annuitization age or date in the contract;
(iii) For contracts with a fixed maturity date, the periodic income amount for at least one of the annuity income options available, based on the guaranteed rates in the contract at the fixed maturity date; and

(iv) The periodic income amount based on the currently available periodic income rates for the annuity income option in item (ii) or item (iii), if desired.

H. Following the narrative summary, an illustration shall include a numeric summary which shall include at minimum, numeric values at the following durations:

1. (a) First ten (10) contract years; or

   (b) Surrender charge period if longer than ten (10) years, including any renewal surrender charge period(s);

2. Every tenth contract year up to the later of thirty (30) years or age seventy (70); and

3. (a) Required annuitization age; or

   (b) Required annuitization date.

I. If the annuity contains a market value adjustment, hereafter MVA, the following provisions apply to the illustration:

1. The MVA shall be referred to as such throughout the illustration;

2. The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the value available upon surrender;

3. The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the death benefit;

4. A statement, containing in substance the following, shall be included:

   When you make a withdrawal the amount you receive may be increased or decreased by a Market Value Adjustment (MVA). If interest rates on which the MVA is based go up after you buy your annuity, the MVA likely will decrease the amount you receive. If interest rates go down, the MVA will likely increase the amount you receive.

5. Illustrations shall describe both the upside and the downside aspects of the contract features relating to the market value adjustment;

6. The illustrative effect of the MVA shall be shown under at least one positive and one negative scenario. This demonstration shall appear on a separate page and be clearly labeled that it is information demonstrating the potential impact of a MVA;

7. Actual MVA floors and ceilings as listed in the contract shall be illustrated; and

8. If the MVA has significant characteristics not addressed by Paragraphs (1) – (6), the effect of such characteristics shall be shown in the illustration.

**Drafting Note:** Appendix A provides an example of an illustration of an annuity containing an MVA that addresses Paragraphs (1) – (6) above.

J. A narrative summary for a fixed indexed annuity illustration also shall include the following unless provided at the same time in a disclosure document:

1. An explanation, in simple terms, of the elements used to determine the index-based interest, including but not limited to, the following elements:
(a) The Index(es) which will be used to determine the index-based interest;

(b) The Indexing Method – such as point-to-point, daily averaging, monthly averaging;

(c) The Index Term – the period over which indexed-based interest is calculated;

(d) The Participation Rate, if applicable;

(e) The Cap, if applicable; and

(f) The Spread, if applicable;

(2) The narrative shall include an explanation, in simple terms, of how index-based interest is credited in the indexed annuity;

(3) The narrative shall include a brief description of the frequency with which the company can re-set the elements used to determine the index-based credits, including the participation rate, the cap, and the spread, if applicable; and

(4) If the product allows the contract holder to make allocations to declared-rate segment, then the narrative shall include a brief description of:

(a) Any options to make allocations to a declared-rate segment, both for new premiums and for transfers from the indexed-based segments; and

(b) Differences in guarantees applicable to the declared-rate segment and the indexed-based segments.

K. A numeric summary for a fixed indexed annuity illustration shall include, at a minimum, the following elements:

(1) The assumed growth rate of the index in accordance with Subsection F(9);

(2) The assumed values for the participation rate, cap and spread, if applicable; and

(3) The assumed allocation between indexed-based segments and declared-rate segment, if applicable, in accordance with Subsection F(9).

L. If the contract is issued other than as applied for, a revised illustration conforming to the contract as issued shall be sent with the contract, except that non-substantive changes, including, but not limited to changes in the amount of expected initial or additional premiums and any changes in amounts of exchanges pursuant to Section 1035 of the Internal Revenue Code, rollovers or transfers, which do not alter the key benefits and features of the annuity as applied for will not require a revised illustration unless requested by the applicant.

Section 67. Report to Contract Owners

For annuities in the payout period with changes in that include non-guaranteed elements, and for deferred annuities in the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least the following information:

A. The beginning and end date of the current report period;

B. The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

C. The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and
D. The amount of outstanding loans, if any, as of the end of the current report period.

Section 78. Penalties

In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of this regulation shall be guilty of a violation of Section [cite state’s unfair trade practices act].

Section 82. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the regulation and its application to other persons or circumstances shall not be affected.

Section 10. [Optional] Recordkeeping

A. Insurers or insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer and other information provided in the disclosure statement (including illustrations) for [insert number] years after the contract is delivered by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

Drafting Note: States should review their current record retention laws and specify a time period that is consistent with those laws.

B. Records required to be maintained by this regulation may be maintained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Drafting Note: This section may be unnecessary in States that have a comprehensive recordkeeping law or regulation.

Section 911. Effective Date

This regulation shall become effective [insert effective date] and shall apply to contracts sold on or after the effective date.
APPENDIX—BUYER’S GUIDE TO FIXED DEFERRED ANNUITIES

Drafting Note: The language of the Fixed Deferred Annuity Buyer’s Guide is limited to that contained in the following pages, or to language approved by the commissioner. Companies may purchase personalized brochures from the NAIC or may request permission to reproduce the Buyer’s Guide in their own type style and format.

[The face page of the Fixed Deferred Annuity Buyer’s Guide shall read as follows:]

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

Reprinted by . . .

It is important that you understand the differences among various annuities so you can choose the kind that best fits your needs. This guide focuses on fixed deferred annuity contracts. There is, however, a brief description of variable annuities. If you’re thinking of buying an equity-indexed annuity, an appendix to this guide will give you specific information. This Guide isn’t meant to offer legal, financial or tax advice. You may want to consult independent advisors. At the end of this Guide are questions you should ask your agent or the company. Make sure you’re satisfied with the answers before you buy.

WHAT IS AN ANNUITY?

An annuity is a contract in which an insurance company makes a series of income payments at regular intervals in return for a premium or premiums you have paid. Annuities are most often bought for future retirement income. Only an annuity can pay an income that can be guaranteed to last as long as you live.

An annuity is neither a life insurance nor a health insurance policy. It’s not a savings account or a savings certificate. You shouldn’t buy an annuity to reach short-term financial goals.

Your value in an annuity contract is the premiums you’ve paid, less any applicable charges, plus interest credited. The insurance company uses the value to figure the amount of most of the benefits that you can choose to receive from an annuity contract. This guide explains how interest is credited as well as some typical charges and benefits of annuity contracts.

A deferred annuity has two parts or periods. During the accumulation period, the money you put into the annuity, less any applicable charges, earns interest. The earnings grow tax deferred as long as you leave them in the annuity. During the second period, called the payout period, the company pays income to you or to someone you choose.

WHAT ARE THE DIFFERENT KINDS OF ANNUITIES?

This guide explains major differences in different kinds of annuities to help you understand how each might meet your needs. But look at the specific terms of an individual contract you’re considering and the disclosure document you receive. If your annuity is being used to fund or provide benefits under a pension plan, the benefits you get will depend on the terms of the plan. Contact your pension plan administrator for information.

This Buyer’s Guide will focus on individual fixed deferred annuities.

Single Premium or Multiple Premium

You pay the insurance company only one payment for a single premium annuity. You make a series of payments for a multiple premium annuity. There are two kinds of multiple premium annuities. One kind is a flexible premium contract. Within set limits, you pay as much premium as you want, whenever you want. In the other kind, a scheduled premium annuity, the contract spells out your payments and how often you’ll make them.

Immediate or Deferred
With an immediate annuity, income payments start no later than one year after you pay the premium. You usually pay for an immediate annuity with one payment.

The income payments from a deferred annuity often start many years later. Deferred annuities have an accumulation period, which is the time between when you start paying premiums and when income payments start.

**Fixed or Variable**

- **Fixed**

During the accumulation period of a fixed deferred annuity, your money (less any applicable charges) earns interest at rates set by the insurance company or in a way spelled out in the annuity contract. The company guarantees that it will pay no less than a minimum rate of interest. During the payout period, the amount of each income payment to you is generally set when the payments start and will not change.

- **Variable**

During the accumulation period of a variable annuity, the insurance company puts your premiums (less any applicable charges) into a separate account. You decide how the company will invest those premiums, depending on how much risk you want to take. You may put your premium into a stock, bond or other account, with no guarantees, or into a fixed account, with a minimum guaranteed interest. During the payout period of a variable annuity, the amount of each income payment to you may be fixed (set at the beginning) or variable (changing with the value of the investments in the separate account).

**HOW ARE THE INTEREST RATES SET FOR MY FIXED DEFERRED ANNUITY?**

During the accumulation period, your money (less any applicable charges) earns interest at rates that change from time to time. Usually, what these rates will be is entirely up to the insurance company.

**Current Interest Rate**

The current rate is the rate the company decides to credit to your contract at a particular time. The company will guarantee it will not change for some time period.

- **Initial rate** is an interest rate the insurance company may credit for a set period of time after you first buy your annuity. The initial rate in some contracts may be higher than it will be later. This is often called a bonus rate.

- **Renewal rate** is the rate credited by the company after the end of the set time period. The contract tells how the company will set the renewal rate, which may be tied to an external reference or index.

**Minimum Guaranteed Rate**

The minimum guaranteed interest rate is the lowest rate your annuity will earn. This rate is stated in the contract.

**Multiple Interest Rates**

Some annuity contracts apply different interest rates to each premium you pay or to premiums you pay during different time periods.

Other annuity contracts may have two or more accumulated values that fund different benefit options. These accumulated values may use different interest rates. **You get only one of the accumulated values depending on which benefit you choose.**

**WHAT CHARGES MAY BE SUBTRACTED FROM MY FIXED DEFERRED ANNUITY?**

Most annuities have charges related to the cost of selling or servicing it. These charges may be subtracted directly from the contract value. Ask your agent or the company to describe the charges that apply to your annuity. Some examples of charges, fees and taxes are:

**Surrender or Withdrawal Charges**
If you need access to your money, you may be able to take all or part of the value out of your annuity at any time during the accumulation period. If you take out part of the value, you may pay a withdrawal charge. If you take out all of the value and surrender, or terminate, the annuity, you may pay a surrender charge. In either case, the company may figure the charge as a percentage of the value of the contract, of the premiums you’ve paid or of the amount you’re withdrawing. The company may reduce or even eliminate the surrender charge after you’ve had the contract for a stated number of years. A company may waive the surrender charge when it pays a death benefit.

Some annuities have stated terms. When the term is up, the contract may automatically expire or renew. You’re usually given a short period of time, called a window, to decide if you want to renew or surrender the annuity. If you surrender during the window, you won’t have to pay surrender charges. If you renew, the surrender or withdrawal charges may start over.

In some annuities, there is no charge if you surrender your contract when the company’s current interest rate falls below a certain level. This may be called a bail-out option. In a multiple-premium annuity, the surrender charge may apply to each premium paid for a certain period of time. This may be called a rolling surrender or withdrawal charge.

Some annuity contracts have a market value adjustment feature. If interest rates are different when you surrender your annuity than when you bought it, a market value adjustment may make the each surrender value higher or lower. Since you and the insurance company share this risk, an annuity with a MVA feature may credit a higher rate than an annuity without that feature.

Be sure to read the Tax Treatment section and ask your tax advisor for information about possible tax penalties on withdrawals.

Free Withdrawal

Your annuity may have a limited free withdrawal feature. That lets you make one or more withdrawals without a charge. The size of the free withdrawal is often limited to a set percentage of your contract value. If you make a larger withdrawal, you may pay withdrawal charges. You may lose any interest above the minimum guaranteed rate on the amount withdrawn. Some annuities waive withdrawal charges in certain situations, such as death, confinement in a nursing home or terminal illness.

Contract Fee

A contract fee is a flat dollar amount charged either once or annually.

Transaction Fee

A transaction fee is a charge per premium payment or other transaction.

Percentage of Premium Charge

A percentage of premium charge is a charge deducted from each premium paid. The percentage may be lower after the contract has been in force for a certain number of years or after total premiums paid have reached a certain amount.

Premium Tax

Some states charge a tax on annuities. The insurance company pays this tax to the state. The company may subtract the amount of the tax when you pay your premium, when you withdraw your contract value, when you start to receive income payments or when it pays a death benefit to your beneficiary.

WHAT ARE SOME FIXED DEFERRED ANNUITY CONTRACT BENEFITS?

Annuity Income Payments

One of the most important benefits of deferred annuities is your ability to use the value built up during the accumulation period to give you a lump sum payment or to make income payments during the payout period. Income payments are usually made monthly but you may choose to receive them less often. The size of income payments is based on the accumulated value in your annuity and the annuity’s benefit rate in effect when income payments start. The benefit rate usually depends on your age and sex, and the annuity payment option you choose. For example, you might choose payments that continue as long as you live, as long as your spouse lives or for a set number of years. There is a table of guaranteed benefit rates in each annuity contract. Most companies have current benefit rates as well. The company can change the current rates at any time, but the current rates can never be less.
than the guaranteed benefit rates. When income payments start, the insurance company generally uses the benefit rate in effect at that time to figure the amount of your income payment.

Companies may offer various income payment options. You (the owner) or another person that you name may choose the option. The options are described here as if the payments are made to you.

- **Life Only**—The company pays income for your lifetime. It doesn’t make any payments to anyone after you die. This payment option usually pays the highest income possible. You might choose it if you have no dependents, if you have taken care of them through other means or if the dependents have enough income of their own.

- **Life Annuity with Period Certain**—The company pays income for as long as you live and guarantees to make payments for a set number of years even if you die. This *period certain* is usually 10 or 20 years. If you live longer than the period certain, you’ll continue to receive payments until you die. If you die during the period certain, your beneficiary gets regular payments for the rest of that period. If you die after the period certain, your beneficiary doesn’t receive any payments from your annuity. Because the “period certain” is an added benefit, each income payment will be smaller than in a life-only option.

- **Joint and Survivor**—The company pays income as long as either you or your beneficiary lives. You may choose to decrease the amount of the payments after the first death. You may also be able to choose to have payments continue for a set length of time. Because the *survivor* feature is an added benefit, each income payment is smaller than in a life-only option.

**Death Benefit**

In some annuity contracts, the company may pay a death benefit to your beneficiary if you die before the income payments start. The most common death benefit is the contract value or the premiums paid, whichever is more.

**CAN MY ANNUITY’S VALUE BE DIFFERENT DEPENDING ON MY CHOICE OF BENEFIT?**

While all deferred annuities offer a choice of benefits, some use different accumulated values to pay different benefits. For example, an annuity may use one value if annuity payments are for retirement benefits and a different value if the annuity is surrendered. As another example, an annuity may use one value for long-term care benefits and a different value if the annuity is surrendered. You can’t receive more than one benefit at the same time.

**WHAT ABOUT THE TAX TREATMENT OF ANNUITIES?**

Below is a general discussion about taxes and annuities. You should consult a professional tax advisor to discuss your individual tax situation.

Under current federal law, annuities receive special tax treatment. Income tax on annuities is deferred, which means you aren’t taxed on the interest your money earns while it stays in the annuity. Tax deferred accumulation isn’t the same as tax-free accumulation. An advantage of tax deferral is that the tax bracket you’re in when you receive annuity income payments may be lower than the one you’re in during the accumulation period. You’ll also be earning interest on the amount you would have paid in taxes during the accumulation period. Most states’ tax laws on annuities follow the federal law. Part of the payments you receive from an annuity will be considered as a return of the premium you’ve paid. You won’t have to pay taxes on that part. Another part of the payments is considered interest you’ve earned. You must pay taxes on the part that is considered interest when you withdraw the money. You may also have to pay a 10% tax penalty if you withdraw the accumulation before age 59½. The Internal Revenue Code also has rules about distributions after the death of a contract holder.

Annuities used to fund certain employee pension benefit plans (those under Internal Revenue Code Sections 401(a), 401(k), 403(b), 457 or 414) defer taxes on plan contributions as well as on interest or investment income. Within the limits set by the law, you can use pretax dollars to make payments to the annuity. When you take money out, it will be taxed.

You can also use annuities to fund traditional and Roth IRAs under Internal Revenue Code Section 408. If you buy an annuity to fund an IRA, you’ll receive a disclosure statement describing the tax treatment.

**WHAT IS A “FREE LOOK” PROVISION?**

Many states have laws which give you a set number of days to look at the annuity contract after you buy it. If you decide during that time that you don’t want the annuity, you can return the contract and get all your money back. This is often referred to as a
free look or right to return period. The free look period should be prominently stated in your contract. Be sure to read your contract carefully during the free look period.

HOW DO I KNOW IF A FIXED DEFERRED ANNUITY IS RIGHT FOR ME?

The questions listed below may help you decide which type of annuity, if any, meets your retirement planning and financial needs. You should think about what your goals are for the money you may put into the annuity. You need to think about how much risk you’re willing to take with the money. Ask yourself:

● How much retirement income will I need in addition to what I will get from Social Security and my pension?

● Will I need that additional income only for myself or for myself and someone else?

● How long can I leave my money in the annuity?

● When will I need income payments?

● Does the annuity let me get money when I need it?

● Do I want a fixed annuity with a guaranteed interest rate and little or no risk of losing the principal?

● Do I want a variable annuity with the potential for higher earnings that aren’t guaranteed and the possibility that I may risk losing principal?

Or, am I somewhere in between and willing to take some risks with an equity-indexed annuity?
Annuity Illustration Example

[The following illustration is an example only
And does not reflect specific characteristics of any actual product for sale by any company]

ABC Life Insurance Company

Company Product Name
Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy
(Contact us at Policyownerservice@ABCLife.com or 555-555-5555)

<table>
<thead>
<tr>
<th>Sex: Male</th>
<th>Initial Premium Payment: $100,000.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at Issue: 54</td>
<td>Planned Annual Premium Payments: None</td>
</tr>
<tr>
<td>Annuitant: John Doe</td>
<td>Tax Status: Nonqualified</td>
</tr>
<tr>
<td>Oldest Age at Which Annuity Payments Can Begin: 95</td>
<td>Withdrawals: None</td>
</tr>
</tbody>
</table>

Initial Interest Guarantee Period: 5 Years

Initial Guaranteed Interest Crediting Rates
First Year (reflects first year only interest bonus credit of 0.75%): 4.15%
Remainder of Initial Interest Guarantee Period: 3.40%

Market Value Adjustment Period: 5 Years
Minimum Guaranteed Interest Rate after Initial Interest Guarantee Period *: 3%

* After the Initial Interest Guarantee Period, a new interest rate will be declared annually. This rate cannot be lower than the Minimum Guaranteed Interest Rate.

Annuity Income Options and Illustrated Monthly Income Values

This annuity is designed to pay an income that is guaranteed to last as long as the Annuitant lives. When annuity income payments are to begin, the income payment amounts will be determined by applying an annuity income rate to the annuity Account Value.

Annuity income options include the following:
- Periodic payments for Annuitant’s life
- Periodic payments for Annuitant’s life with payments guaranteed for a certain number of years
- Periodic payments for Annuitant’s life with payments continuing for the life of a survivor annuitant

Illustrated Annuity Income Option: Monthly payments for annuitant’s life with payments guaranteed for 10-year period.
Assumed Age When Payments Start: 70

<table>
<thead>
<tr>
<th></th>
<th>Account Value</th>
<th>Monthly Annuity Income Rate/$1,000 of Account Value *</th>
<th>Monthly Annuity Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on Rates Guaranteed in the Contract</td>
<td>$164,798</td>
<td>$5.00</td>
<td>$823.99</td>
</tr>
<tr>
<td>Based on Rates Currently Offered by the Company</td>
<td>$171,976</td>
<td>$6.50</td>
<td>$1,117.84</td>
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</table>

* If, at the time of annuitization, the annuity income rates currently offered by the company are higher than the annuity income rates guaranteed in the contract, the current rates will apply.
### Values Based on Guaranteed Rates

<table>
<thead>
<tr>
<th>Contract Year/Age</th>
<th>Premium Payment</th>
<th>Interest Crediting Rate</th>
<th>Account Value Before MVA</th>
<th>Minimum Cash Surrender Value Before MVA</th>
<th>Interest Crediting Rate</th>
<th>Account Value After MVA</th>
<th>Minimum Cash Surrender Value After MVA</th>
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</thead>
<tbody>
<tr>
<td>1 / 55</td>
<td>$ 100,000</td>
<td>4.15%</td>
<td>$ 104,150</td>
<td>$ 95,818</td>
<td>4.15%</td>
<td>$ 104,150</td>
<td>$ 95,818</td>
</tr>
<tr>
<td>2 / 56</td>
<td>0</td>
<td>3.40%</td>
<td>$ 107,691</td>
<td>$ 100,153</td>
<td>3.40%</td>
<td>$ 107,691</td>
<td>$ 100,153</td>
</tr>
<tr>
<td>3 / 57</td>
<td>0</td>
<td>3.40%</td>
<td>$ 111,353</td>
<td>$ 104,671</td>
<td>3.40%</td>
<td>$ 111,353</td>
<td>$ 104,671</td>
</tr>
<tr>
<td>4 / 58</td>
<td>0</td>
<td>3.40%</td>
<td>$ 115,139</td>
<td>$ 109,382</td>
<td>3.40%</td>
<td>$ 115,139</td>
<td>$ 109,382</td>
</tr>
<tr>
<td>5 / 59</td>
<td>0</td>
<td>3.40%</td>
<td>$ 119,053</td>
<td>$ 114,291</td>
<td>3.40%</td>
<td>$ 119,053</td>
<td>$ 114,291</td>
</tr>
<tr>
<td>6 / 60</td>
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<td>3.00%</td>
<td>$ 122,625</td>
<td>$ 118,946</td>
<td>3.00%</td>
<td>$ 122,625</td>
<td>$ 118,946</td>
</tr>
<tr>
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<td>3.00%</td>
<td>$ 126,304</td>
<td>$ 123,778</td>
<td>3.00%</td>
<td>$ 126,304</td>
<td>$ 123,778</td>
</tr>
<tr>
<td>8 / 62</td>
<td>0</td>
<td>3.00%</td>
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<td>$ 130,093</td>
<td>3.00%</td>
<td>$ 130,093</td>
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</tr>
<tr>
<td>9 / 63</td>
<td>0</td>
<td>3.00%</td>
<td>$ 133,996</td>
<td>$ 133,996</td>
<td>3.00%</td>
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</tr>
<tr>
<td>10 / 64</td>
<td>0</td>
<td>3.00%</td>
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<td>3.00%</td>
<td>$ 138,015</td>
<td>$ 138,015</td>
</tr>
<tr>
<td>11 / 65</td>
<td>0</td>
<td>3.00%</td>
<td>$ 142,156</td>
<td>$ 142,156</td>
<td>3.00%</td>
<td>$ 142,156</td>
<td>$ 142,156</td>
</tr>
<tr>
<td>16 / 70</td>
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<td>3.00%</td>
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<td>$ 164,798</td>
<td>3.00%</td>
<td>$ 164,798</td>
<td>$ 164,798</td>
</tr>
<tr>
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<td>$ 191,046</td>
<td>3.00%</td>
<td>$ 191,046</td>
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</tr>
<tr>
<td>26 / 80</td>
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<td>$ 221,474</td>
<td>$ 221,474</td>
<td>3.00%</td>
<td>$ 221,474</td>
<td>$ 221,474</td>
</tr>
<tr>
<td>31 / 85</td>
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<td>3.00%</td>
<td>$ 256,749</td>
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</tr>
<tr>
<td>36 / 90</td>
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<td>3.00%</td>
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<td>$ 297,643</td>
<td>3.00%</td>
<td>$ 297,643</td>
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</tr>
<tr>
<td>41 / 95</td>
<td>0</td>
<td>3.00%</td>
<td>$ 345,050</td>
<td>$ 345,050</td>
<td>3.00%</td>
<td>$ 345,050</td>
<td>$ 345,050</td>
</tr>
</tbody>
</table>

For column descriptions, turn to page 3
**Column Descriptions**

1. **Ages** shown are measured from the Annuitant's age at issue.
2. **Premium Payments** are assumed to be made at the beginning of the Contract Year shown.

**Values Based on Guaranteed Rates**

3. **Interest Crediting Rates** shown are annual rates; however, interest is credited daily. During the Initial Interest Guarantee Period, values developed from the Initial Premium Payment are illustrated using the Initial Guaranteed Interest Rate(s) declared by the insurance company, which include an additional first year only interest bonus credit of 0.75%. The interest rates will be guaranteed for the Initial Interest Guarantee Period, subject to an MVA. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually, but can never be less than the Minimum Guaranteed Interest Rate shown.

4. **Account Value** is the amount you have at the end of each year if you leave your money in the contract until you start receiving annuity payments. It is also the amount available upon the Annuitant's death if it occurs before annuity payments begin. The death benefit is not affected by surrender charges or the MVA.

5. **Cash Surrender Value Before MVA** is the amount available at the end of each year if you surrender the contract (after deduction of any Surrender Charge) but before the application of any MVA. Surrender charges are applied to the Account Value according to the schedule below until the surrender charge period ends, which may be after the Initial Interest Guarantee Period has ended.

<table>
<thead>
<tr>
<th>Years Measured from Premium Payment:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surrender Charges:</td>
<td>8%</td>
<td>7%</td>
<td>6%</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

6. **Minimum Cash Surrender Value After MVA** is the minimum amount available at the end of each year if you surrender your contract before the end of five years, no matter what the MVA is. The minimum is set by law. The amount you receive may be higher or lower than the cash surrender value due to the application of the MVA, but never lower than this minimum. Otherwise the MVA works as follows: If the interest rate available on new contracts offered by the company is LOWER than your Initial Guaranteed Interest Rate, the MVA will INCREASE the amount you receive. If the interest rate available on new contracts offered by the company is HIGHER than your initial guaranteed interest rate, the MVA will DECREASE the amount you receive. Page 4 of this illustration provides additional information concerning the MVA.

**Values Based on Assumption that Initial Guaranteed Rates Continue**

7. **Interest Crediting Rates** are the same as in Column (3) for the Initial Interest Guarantee Period. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually. For the purposes of calculating the values in this column, it is assumed that the Initial Guaranteed Interest Rate (without the bonus) will continue as the new renewal interest rate in all years. The actual renewal interest rates are not subject to an MVA and will very likely NOT be the same as the illustrated renewal interest rates.

8. **Account Value** is calculated the same way as column (4).

9. **Cash Surrender Value Before and After MVA** is the Cash Surrender Value at the end of each year assuming that Initial Guaranteed Interest Rates continue, and that the continuing rates are the rates offered by the company on new contracts. In this case the MVA would be zero, and Cash Surrender Values before and after the MVA would be the same.

**Important Note:** This illustration assumes you will take no withdrawals from your annuity before you begin to receive periodic income payments. **Withdrawals will reduce both the annuity Account Value and the Cash Surrender Value.** You may make partial withdrawals of up to 10% of your account value each contract year without paying surrender charges. Excess withdrawals (above 10%) and full withdrawals will be subject to surrender charges.

This illustration assumes the annuity’s current interest crediting rates will not change. It is likely that they will change and actual values may be higher or lower than those in the illustration.

The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. For more information, read the annuity disclosure and annuity buyer’s guide.
The graphs below show MVA-adjusted Cash Surrender Values (CSVs) during the first five years of the contract, as illustrated on page 2 ($100,000 single premium, a 5-year MVA Period) under two sample scenarios, as described below.

Graph #1 shows if the interest rate on new contracts is 3% LOWER than your Initial Guaranteed Interest Rate, the MVA will increase the amount you receive (green line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

Graph #2 shows if the interest rate on new contracts is 3% HIGHER than your Initial Guaranteed Interest Rate, the MVA will decrease the amount you receive, but not below the minimum set by law (Column (6) on Page 2), which in this scenario limits the decrease for the first 2 years (yellow line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

These graphs and the sample guaranteed interest rates on new contracts used are for demonstration purposes only and are not intended to be a projection of how guaranteed interest rates on new contracts are likely to behave.
STRANGER-ORIGINATED ANNUITY TRANSACTIONS
NAIC SAMPLE BULLETIN

To: All Insurers Selling Life Insurance or Annuities in [State]
From: [Commissioner, Director, Superintendent]
Date: [Insert Date]
Re: Protect Against Stranger-Originated Annuity Transactions

Insurance companies are encouraged to put safeguards in place to prevent or limit their exposure to stranger-originated annuity transactions (STOAs).

Like stranger-originated life insurance transactions (STOLI), in stranger-originated annuity transactions (STOAs), some producers and/or investors offer an individual, who is usually a “stranger” to the producer and/or investor, a nominal fee for the use of the individual’s identity as the annuitant, or measuring life, in an investment-oriented annuity. Typically, individuals targeted to serve as annuitants are in extremely poor health and are not expected to live beyond the first year of the policy. In order to find individuals who meet the aforementioned criteria, these producers and/or investors have been known to take out advertisements in papers as well as solicit individuals residing in nursing homes or hospice.

Once an individual has agreed to the set of conditions posed, the producer will complete the annuity application, ensuring that particular riders, such as a bonus rider or a guaranteed minimum death benefit, are in place to maximize the rate of return for those financing the transaction. Depending on the number of companies the producer represents and the commission policies in effect, the producer may seek to use multiple policies from various companies.

To avoid added scrutiny of the policy or detection of the scheme, producers involved in STOAs will often take precautions to ensure that the dollar amount of the annuity falls below specific underwriting guidelines. A trust or an organization may additionally be named as beneficiary of the annuity in order to hide the true identity of those who will benefit from the annuitant’s death.

As the financial implications of STOA transactions could be detrimental to both companies and consumers, it is suggested that companies:

 Review chargeback policies and consider reserving the right to adjust commissions if a policy is annuitized or a death benefit is paid within its first policy year and the facts indicate the policy was used to facilitate STOA transactions.
 Create detection methods to identify STOA transactions and those producers who may be involved in facilitating such transactions, including controls to flag questionable applications.
 Revisit annuity application processes to ensure that specific questions are posed with regard to the relationship between the annuitant and contract owner, and the manner in which the contract is being funded.
 Report actual and potential STOA transactions to the [Department of Insurance].

For questions regarding this matter, please contact [insert name and contact information].
Report of
Health Insurance and Managed Care (B) Committee

The Health Insurance and Managed Care (B) Committee met Sept. 19, 2011 via conference call. During this meeting, the Committee:

1. Adopted its July 6, June 22, June 7 and April 4, 2011 conference call minutes.

2. Established a new subgroup on medical loss ratio (MLR) quality improvement (QI) initiatives as recommended by the Health Reform Solvency Impact (E) Subgroup. The new subgroup will be charged with periodically reviewing new QI initiatives, in adherence to the definition and standards of quality improvement, for possible incorporation into, or exclusion from, the annual statement instructions related to MLR for future reporting purposes.

3. Adopted its subgroup, working group and task force reports: Consumer Information (B) Subgroup, Exchanges (B) Subgroup, Limited Medical Benefit Plan (B/D) Working Group, Health Actuarial (B) Task Force, Regulatory Framework (B) Task Force and Senior Issues (B) Task Force.
Report of the
Property and Casualty Insurance (C) Committee

The Property and Casualty Insurance (C) Committee met via conference call Sept. 16, 2011. During this meeting, the Committee:

1. Adopted the April 26 conference call minutes of the Catastrophe Insurance (C) Working Group.
2. Discussed a memo on producer controlled insurers and risk retention groups and assigned the matter to the Risk Retention (C) Working Group for review and comment.
3. Adopted a risk classification survey instrument for personal auto insurance.
5. Adopted the Title Agent Statistical Data Plan Implementation Guideline.
6. Adopted a motion to cease work on drafting a model law to provide a regulatory framework for credit scoring information vendors.
7. Discussed federal efforts to reauthorize the National Flood Insurance Program.
8. Distributed its draft 2012 Proposed Charges and established a deadline for written comments.
9. Adopted its task force and working group reports: Casualty Actuarial and Statistical (C) Task Force; Surplus Lines (C) Task Force; Title Insurance (C) Task Force; Workers’ Compensation (C) Task Force; Advisory Organization Examination Oversight (C) Working Group; Catastrophe Insurance (C) Working Group; Risk Retention (C) Working Group; and Transparency and Readability of Consumer Information (C) Working Group.
Attachment to

Property and Casualty Insurance (C) Committee
March 28, 2011

A Consumer’s Guide to Earthquake Insurance

February 4, 2011 Draft by the
Earthquake (C) Study Group
A Consumer’s Guide to Earthquake Insurance

This guide provides information on how to make decisions when you buy earthquake insurance.

- Why Buy Earthquake Insurance
- Who Needs Earthquake Insurance
- What Earthquake Insurance Covers
- What Isn’t Covered
- How Much Coverage Do You Need
- Understanding Earthquake Deductibles
- How Insurers Determine Your Earthquake Premium
- Smart Shopping
- Your Responsibilities
- After an Earthquake
- Filing a Claim
- Steps to Protect You and Your Home
- For More Information

Why Buy Earthquake Insurance

Earthquakes can cause a great deal of damage that won’t be covered under your homeowners, renters or condominium insurance policy. These policies don’t cover damage due to natural disasters such as earthquake, flood and landslide. Your home is insured for earthquake damage only if you’ve added an endorsement to your policy or bought a separate earthquake policy. A homeowners policy and earthquake insurance don’t overlap, but work together to give your home more insurance protection.

Waiting until after an earthquake to buy insurance is never a good idea. First, you can’t buy insurance to cover damage that’s already happened. Second, after an earthquake, insurers likely won’t sell coverage for some period of time and when they do, premiums may be higher.

Who Needs Earthquake Insurance

Whether you should buy earthquake insurance depends on several factors. One is if you live in a quake-prone area. Earthquakes can happen in all 50 states and U.S. territories. About 90% of us live in areas that have earthquakes. California has the most frequent damaging earthquakes while Alaska has the largest earthquakes, mostly where no one lives. Most earthquakes are west of the Rocky Mountains, but some of the most violent earthquakes have been in the central U.S.
As the 2008 United States Geological Survey’s (USGS) National Seismic Hazard Map shows, every state has some risk of earthquake damage. The areas in red and orange have the highest risk.

### 2008 United States National Seismic Hazard Map

![2008 United States National Seismic Hazard Map](http://pubs.usgs.gov/fs/2008/3018/pdf/FS08-3018_508.pdf)

Colors on this map show the levels of horizontal shaking that have a 2-in-100 chance of being exceeded in a 50-year period. Shaking is expressed as a percentage of g (g is the acceleration of a falling object due to gravity).


Also, think about how you would manage the costs to recover from an earthquake. Without insurance, how would you pay to repair or rebuild your home? How would you pay the costs to live somewhere else while your home is being repaired or rebuilt? How much would you owe a lender, who will expect you to repay the mortgage or home equity loan even if your home is destroyed? How much would you lose if your home were damaged or destroyed by an earthquake and you couldn’t afford to repair it? Earthquake insurance can help with all of these costs.

Finally, how likely is it that your home will be damaged in a quake? Brick homes, wood frame homes with crawl spaces, and multi-story homes are more likely to be damaged in an earthquake. A qualified contractor or engineer can help you assess your home’s risk for earthquake damage.

### What Earthquake Insurance Covers

Earthquake insurance covers repairs needed because of earthquake damage to your dwelling and may cover other structures not attached to your house, like a garage. It insures your personal property against damage from an earthquake. It may cover increased costs to meet current building codes and costs to stabilize the land under your home. Earthquake insurance covers the cost to remove debris. It also pays for extra living expenses you may have while your home is being rebuilt or repaired.
While insurance for earthquake damage isn’t part of your homeowners insurance, you may be able to add it by buying an endorsement (a written change to your coverage) and paying an extra premium. Or, you may buy a separate earthquake insurance policy. Either way, it’s likely there will be important differences between your earthquake insurance and your homeowners insurance policy. Ask your insurance agent to explain those differences.

What Isn’t Covered

What your earthquake insurance doesn’t cover (the exclusions) varies by insurance company. Review your earthquake coverage and declaration page to learn what the exclusions are.

Some of the most common exclusions in earthquake insurance are:

- **Fire.** Earthquake insurance usually won’t cover anything your homeowners insurance policy already covers. It won’t, for instance, cover fire damage to your home—even if the fire started because an earthquake ruptured a gas line. Your homeowners policy would cover losses from a fire.

- **Land.** Typically, earthquake insurance doesn’t cover damage to your land, such as sinkholes from erosion or other hidden openings under your land. Earthquake insurance wouldn’t pay to fill in large cracks or holes that appear in the middle of your yard after an earthquake. If your insurance includes Engineering Costs coverage, it will pay at least part of the cost to stabilize the land that supports your home.

- **Vehicles.** Earthquake insurance doesn’t cover damage to your vehicles, even if an earthquake damaged cars in your garage. Your automobile insurance policy may cover that damage.

- **Pre-Existing Damage.** Earthquake insurance won’t cover damage to your home that was there before the earthquake.

- **External Water Damage.** Earthquake insurance doesn’t cover water damage from external sources—such as from sewer or drain backup or flood. For example, if you live near a lake that floods your home after an earthquake, earthquake insurance won’t pay to repair the damage. A flood insurance policy will cover your property for that damage.

- **Masonry (Brick) Veneer.** Some earthquake insurance doesn’t cover masonry veneer—the brick, rock or stone that covers your home’s outside instead of stucco or siding. If masonry veneer isn’t covered, the insurer usually deducts its value from the total cost of your loss before applying the deductible. That means the cost to repair a home damaged in an earthquake would be based on using siding materials that cost less than masonry veneer. If you have any masonry veneer on your home, ask your insurance agent if it would be covered.

How Much Coverage Do You Need

How much coverage is right for you will depend on your situation. Insurance policies have “limits of coverage” that tell you the largest dollar amount covered for different types of losses. A policy may even have sublimits. For example, a policy could have a $50,000 limit for personal property and a $5,000 sublimit for computers. That sublimit would mean that the insurer would pay no more than $5,000 to repair or replace your computers.
Insuring your home for its *appraisal or loan value* likely means you’ll only have enough coverage to repay your lender. It may not be enough to repair or rebuild your home, especially if it’s a total loss. Usually the dwelling coverage limit will be the same on your homeowners insurance policy and your earthquake insurance. If you don’t have enough homeowners insurance coverage, you probably won’t have enough earthquake insurance either. You should review your dwelling coverage from time to time to be sure it doesn’t drop below the cost to replace your home. If it drops below 80% of the full replacement cost of your home, your insurance company may reduce the amount that it will pay on a claim.

The following are questions that may help you decide how much coverage you need:

*For dwelling coverage to repair or rebuild your house:*

- How much would it cost to repair or rebuild your home? How much of that cost could you personally pay?

*For contents coverage:*

- How much would it cost to replace your household items (such as furniture, appliances, electronics and clothing)? Could you afford it? Ask what you need to do to be sure the insurance will cover all of your personal property, especially valuable or breakable items such as artwork or porcelain.

*For additional living expense coverage:*

- How much would it cost to find a temporary place to live because you couldn’t live in your home after an earthquake? You could be out of your house for many months if there’s major damage to your home. This coverage pays the extra costs you have to pay because you aren’t able to live in your home. For example, it would pay rent for temporary housing while you continue to pay your home mortgage. This coverage does **not** pay your regular costs of living—for example, your groceries or your car payment.

**Understanding Earthquake Deductibles**

A deductible is the amount you (the homeowner) are responsible for on each claim. The insurer is responsible for the amount greater than the deductible, up to the coverage limit.

The deductible for earthquake insurance usually is 10 to 20 percent of the *coverage limit*. Depending on the policy, there may be separate deductibles for the dwelling, outside structures (such as outbuildings, detached garages and yard fences), and personal contents. This is different from a homeowners policy where there usually is only one flat amount deductible, like $500 or $1,000. You may not be responsible for a deductible for additional living expenses coverage.

As coverage and terms of insurance can vary from company to company, ask your agent how the deductibles will be calculated under your policy.

Assume that an earthquake totally destroys your home and you have earthquake insurance that covers all the damage. The following table explains how one type of earthquake deductible may work.
### One Example of an Earthquake Deductible

Some policies may pay up to the total of one or more of the coverage limits if the damage is more than the coverage limits. The following table gives an example of how the deductible may work in that type of arrangement. Always check with your agent for an explanation of how the deductible may work for your earthquake coverage.

<table>
<thead>
<tr>
<th>Coverage Limits</th>
<th>Dwelling</th>
<th>Outside Structures</th>
<th>Personal Contents</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$100,000</td>
<td>$10,000</td>
<td>$50,000</td>
<td>$160,000</td>
</tr>
<tr>
<td>Your Property Damage</td>
<td>$110,000</td>
<td>$8,500</td>
<td>$62,000</td>
<td>$180,500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible Amount (Your Responsibility)</th>
<th>$20,000</th>
<th>$2,000</th>
<th>$10,000</th>
<th>$32,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>($100,000 x 20%)</td>
<td>($10,000 x 20%)</td>
<td>($50,000 x 20%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Amount Insurer May Pay</th>
<th>$90,000</th>
<th>$6,500</th>
<th>$50,000</th>
<th>$146,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>The greater of: (covered loss – deductible) or policy limits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the table above, the deductible is 20 percent for each type of coverage. You would be responsible for the deductible for the dwelling, or $20,000 in this case. You also would be responsible for the $2,000 deductible on outside structures and the $10,000 deductible on personal property.

The earthquake damage to the dwelling and personal property is more than the coverage limit for both of these types of property. For example, there is $110,000 in damages to the dwelling versus a $100,000 coverage limit. But the damage to outside structures is less ($8,500) than the $10,000 coverage limit.

Total reimbursement to you would be based on the difference between your property damage and the deductible, up to the coverage limit. In this example, the insurer would pay $90,000 ($110,000–$20,000) for the dwelling and $6,500 ($8,500–$2,000) for outside structures. In each of these, the net loss was less than the coverage limit.

The insurer’s payment for personal property would be calculated the same way—property damage ($62,000) minus deductible ($10,000). Your net loss would be $52,000. But your policy limit is $50,000 for personal contents, so the total amount you would be paid for your personal property loss would be capped at the coverage limit, or $50,000.

In this example, your total loss is $180,500. You would be responsible for $32,000 in deductibles plus $2,000 in unreimbursed or non-covered damage to your personal property. The insurer’s total payment for this claim would be $146,500.

When you shop for insurance, you may be asked what deductible you want. Remember that earthquake deductibles are already much larger than a typical homeowners insurance deductible. If your deductible is too high, you may never be able to use your earthquake insurance because the damage will never be greater than the deductible.

The deductible you pay is considered an uninsured loss. You’re entitled to federal disaster loans to help cover uninsured losses. Remember that you’re expected to repay a loan.

Another unique feature of earthquake insurance is time limits. Typically, all earthquake events in a 72-hour (3-day) period are considered one event—with one claim and one set of deductibles. Damage caused by aftershocks more than 72 hours after the first quake could mean a second claim with a second set of deductibles. The period of time may not be 72 hours in all policies. Ask your insurance agent.
How Insurers Determine Your Earthquake Premium

Premiums for earthquake insurance vary by your home’s characteristics. Some common characteristics are:

1) **Your home’s location.** Is your home in an earthquake-prone area? If the area where you live is likely to have earthquake activity, your premiums will be higher.

2) **The age of your home.** The premium can be higher for older homes.

3) **The construction of your home.** How large is your home and how many stories does it have? Is it a wood frame home or masonry (brick) home? Does it have a masonry (brick) veneer? Does your home have a basement or is it on a concrete slab block foundation?

4) **The cost to rebuild your home.** You can choose to insure your home and its contents for either replacement cost or actual cash value. Replacement cost is the cost to rebuild your home or repair damages using materials of similar kind and quality. Actual cash value is the value of your home considering its age and wear and tear. Actual cash value coverage pays you for your loss, but often doesn’t pay enough to fully repair or replace the property.

5) **The deductible(s).** As with homeowners insurance, a larger deductible means you’ll be responsible for more of the loss. It also means a lower premium for you. Insurance premiums are lower when insurers pay less in claims.

**Smart Shopping**

You can find insurance companies and agents through the phonebook, on the Internet and television, and by asking friends and neighbors. The state insurance department also may have a list of insurers licensed to sell earthquake coverage in your state.

If you already have homeowners insurance, you can begin your search for earthquake insurance by contacting your current agent or company. You may be able to buy earthquake insurance as an endorsement (a written change to your coverage) to an existing homeowners policy. If earthquake coverage isn’t available as an endorsement to your homeowners policy, your insurer may connect you with another company to buy a stand-alone policy.

If you can’t buy earthquake insurance from your current agent or company, you still may be able to get earthquake insurance from a “surplus lines” company by contacting an agent in your state. These companies have permission to sell insurance in the state and are willing to sell insurance to cover risks when other insurers aren’t. However, as a buyer you don’t have the same consumer protections when you buy from a surplus lines company as when you buy from an “admitted” carrier. The state insurance department can tell you what you need to know when you buy insurance from a surplus lines company.

If there’s been a recent earthquake, most insurers won’t sell any new earthquake insurance for 30 to 60 days. The time to buy the coverage is before there’s an earthquake.

Different insurance companies charge different rates for the same coverage. Not all insurance companies provide the same level of claims service. Customer service is important to most consumers, particularly when they have a claim. So, it makes sense to shop around for the best insurance company for your needs. You can get a sense of how well an insurer serves its customers from a complaint index. Some state insurance departments post complaint index information on their websites. A complaint index measures how many complaints your state insurance department receives relative to the size of the company.

It’s illegal for unlicensed insurance companies or agents to sell insurance. Business cards and websites aren't proof an agent is licensed. If you buy from an unlicensed agent or insurance company, the insurance company may not pay your claims; or, if you cancel your policy, the insurance company may not refund your premiums. To find out if an agent or company is licensed, check with your state insurance department.

Buy insurance from a company that’s financially sound. To check the financial health of an insurance company, use ratings from independent ratings agencies such as Standard and Poor’s, A.M. Best and Moody’s.

As you compare premiums, be sure the quotes are for the same or very similar coverage. A worksheet to help you compare coverage is available at www.uhelp.org. Be sure to get rate quotes and coverage information in writing.

**Your Responsibilities**
An insurance policy is a legal contract. Read your policy and contact your insurance agent or company if you have questions. If they can’t answer your questions, contact your state insurance department.

When you buy earthquake insurance, you’ll receive a policy—not a photocopy. If you don't receive a policy within 30 days, contact the insurance company. If you need a company’s toll-free number, check their website, call your agent or contact your state insurance department.

Keep your policy in your home files. Know the name of your insurer.

Other helpful tips for earthquake insurance—and any other types of insurance—are:

- Pay the premium on time. Some insurers don’t accept late payments. If an insurer accepts your payment late, it may increase your premium at renewal.
- Keep a file of all paperwork you completed online or received in the mail and signed, including the policy, changes to your policy, renewal notices, correspondence, copies of advertisements, premium payment receipts, notes of conversations and any claims submitted. It’s a good idea to keep a second copy outside your home, such as at your workplace.
- Make a household inventory.
  - Go through each room; write down and take pictures or videos of everything in the room. Don’t forget valuable items such as antiques, electronics, jewelry, collectibles and guns.
  - Store your home inventory in a secure place at another location, such as your workplace, a safe deposit box, a relative’s house or online. Keep a copy at home.
  - Review and update your home inventory, including your pictures/videos each year. Also update your inventory when you buy new items and make repairs. Keep receipts with your home inventory.

After an Earthquake

If there’s been an earthquake in your area, there are several things that you should do as soon as possible:

- Find a radio, television, or Internet connection to learn about emergency instructions from your local officials.
- Expect aftershocks, which can cause more damage in the hours, weeks, days or even months after the quake.
- Check utility lines and appliances for damage. If you smell gas, open windows and turn off the main gas valve. If your home’s electric power goes on and off, turn off your home’s main circuit breaker to prevent power surges.
- Check chimneys for cracks or other damage before making a fire.
- If your home has been damaged, do whatever you need to prevent more damage or property loss. This could include boarding up windows to prevent theft.
- Call your agent or the insurance company. Ask about your coverage for earthquake damage and what to expect next. Most importantly, ask when and how a claims adjuster will contact you.
- Keep notes about your contacts with the insurer, your agent and any other insurance company personnel about your claim. Include dates, times and names. Keep copies of correspondence.
- Check your own documents to find your policy and declarations page. Both will tell you more about your coverage.
- Find your household inventory.

Filing a Claim
Each state has its own laws about the claims process, and both you and your insurer will need to follow those rules.

The insurance company will assign a claims adjuster to assess the damages and determine the payment. These adjusters may be employees of the company or independent contractors. You should cooperate with the adjuster’s investigation of your claim. The adjuster probably will want to meet with you to inspect the damage.

Even if you don’t think the damage to your home is greater than your deductible, let your insurance company know that your home has been damaged. A qualified professional should inspect your home for both structural (hidden) and cosmetic damage. You or your insurer can hire this professional, who can be an engineer or an experienced and licensed contractor. The inspection should include the attic, basement, walls, foundation and chimney. After an inspection, you also may want to get other independent estimates of what repairs are needed and how much they will cost.

If you, the insurer and the claims adjuster disagree, first try to resolve the differences with your insurer. Your agent may be helpful. It also might help to have your contractor meet with you and the insurance adjuster.

Don’t feel rushed or pushed to agree with something you aren’t comfortable with; your insurer doesn’t have the last word. Ask questions and ask the adjuster for a written explanation of his decisions.

If you and the insurer still disagree about the claim handling or settlement, you may ask for help from the consumer services personnel in your state insurance department. If you disagree about the value of the claim, check your policy for an appraisal clause.

Another choice is to hire an attorney or a public adjuster. A public adjuster isn’t an attorney or a government employee. States that allow public adjusters require them to be licensed and to follow certain guidelines. If you have questions about the use of public adjusters in your state, call your state insurance department.

**Steps to Protect You and Your Home**

A homeowner can take steps to lower the risk of earthquake damage. Some of these steps also can mean a lower earthquake insurance premium. Retrofitting (changes to your home to reduce damage) may be an easy and inexpensive way to protect some homes. However, changes to the structure and to some types of homes could be very expensive. A qualified contractor or engineer can advise if retrofitting is practical for your home.

Some inexpensive ways to retrofit your home are:

- Bolt down items such as bookcases, dressers and televisions. Securing heavy items not only can reduce property damage but also can mean fewer injuries.
- Secure and brace the water heater to the dwelling frame.
- Install automatic gas shut-off valves.

More expensive, structural retrofit measures are:

- Anchor a house to its foundation through seismic bolting.
- Install bracing; one approach is to cover cripple walls (in the space between the foundation and the floor where the crawl space is) with plywood.

The Earthquake Country Alliance, based in California, gives specific instructions on how to secure furniture and other items in your home to prevent both injuries and damages in your home. Instructions can be found at the following Web address: [www.daretoprepare.org/secure_your_stuff.html](http://www.daretoprepare.org/secure_your_stuff.html).


Another source on how to prepare for earthquakes is the Institute for Building and Home Safety’s website: [www.disastersafety.org](http://www.disastersafety.org) (Click on Get Prepared, then Earthquakes).
Emergency experts advise you to always have basic supplies (such as water, food and flashlights) on hand in case there’s an emergency. The Federal Emergency Management Agency (FEMA—www.fema.org) and your state or local emergency services offices have more information on preparing for an emergency.

For More Information

- For information about your consumer rights or filing a complaint, or if you can’t find insurance, visit your state insurance department’s website. To find the website address of your state department, visit the National Association of Insurance Commissioners (NAIC) website at www.naic.org/state_web_map.htm and select your state on the map.

- Visit the NAIC Insure U consumer education website at www.InsureUonline.org.

- Learn more about the National Flood Insurance Program at www.floodsmart.gov.
REGISTRATION AND REGULATION OF THIRD PARTY ADMINISTRATORS (TPAs)
(An NAIC Guideline)

This Guideline, offered in two versions, is a revision of the Third Party Administrator Statute, which was first adopted by the NAIC as a model law in 1977 and which had been most recently amended in 2001. Version 1 of the Guideline expands the scope of the prior model by adding workers’ compensation and stop-loss coverages. Version 2 of the Guideline omits workers’ compensation, which makes it similar in scope to the prior model, with the difference being in those states where stop-loss insurance was defined as liability insurance and not as health insurance.

A state’s best use of the Guideline will depend on whether it currently has a TPA law and/or whether it wants to have a TPA law that extends to the handling of workers’ compensation claims:

- For a state that wishes to enact a TPA law that extends to workers’ compensation, Version 1 should be an excellent starting point. Study the language carefully to make whatever amendments may be necessary on account of state-specific issues with workers’ compensation, agent licensing and adjuster licensing statutes. The adjuster licensing statutes will probably require an especially careful examination to have a good “mesh” and to avoid duplicative requirements, while workers’ compensation statutes will need to be studied to determine whether the provisions of this document regarding the rights of employers to involve themselves in claims handling or disputes are in agreement. While part of a possible response to conflicts could be to change adjuster licensing or workers’ compensation laws to match this document, it is not the purpose of the Guideline to call for changes to other statutes. Although drafting notes will provide assistance in this regard, one should not skim over sections without drafting notes. There are more state-to-state differences than can be easily summarized by drafting notes.

- A state that already has a TPA law, but that wants to extend it to workers’ compensation, will also find Version 1 to be an excellent reference. The advice for such a state is again to review this document carefully, looking to see where it differs from the state’s current law and carefully noting where the changes proposed in this document may conflict with the state’s other statutes.

- A state with or without a current TPA law, that wants to have a TPA law that does not extend to workers’ compensation, is advised to consider Version 2. Version 2 is essentially the same as Version 1, but with provisions and language related to workers’ compensation removed. This law still includes stop-loss and other refinements made to the previous NAIC model. Admittedly, the motivation for a state to make changes to its existing laws is likely to depend on whether it has identified a reason that it needs to “fix” its current laws. Absent the identification of any practical problems, states may assign a lower priority to the improvements contained in this document.

In addition to numerous editorial changes, some of the substantive changes to what was previously in the 2001 NAIC model law are as follow:

(a) The language of the 2001 model required individuals adjusting life and health claims to be licensed as TPAs, even though it is clear that it was never the intent of the drafters or the states that adopted the model to implement a licensure requirement for employees of TPAs or insurers adjusting life and health claims. In addition, the licensing provisions in the 2001 model allowed an individual to become licensed to act as a full-fledged TPA. While the Guideline has language to allow previously licensed individuals to be “grandfathered,” it provides that only business entities can be newly licensed as TPAs. As a practical matter, licensure requirements are not cleanly met by an individual.

(b) The 2001 model exempted licensed insurers operating as TPAs from all requirements of the Act. The Guidelines maintain this exemption for lines other than workers’ compensation. For workers’ compensation, while Version 1 exempts insurers from licensure requirements and from audit and reporting requirements when they handle workers’ compensation claims for an employer that is not their policyholder, it subjects such insurer/TPAs to many other operational requirements of the Act for workers’ compensation.

(c) The Guideline adds cease & desist orders to those actions available to the commissioner and also addresses concerns that the 2001 model may have been deficient with regard to due process.

(d) The Guideline extends the life & health scope of the 2001 model to so-called “stop-loss” insurance. This may be viewed a clarification in states where stop-loss is already considered to be health insurance and cannot be written as liability insurance, but it will be a modest expansion in other states.
(e) Version 1 extends the scope of the 2001 model to workers’ compensation insurance. One should note, however, that various provisions of the model applying to life & health are not uniformly extended to workers’ compensation. There is an extensive new section dealing with workers’ compensation contracts between insurers and TPAs, and between TPAs and insured employers.

(f) Version 1 will not allow a TPA to agree with an employer to have the employer adjust its own workers’ compensation claims, and an employer cannot avoid this prohibition by simply licensing an affiliated business entity as a TPA in order to handle its own workers’ compensation claims.

(g) Version 1 exempts payments made by employers to TPAs for handling workers’ compensation claims under a large deductible contract from premium taxes.

(h) The account-related provisions in the 2001 model were substantially revised. Most notably, the Guideline deletes the requirement that accounts administered by the TPA must be in the name of the insurance company, as long as claims trust funds held by the TPA are not commingled with premium trust funds.
THIRD PARTY ADMINISTRATOR ACT
(NAIC Guideline Version 1)

Drafting Note: This “version 1” guideline includes workers’ compensation, while the “version 2” guideline excludes workers’ compensation. A state that intends to adopt a TPA law should start with the version that is appropriate for its needs.

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Section 1. Definitions

For purposes of this Act:

A. “Affiliate or affiliated” means a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another specified person.

B. “Business entity” means a corporation, association, partnership, limited liability company or other legal entity.

Drafting Note: Many laws use very broad definitions of “entity” that include individuals. Provisions of this Act referring to business entities are specifically intended to exclude individuals, as the full scope of TPA responsibilities and requirements are not well-suited to licensure of an individual. In addition, an overbroad definition of entity or “business entity” could result in individuals working for TPAs being required to be individually licensed as TPAs.

C. “Collateral” means funds, letters of credit or any item with economic value owned by the payor but held by an insurer or TPA in case it needs to be used to fulfill premium or loss reimbursement obligations in accordance with a contract between the insurer or TPA and the payor. “Collateral” shall include anticipated loss prepayments made prior to the payment of losses, pursuant to arrangements where reimbursement is not due until after losses have been paid.

D. “Commissioner” means the Commissioner of Insurance of this state.

E. “Control” (including the terms “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods
or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by [insert appropriate reference to state law regulating holding companies] that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

F. “GAAP” means United States generally accepted accounting principles consistently applied.

G. “Home state” means the United States jurisdiction that has adopted this Act or a substantially similar law governing TPAs and that has granted the TPA a home state TPA license.

H. “Insurer” means an entity licensed in a United States jurisdiction to provide life, annuity, health or stop-loss coverage as an insurance company, health maintenance organization, fraternal benefit society or prepaid hospital or medical care plan.

Drafting Note: States that license multiple employer welfare arrangements (MEWAs) or workers’ compensation self-insurance groups, or that authorize employee leasing companies or professional employer organizations (PEOs) to provide employee welfare benefits on a self-funded basis, will want to include these entities in the list of entities that are included in the definition of insurer for purposes of this Act, but only to the extent of their license or authorization. It is not the intention of this drafting note to include employee leasing companies or PEOs authorized to self-insure workers’ compensation within the definition of “insurer.” Rather, this Act contemplates that such an entity, when authorized as a workers’ compensation self-insurer, will be considered to be a “workers’ compensation self-insurer,” which is a term that is already defined under this Act.

I. “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

Drafting Note: States that use different terminology such as “agent” and/or “broker” should make appropriate adjustments to this language. In states that do not license business entities as insurance producers, use the following definition:

I. “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, and also includes a business entity whose primary activities are the sales, solicitation and negotiation of insurance.

J. “Master services agreement” means a written agreement between an insurer and a TPA that specifies standards for the handling of workers’ compensation claims and the handling of funds belonging to the insurer or policyholder in connection therewith.

K. “Nonresident TPA” means a TPA whose home state is any jurisdiction other than this state.

L. “Payor” means an insurer, a workers’ compensation self-insurer, or an employer administering its employee benefit plan or the employee benefit plan of an affiliated employer under common management and control.

M. “Person” means an individual or a business entity.

N. “Stop-loss insurance” means insurance protecting an employer or other person responsible for an otherwise self-insured health or life benefit plan against obligations under the plan, but “stop-loss insurance” does not include reinsurance written for an insurance company.

Drafting note: The inclusion of the stop-loss definition and the inclusion of stop-loss throughout this law are not necessary in states where stop-loss is clearly stipulated to be health insurance and cannot be interpreted to be liability insurance or some other form of insurance. In such states, references to stop-loss may be deleted or – if retained – viewed as a clarification (as stop-loss is considered to be liability insurance in some states).
O. “Third party administrator” or “TPA” means a person who directly or indirectly underwrites, collects charges, collateral or premiums from, or adjusts or settles claims on residents of this state, in connection with life, annuity, health, stop-loss or workers’ compensation coverage, except that a person shall not be considered a TPA if that person’s only actions that would otherwise cause it to be considered a TPA are among the following:

1. A person working for a TPA to the extent that the person’s activities are subject to the supervision and control of the TPA;

2. An employer administering its employee benefit plan or the employee benefit plan of an affiliated employer under common management and control, except that workers’ compensation shall not be considered as an “employee benefit plan;”

3. The administration of a bona fide employee benefit plan established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974, as the act existed on [an appropriate recent date should be selected];

4. A workers’ compensation self-insurer that has been approved by [agency responsible for the approval of workers’ compensation self-insurance] or an employer otherwise authorized by law to administer its workers’ compensation obligations to its employees or co-employees, while administering workers’ compensation benefits for its employees or co-employees;

5. A union administering a benefit plan on behalf of its members;

6. An insurer administering insurance coverage for its policyholders, subscribers or certificate holders, or those of an affiliated insurer under common management and control;

7. An insurer directly or indirectly underwriting, collecting charges, collateral or premiums from, or adjusting or settling claims for life, annuity, health or stop-loss insurance on behalf of a client that is not a policyholder, subscriber or certificate holder, and that has its United States headquarters or principal location of business in a jurisdiction in which the insurer is licensed to write that coverage;

8. An insurer directly or indirectly underwriting, collecting charges, collateral or premiums, or adjusting or settling claims for life, annuity, health or stop-loss insurance, provided that the insurer is licensed in this state to write that line of insurance coverage;

9. An insurance producer selling insurance or engaged in related activities within the scope of the producer’s license, except that this shall not include the adjusting or settling of workers’ compensation claims;

10. A creditor acting on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

11. A trust and its trustees and agents acting pursuant to such trust established in conformity with 29 U.S.C. Section 186;

12. A trust exempt from taxation under Section 501(a) of the Internal Revenue Code and its trustees acting pursuant to such trust, or a custodian and the custodian’s agents acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;

13. A credit union or a financial institution that is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, when collecting or remitting premiums to licensed insurance producers or to limited lines producers or authorized payors in connection with loan payments;
(14) A credit card issuing company advancing or collecting insurance premiums or charges from its credit card holders who have authorized collection;

(15) An individual adjusting or settling claims in the normal course of that individual’s practice or employment as an attorney at law and who does not collect charges or premiums in connection with insurance coverage;

(16) A person licensed as a managing general agent in this state when acting within the scope of that license; or

(17) A business entity licensed pursuant to [insert statutory reference] to adjust workers’ compensation loss claims, but only if that entity does not receive or manage funds from employers or other persons whose workers’ compensation claims are being adjusted and does not manage or control related funds of the payor that is ultimately responsible for the claims.

**Drafting Note:** The above exception to the definition of “third party administrator” and “TPA” should be included if the state licenses adjusting firms to handle workers’ compensation or other claims that would fall under the scope of this act. The drafting shown is for a state that licenses firms to adjust workers’ compensation claims, but not other types of claims subject to this act. If the state also licenses firms to adjust life, health or stop-loss claims, then this wording should be amended accordingly. If the state licenses individuals but not business entities to adjust claims, the state should consider whether to include an exemption for business entities that do not handle client funds and whose only TPA activities are claims adjustment performed by licensed adjusters.

(18) A business entity that is affiliated with a licensed insurer while acting as a TPA for the direct and assumed insurance business of an affiliated insurer;

(19) A person providing network access services or the re-pricing of charges of participating providers for medical care rendered persons covered under workers’ compensation, including related case management or credentialing services, as long as such person does not manage or control related funds of the payor that is ultimately responsible for the workers’ compensation claims, and as long as such person does not engage in advising or determining whether a workers’ injury is eligible for workers’ compensation coverage.

P. “Underwrites” or “underwriting” means, but is not limited to, the acceptance of employer or individual applications for coverage of individuals and the overall planning and coordination of a benefits program.

Q. “Uniform Application” means the current version of the NAIC Uniform Application for Third Party Administrators.

R. “Workers’ compensation” means a government-mandated or authorized system of medical and disability benefits applying to workers and their dependents or other beneficiaries, and which arise from on-the-job injuries or disease. Workers’ compensation does not include indemnification of an employer under excess workers’ compensation policies, when that employer has been approved by the responsible government agency to self-insure its responsibility to provide benefits.

S. “Workers’ compensation self-insurer” means an employer or co-employer approved by [agency responsible for the approval of workers’ compensation self-insurance] or otherwise authorized by law to assume primary financial responsibility for the payment of workers’ compensation benefits to its employees or co-employees, instead of transferring this primary financial responsibility to an insurer in exchange for an insurance premium, whether the payment of such benefits is administered by the employer, co-employer or a TPA.

**Section 2. Licensing Necessary**

A. No person shall act as a TPA in this state unless that person is licensed as a TPA pursuant to this Act or unless the TPA is exempted from this Act’s licensing requirement pursuant to subsection B of this section.
or subsections G or H of section 15 of this Act. This prohibition shall not apply to a person while
employed by, or when operating under contract to, a TPA that is licensed pursuant to this Act, or exempted
from this Act’s licensing requirements pursuant to subsection B of this section or subsections G or H of
section 15 of this Act. The authority granted to a TPA pursuant to this Act does not exempt its employees
from the licensing requirements of [reference to adjuster licensing act].

Drafting Note: The last sentence of the preceding subsection should be deleted in states that do not require the licensing of
adjusters for any of the lines of insurance falling within the scope of this Act.

B. An insurer that also operates as a TPA for workers’ compensation in this state shall be exempt from
sections 13 through 16 of this Act if it is licensed to write workers’ compensation insurance in this state.

Section 3. Workers’ Compensation; Agreement with an Affiliated TPA

If an agreement between a TPA and an insurer would result in the expectation that more than thirty percent of the workers’
compensation claim costs to be adjusted by the TPA in this state would be for employees or co-employees of the TPA or its
affiliates, then the TPA and the insurer must submit the agreement to the [agency responsible for the approval of workers’
compensation self-insurance] for prior approval and the agreement may not take effect until it has been approved. In
considering the proposed agreement for approval or disapproval, the [agency responsible for the approval of workers’
compensation self-insurance] shall apply the same standards that are applied to consider approval of the claims-handling
activities of workers’ compensation self-insurers in this state. To determine the expectation of claim costs, the TPA and the
insurer shall use the [rates or loss costs] published by the state’s designated workers’ compensation advisory organization.

Drafting Note: The reference in the last sentence of this paragraph should be fitted to the state’s workers’ compensation rate
regulatory structure.

Section 4. Payment to a TPA

If an insurer utilizes the services of a TPA, any premiums or charges for insurance paid to the TPA by or on behalf of the
insured party, or any collateral furnished to the TPA by or on behalf of the insured party, shall be deemed to have been
received by the insurer, and the return of collateral or the payment of return premiums or claim payments forwarded by the
insurer to the TPA shall not be deemed to have been paid to the insured party or claimant until the payments are received by
the insured party or claimant. Nothing in this section limits any right of the insurer against the TPA resulting from the failure
of the TPA to make payments to the insurer, insured parties or claimants.

Section 5. Maintenance of Information

A. A TPA shall maintain and make available to the payor complete books and records of all transactions
performed on behalf of the payor. The books and records shall be maintained in accordance with prudent
standards of insurance record keeping and shall be maintained for a period of not less than five (5) years
from the date of their creation.

B. The commissioner shall have access to books and records maintained by a TPA for the purposes of
examination, audit and inspection. Any documents, materials or other information in the possession or
control of the commissioner that are furnished by a TPA, payor, insurance producer or an employee or
agent thereof acting on behalf of the TPA, payor or insurance producer, or obtained by the commissioner in
an investigation shall be confidential by law and privileged, shall not be subject to [insert open records,
freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and
shall not be subject to discovery or admissible in evidence in any private civil action. However, the
commissioner is authorized to use such documents, materials or other information in the furtherance of any
regulatory or legal action brought as a part of the commissioner’s official duties.

C. Neither the commissioner nor any person who receives documents, materials or other information while
acting under the authority of the commissioner shall be permitted or required to testify in any private civil
action concerning confidential documents, materials, or information subject to Subsection B of this section.

D. In order to assist in the performance of his or her duties, the commissioner:
May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection B of this section, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or 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;  

May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or 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  

[OPTIONAL] May enter into agreements governing sharing and use of information consistent with this subsection.

**Drafting Note:** The language in Subsection D(1) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

**E.** No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection D of this section.

**F.** Nothing in this Act shall prohibit the commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to [insert appropriate reference to state law] to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

**G.** Notwithstanding any contractual agreements between the payor and the TPA that operate to the contrary, the TPA shall retain the right to sufficient continuing access to books and records to permit the TPA to fulfill all of its contractual obligations to insured parties, claimants, and the payor.

**H.** In the event the payor or the TPA cancel their agreement; notwithstanding the provisions of Subsection A of this section, the TPA may, by written agreement with the payor, transfer all records to a new TPA rather than retain them for five (5) years. In such cases, the new TPA shall acknowledge, in writing, that it is responsible for retaining the records of the prior TPA as required in Subsection A of this section.

**Section 6. Approval of Advertising**

A TPA that advertises on behalf of its client may only use advertising that has been approved in writing by the client in advance of its use. A TPA that mentions any current or former client in its advertising must obtain the client’s prior written consent.

**Section 7. Responsibilities of the Payor and TPA**

**A.** No TPA shall act as such without a written agreement between the TPA and the payor. A copy of the agreement shall be retained by the TPA for the duration of the agreement and for five (5) years thereafter. The agreement shall contain all provisions required by this section, except insofar as the TPA does not perform all of the functions referenced in this section.

**B.** A payor that utilizes the services of a TPA shall retain responsibility for the benefits, premium rates, collateral and reimbursement procedures, underwriting criteria and claims payment procedures applicable to the coverage and for securing reinsurance or stop-loss insurance, if any. The rules pertaining to these
matters, to the extent that they are relevant to the duties of the TPA, shall be agreed to in writing by the 
payor and the TPA.

C. An insurer utilizing the services of a TPA is responsible for the acts of the TPA and is responsible for 
providing the TPA’s books and records relevant to the insurer to the commissioner upon request.

D. The written agreement between the TPA and the payor shall provide that communications between the TPA 
and claimants shall avoid deceptive statements with regard to the responsibilities of the TPA, payor and any 
insurer with regard to claims or premiums.

1. If the TPA is also an insurer, then communications with claimants shall be designed to avoid the 
impression that coverage provided for the claimants is pursuant to insurance written by the insurer 
or an affiliated insurer.

2. For workers’ compensation coverage, if the TPA is employed by an insurer or by a large 
deductible policyholder, then communications with claimants shall be designed to avoid the 
impression that coverage provided to the claimants is pursuant to self-insurance by an employer or 
other entity, even when the amounts payable by the employer or other entity are a function of the 
claims paid on its behalf.

E. In the event of a dispute between the payor and the TPA regarding which of them is to fulfill a lawful 
obligation with respect to a policy, certificate or claim subject to the written agreement, the payor shall 
fulfill such obligation.

F. For workers’ compensation, the TPA shall establish and maintain means for the payor to identify a 
responsible person with the TPA when the payor is contacted by a claimant or a representative of a 
claimant, or by the insurance department or industrial commission. Upon request, the payor shall provide 
this information to a claimant, a representative of a claimant, or to the insurance department or industrial 
commission.

G. The payor has the duty to provide for competent administration of its programs administered by a TPA and 
within the scope of this Act.

H. When a TPA administers benefits in connection with life, annuity, health and employee benefit stop-loss 
coverage for more than one hundred (100) certificate holders, subscribers, claimants or policyholders on 
behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the TPA. 
At least one such review shall include an on-site audit of the operations of the TPA. The cost of such 
reviews or audits shall be borne by the insurer and not reimbursed by the TPA. The requirements of this 
subsection shall not apply when the TPA and the insurer are affiliated.

Section 8. Premium Collection and Payment of Claims

A. All insurance charges, premiums, collateral and loss reimbursements collected by a TPA on behalf of or for 
a payor, the return of premiums or collateral received from a payor, and any funds held by the TPA for the 
payment of claims, shall be held by the TPA in a fiduciary capacity. Funds shall be immediately remitted to 
the person entitled to them or shall be deposited promptly in a fiduciary account established and maintained 
by the TPA in a federally insured financial institution. The TPA shall render a periodic accounting to the 
payor detailing all transactions performed by the TPA pertaining to the business of the payor, and the 
written agreement between the payor and the TPA shall include the specifications of this reporting.

B. The TPA shall keep copies of all records of any fiduciary account maintained or controlled by the TPA, 
and, upon request of a payor, shall furnish the payor with copies of the records pertaining to the deposits 
and withdrawals made on behalf of the payor. If funds deposited in a fiduciary account have been collected 
on behalf of or for more than one payor, or for the payment of claims associated with more than one policy, 
the TPA shall keep records clearly recording the deposits in and withdrawals from the account on behalf of 
each payor and relating to each policyholder.
C. The TPA shall not pay any claim by withdrawals from a fiduciary account in which premiums or charges, other than collateral or loss reimbursements for workers’ compensation, are deposited. Withdrawals from a fiduciary account shall be made as provided in the written agreement between the TPA and the payor, and only for the following purposes:

1. Remittance to a payor entitled to remittance;
2. Deposit in an account maintained in the name of the payor;
3. Transfer to and deposit in a claims-paying account, with claims to be paid as provided in Subsection D of this section;
4. Payment to a group policyholder for remittance to the payor entitled to such remittance;
5. Payment to the TPA of its earned commissions, fees or charges;
6. Remittance of return premium to the person or persons entitled to such return premium; and
7. Payment to other service providers as authorized by the payor.

D. All claims paid by the TPA from funds collected on behalf of or for a payor shall be paid only as authorized by the payor. Payments from an account maintained or controlled by the TPA for purposes including the payment of claims may be made only for the following purposes:

1. Payment of valid claims;
2. Payment of expenses associated with claims handling to the TPA or to other service providers approved by the payor;
3. Remittance to the payor, or transfer to a successor TPA as directed by the payor, for the purpose of paying claims and associated expenses; and
4. Return of funds held as collateral or prepayment, to the person entitled to those funds, upon a determination by the payor that those funds are no longer necessary to secure or facilitate the payment of claims and associated expenses.

Section 9. Compensation to the TPA

A. A TPA shall not enter into an agreement or understanding with a payor or, with regard to workers’ compensation, a payor, employer or co-employer in which the effect is to make the amount of the TPA’s commissions, fees, or charges contingent upon savings effected in the payment of losses covered by the payor’s obligations. This provision shall not prohibit a TPA from receiving performance-based compensation for providing hospital or other auditing services, from providing managed care or related services, or from being compensated for subrogation expenses.

B. A payor shall not enter into an agreement with a TPA in violation of this section.

C. This section shall not prevent the compensation of a TPA from being based on premiums or charges collected or the number of claims paid or processed.

Section 10. Disclosure of Charges and Fees

A. When a TPA collects funds, the reason for collection of each item shall be identified to the insured party and each item shall be shown separately from any premium. Additional charges may not be made for services to the extent the services have been already paid for by the payor.
B. The TPA shall disclose to the payor all charges, fees and commissions that the TPA receives arising from services it provides for the payor, including any fees or commissions paid by payors providing reinsurance or stop-loss insurance.

Section 11. Workers’ Compensation; Agreements and Communication between Employers, TPAs and Insurers

No TPA shall enter into any agreement with any employer or co-employer, except a workers’ compensation self-insurer, for the adjustment or handling of workers’ compensation claims for its employees or co-employees that are residents of this state, or accept compensation of any kind for the adjustment or handling of workers’ compensation claims for employees or co-employees that are residents of this state, unless it has a master services agreement applying to such claims with the insurer responsible for the payment of claims attributable to the employer or co-employer. This section does not apply when the employer or co-employer is an insurer.

A. The following provisions apply to master services agreements:

1. The insurer may have more than one master services agreement with a given TPA, but it must be unambiguous which master services agreement applies for a given claim.

2. The provisions of this Act shall prevail in the case of any conflicts between it and the master services agreement.

3. The provisions of the master services agreement shall prevail in the case of any conflicts between it and a contract or agreement between the TPA and the employer or co-employer.

4. The provisions of this Act shall prevail in the case of any conflicts between it and the contract or agreement between the TPA and the employer or co-employer.

5. The master services agreement shall address any conversion of collateral held by the TPA on behalf of the insurer and shall address other details of funds management.

6. If the TPA receives funds directly from the employer or co-employer for claims or claims handling expense, then the master services agreement must provide for uninterrupted claims handling in the event that the employer or co-employer stops paying the TPA for any reason.

7. Each insurer and TPA must maintain copies of all master services agreements to which they are a party. These agreements shall be made available for inspection by the insurance department or the industrial commission upon request, but these agreements shall be treated as proprietary and this availability shall not be used to disclose an agreement to a third party without the permission of all parties to the agreement.

8. The insurer may terminate the obligation and the ability of the TPA to settle claims on its behalf for an employer or co-employer at any time upon advance notice to the TPA and to the employer or co-employer.

9. The master services agreement must make provisions for statistical reporting as required by law or regulation, and must make provision for statistical reporting and records management in the event of termination of the TPA’s responsibility for the handling of an employer or co-employer, or in the event of termination of the master services agreement.

B. Subject to other provisions of this Act, contracts or agreements between a TPA and an employer or co-employer relating to workers’ compensation for the employer’s or co-employer’s employees or co-employees may have the TPA paid or paid in part by the employer or co-employer. The following provisions apply to such funds and to reimbursements made through the conversion of collateral held by an TPA relating to a employer or co-employer:

1. When a TPA enters into a contract or agreement with an employer or co-employer relating to workers’ compensation for the employer’s or co-employer’ employees, the TPA shall disclose to
the employer or co-employer any charges, fees or commissions that it receives as compensation for such work from any insurer.

(2) The master services agreement may authorize the TPA to handle receipts and payments on behalf of the insurer relating to premium, collateral, and reimbursement for loss payments and expenses arising out of the adjusting of claims.

(3) Payments by the employer or co-employer to the TPA for its claims adjusting services under a large deductible policy, if made directly to the TPA and not by the insurer to the TPA, and if the insurer does not assume a risk that such payments may be higher than an expected amount, do not need to be reported by the insurer as premium on its Annual Statement. All other payments, other than collateral, made by the employer or co-employer to a TPA relating to coverage under a large deductible policy must be reported by the TPA to the insurer and reported by the insurer as premium on its Annual Statement. For purposes of this section, a large deductible policy is considered to be any workers’ compensation deductible policy approved by the Commissioner with a per-accident deductible of no less than one hundred thousand dollars and, if applicable, an aggregate deductible of no less than two hundred fifty thousand dollars, provided that both such deductibles must be retained by the employer or co-employer and not insured or reinsured in any fashion by any insurer not affiliated with the employer or co-employer.

Drafting Note: The definition of large deductible in Subsection B(2) should be made consistent with the minimum standards for large deductible approval otherwise contemplated in state law.

(4) Any payments made by the employer or co-employer to the TPA, that are not collateral and are not reimbursement for claims or claim adjusting expenses, and are attributable to workers’ compensation for employees or co-employee that are residents of this state, shall be reported by the insurer as premium on its Annual Statement. For purposes of this paragraph, conversion of collateral to satisfy an obligation of the employer or co-employer shall be considered a payment.

C. The TPA must retain copies of all contracts, agreements and amendments thereto between the TPA and an employer or co-employer relating to claims covered by the insurer under a statutory workers’ compensation policy. Upon request, the TPA must promptly provide the insurer with a copy of any contract, agreement or amendment thereto between the TPA and an employer or co-employer relating to claims covered by the insurer under a statutory workers’ compensation policy. The insurer and the TPA shall make all such agreements in their possession available for inspection by the insurance department or the industrial commission upon request, but these agreements shall be treated as proprietary and this availability shall not be used to disclose an agreement to a third party without the permission of all parties to the agreement.

D. If provision for such cancellation is contained in the insurance policy, an insurer may cancel the policy for nonpayment if the employer fails to pay the TPA for services relating to claims that are the ultimate responsibility of the insurer. The endorsement addressing the use of the TPA and the employer’s or co-employer’s obligation to pay the TPA may provide that the employer or co-employer is also obligated to pay the insurer for any amounts that the insurer pays the TPA should the employer or co-employer not pay the TPA on a timely basis.

E. No contract between an employer and a TPA may provide or allow administration of claims by the employer or co-employer unless self-administration of claims by the employer or co-employer has either been approved by the [agency responsible for approval of workers’ compensation self-insurance] or the employer or co-employer is otherwise authorized by law to administer its own claims in this state.

F. No contract or agreement between an employer and a TPA or an insurer may give the employer the right to deny a claim. If an employer recommends that a TPA deny a claim, then the TPA may do so if such action is consistent with the claims handling standards provided by the insurer.

Drafting Note: Subsection F should be amended as necessary in those states that give the employer specific rights to dispute or deny workers’ compensation claims. The section is not intended to reduce the rights of the employer to less than it would otherwise have under state law.
G. An insurer shall not permit a TPA to delegate authority to an employer or co-employer in violation of this section.

H. A contract or an agreement between an employer and a TPA may give the employer the right to have amounts paid that otherwise may be disputed by the insurer or the TPA. In the event that a contract or agreement has this provision, the insurer must be given a copy of the contract or advised of the existence of these provisions on a timely basis after the contract or agreement is entered into or amended to include a provision of this nature, except when the insurer has already given the TPA or the policyholder written permission for this arrangement. This subsection shall not be interpreted, however, to give this right to an employer absent a provision in the contract or agreement between it and the TPA, and it shall not be interpreted as meaning that the insurer that has not already given permission cannot refuse to accept such provisions within a reasonable time after their receipt by the insurer.

I. When a contract or agreement exists between the TPA and the employer, there must be an endorsement attached to each related statutory workers’ compensation policy to indicate the existence of that contract or agreement. If applicable, the endorsement must recognize the obligations of the policyholder to pay the TPA. If applicable, this endorsement must recognize the obligation of the employer or co-employer to reimburse the insurer if the insurer pays the TPA to assure continued claims services in the event of the employer’s or co-employer’s failure to pay. In addition, the endorsement shall provide that, in the event that the insurer terminates the TPA’s role in handling claims for the employer, the employer or co-employer shall have the ability to cancel the policy without a short rate penalty if it replaces its insurance with another insurer, but using the same TPA.

Section 12. Delivery of Materials to Covered Individuals

Any policies, certificates, booklets, termination notices or other written communications delivered by the payor to the TPA for delivery to insured parties or covered individuals shall be delivered by the TPA promptly after receipt of instructions from the payor to deliver them.

Section 13. Home State TPA License

A. If a TPA is incorporated in this state or this state is its principal place of business within the United States, then the TPA may designate this state as its home state and apply to this state for licensure as a TPA. If neither the state in which a TPA is incorporated nor the state that is its principal place of business have adopted this Act or a substantially similar law governing TPAs, and if the TPA has not designated any other state that has adopted this Act or a substantially similar law governing TPAs as its home state, then the TPA may apply for licensure to this state as its home state.

B. A TPA applying to this state as its home state shall apply for licensure using the Uniform Application and designate an individual as the TPA’s contact person for department communications.

Drafting note: The contact person requirement in subsection B and the related part of the notification requirement in subsection J are recommended options for those states with computer systems or licensing and filing procedures for which the designation of a “responsible person” is necessary.

C. If a TPA designates this state as its home state because neither its state of incorporation nor the state that is its principal place of business within the United States have adopted this Act or a substantially similar law governing TPAs, but if one or both of these other jurisdictions have licensed the TPA, then the commissioner may consult with that state or states and may give due consideration to any relevant findings made by that state or states in order to avoid an unnecessarily duplicative review of the application.

D. The Uniform Application shall include or be accompanied by the following information and documents:

(1) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable documents and all amendments to such documents;
(2) The bylaws, rules, regulations or similar documents regulating the internal affairs of the applicant;

(3) NAIC Biographical Affidavit for the individuals who are responsible for the conduct of affairs of the applicant; including all members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholders or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the applicant; and any other person who exercises control or influence over the affairs of the applicant;

(4) Audited annual financial statements or reports for the two (2) most recent fiscal years that prove that the applicant has a positive net worth. If the applicant has been in existence for less than two (2) fiscal years, the Uniform Application shall include financial statements or reports, certified by an officer of the applicant and prepared in accordance with GAAP, for any completed fiscal years, and for any month during the current fiscal year for which such financial statements or reports have been completed. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following: a) amounts shown on the consolidated audited financial report shall be shown on the worksheet; b) amounts for each entity shall be stated separately, and c) explanations of consolidating and eliminating entries shall be included. The applicant shall also include such other information as the commissioner may require to review the current financial condition of the applicant.

(5) A statement describing the business plan including information on staffing levels and activities proposed in this state and nationwide. The plan shall provide details setting forth the applicant’s capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping and underwriting; and

(6) Such other pertinent information as may be required by the commissioner.

E. A TPA licensed or applying for licensure under this section shall make available for inspection by the commissioner copies of all contracts with payors or other persons utilizing the services of the TPA.

F. A TPA licensed or applying for licensure under this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the commissioner.

G. The commissioner may refuse to issue a license if the commissioner determines that the TPA or any individual responsible for the conduct of affairs of the TPA is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or a TPA certificate of authority or license denied or revoked for cause by any jurisdiction, or if the commissioner determines that any of the grounds set forth in Section 15 of this Act exists with respect to the TPA.

H. A license issued under this section shall remain valid, unless surrendered, suspended or revoked by the commissioner, for so long as the TPA continues in business in this state and remains in compliance with this Act.

I. An individual may not qualify for licensure under this section, except that an individual previously licensed as a TPA with this state as its home state shall retain that license, unless surrendered, suspended or revoked by the commissioner, for so long as the TPA continues in business in this state and remains in substantial compliance with this Act.

Drafting Note: The “grandfather” provision in Subsection I addresses situations where states amending their TPA Act may already have individuals licensed under their current TPA law. The old TPA model allowed (and ostensibly required) individuals fulfilling TPA functions to be licensed as TPAs. It was never the intent of the previous drafting to require that every individual employed by a TPA to be individually licensed, although it arguably may have been intended that an
individual could form a TPA without incorporating and get a license for that operation. This subsection can be removed in states that have an existing TPA law, but where all current licensees qualify as “business entities.” States that are newly adopting a TPA law can also delete this subsection, as no entity could have previously held a license as a TPA.

J. A TPA licensed or applying for licensure under this section shall notify the commissioner within thirty days of any material change in its ownership, control, contact person for the TPA or other fact or circumstance affecting its qualification for a license in this state. The commissioner shall report any such changes to (insert name of the appropriate electronic database).

K. A TPA licensed or applying for a license under this section that administers or will administer governmental or church self-insured plans in this state or any other state shall maintain a surety bond for the use and benefit of the commissioner and the insurance regulatory authority of any additional state in which the TPA is authorized to conduct business and cover individuals and persons who have remitted premiums or insurance charges or other monies to the TPA in the course of the TPA’s business in the greater of the following amounts:

(1) $100,000; or

(2) Ten percent (10%) of the aggregate total amount of self-funded coverage under church plans or governmental plans handled in this state and all additional states in which the TPA is authorized to conduct business.

Section 14. Registration Requirement

A person who is not required to be licensed as a TPA under this Act and who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, only in connection with life, annuity or health coverage provided by a self-funded plan other than a governmental or church plan, shall register with the commissioner annually, verifying its status as herein described. This section shall not apply to an insurer or to an individual performing these actions as an employee of an insurer. This section shall also not apply to a person performing these actions under contract to or as an employee of a TPA.

Section 15. Nonresident TPA License

A. Unless a TPA has obtained a license in this state under Section 13, any TPA who performs TPA duties in this state shall obtain a nonresident TPA license in accordance with this section by filing with the commissioner the Uniform Application, accompanied by a letter of certification. In lieu of requiring a TPA to file a letter of certification with the Uniform Application, the commissioner may verify the nonresident TPA’s home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

B. A TPA shall not be eligible for a nonresident TPA license under this section if it does not hold a home state certificate of authority or license in a state that has adopted this Act or that applies substantially similar provisions as are contained in this Act to that TPA. If the Act in the TPA’s home state does not extend to stop-loss and workers’ compensation insurance, but if the home state otherwise applies substantially similar provisions as are contained in this Act to that TPA, then that omission shall not operate to disqualify the TPA from receiving a Nonresident TPA license in this state.

C. Except as provided in Subsection B of this section and in section 17, the commissioner shall issue a nonresident TPA license to the TPA promptly upon receipt of a complete application.

D. Unless notified by the commissioner that the commissioner is able to verify the nonresident TPA’s home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, each nonresident TPA shall annually file a statement that its home state TPA certificate of authority or license remains in force and has not been revoked or suspended by its home state during the preceding year.
E. At the time of filing the statement required under Subsection D of this section or, if the commissioner has notified the nonresident TPA that the commissioner is able to verify the nonresident TPA’s home state certificate of authority or license status through an electronic database, on an annual date determined by the commissioner, the nonresident TPA shall pay a filing fee as required by the commissioner.

Drafting Note: The filing of the statement or time set for payment of the fee should be after September 1 so that it follows the nonresident TPA’s annual renewal of its home state certificate of authority or license.

F. A TPA licensed or applying for licensure under this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the commissioner.

G. A nonresident TPA licensed in its home state is not required to hold a nonresident TPA license in this state if the TPA’s duties in this state are limited to the administration of group policies or plans of insurance and no more than one hundred (100) certificate holders for all such plans reside in this state.

H. A nonresident TPA licensed in its home state is not required to hold a nonresident TPA license in this state if the TPA’s duties in this state are limited to the administration of workers’ compensation claims and the TPA administers less than twenty-five workers’ compensation claims per calendar year in this state. This exemption shall continue to apply to a nonresident TPA exempted by this subsection until ninety days after the date that it has had twenty-five claims reported to it during a calendar year by employees whose claimed injury or disease arose from employment in this state. A TPA with a current nonresident TPA license shall be eligible for this exemption at its next renewal date following a calendar year in which it has had less than twenty-five claims reported to it during that calendar year by employees whose claimed injury or disease arose from employment in this state. The exemption described in this subsection shall not apply, however, to a TPA with a client that is an employer principally based in this state, or that has a professional employer organization as a client that is responsible for the workers’ compensation obligations of a client that is principally located in this state.

Section 16. Annual Report and Filing Fee

A. Each TPA licensed under Section 13 shall file an annual report for the preceding calendar year with the commissioner on or before July 1 of each year, or within such extension of time as the commissioner for good cause may grant. The annual report shall include an audited financial statement performed by an independent certified public accountant. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following: a) amounts shown on the consolidated audited financial report shall be shown on the worksheet; b) amounts for each entity shall be stated separately, and c) explanations of consolidating and eliminating entries shall be included. The report shall be in the form and contain such matters as the commissioner prescribes and shall be verified by at least two (2) officers of the TPA.

B. The annual report shall include the complete names and addresses of all payors with which the TPA had agreements during the preceding fiscal year.

C. At the time of filing its annual report, the TPA shall pay a filing fee as required by the commissioner.

D. The commissioner shall review the most recently filed annual report of each TPA on or before September 1 of each year. Upon completion of its review, the commissioner shall either:

1. Issue a certification to the TPA that the annual report shows that the TPA has a positive net worth as evidenced by audited financial statements and is currently licensed and in good standing, or noting any deficiencies found in that annual report and financial statements; or

2. Update any electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicating that the annual report shows that the TPA has a positive net worth as evidenced by audited financial statements and complies with existing law, or noting any deficiencies found in the annual report.
Section 17. Grounds for Denial, Suspension or Revocation of Licensure

A. The commissioner shall, deny, suspend or revoke the license of a TPA, or shall issue a cease and desist order should the TPA not have a license if, after notice and opportunity for hearing, the commissioner finds that the TPA:

1. Is in an unsound financial condition;

2. Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this state hazardous or injurious to insured persons or the public; or

3. Has failed to pay any judgment rendered against it in this state within sixty (60) days after the judgment has become final.

B. The commissioner may deny, suspend or revoke the license of a TPA, or may issue a cease and desist order should the TPA not have a license if, after notice and opportunity for hearing, the commissioner finds that the TPA:

1. Has violated any lawful rule or order of the commissioner or any provision of the insurance laws of this state;

2. Has refused to be examined or to produce its accounts, records and files for examination, or if any individual responsible for the conduct of affairs of the TPA, including members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholder or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the TPA; and any other person who exercises control or influence over the affairs of the TPA; has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to an examination, when required by the commissioner;

3. Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused covered individuals to accept less than the amount due them or caused covered individuals to employ attorneys or bring suit against the TPA or a payor which it represents to secure full payment or settlement of such claims;

4. Is required pursuant to this Act to have a license and fails at any time to meet any qualification for which issuance of a license could have been refused had the failure then existed and been known to the commissioner, unless the commissioner issued a license with knowledge of the ground for disqualification and had the authority to waive it;

5. If any of the individuals responsible for the conduct of its affairs, including members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholder or member holding directly or indirectly ten percent (10%) or more of its voting stock, voting securities or voting interest; and any other person who exercises control or influence over its affairs; has been convicted of, or has entered a plea of guilty or nolo contendere to, a felony without regard to whether adjudication was withheld;

6. Is under suspension or revocation in another state; or

7. Has failed to file a timely annual report pursuant to Section 16, if a resident TPA, or a timely statement and filing fee, as applicable, pursuant to Sections 15D and E, if a nonresident TPA. This requirement does not apply to a TPA that is an insurer exempted pursuant to Section 2B.
C. (1) The commissioner, in his or her discretion, without advance notice, and before a hearing, may issue an order immediately suspending the license of a TPA, or may issue a cease and desist order should the TPA not have a license, if the commissioner finds that one or more of the following circumstances exist:

(a) The TPA is insolvent or impaired;

(b) A proceeding for receivership, conservatorship, rehabilitation or other delinquency proceeding regarding the TPA has been commenced in any state; or

(c) The financial condition or business practices of the TPA otherwise pose an imminent threat to the public health, safety or welfare of the residents of this state.

(2) At the time an order has been issued by the commissioner in accordance with Paragraph (1) of this subsection, the commissioner shall serve notice to the TPA that the TPA may request a hearing within ten business days after the receipt of the order. If a hearing is requested, the commissioner shall schedule a hearing within ten business days after receipt of the request. If a hearing is not requested and the commissioner orders none, the order shall remain in effect until modified or vacated by the commissioner.

D. If the commissioner finds that one or more grounds exist for the suspension or revocation of a license issued under this part, or for a cease and desist order, the commissioner may, in lieu of or in addition to the suspension, revocation or cease and desist order, impose a fine upon the TPA.

Drafting Note: States with disciplinary provisions of general applicability for regulated insurance entities may wish to incorporate such provisions by reference and should revise the provisions of this section to the extent inconsistent with the state’s general statutory scheme.

Section 18. Effective Date

Drafting Note: If a TPA act was already in effect, but is now being amended to include workers’ compensation and stop-loss insurance, it will be necessary to include a prospective effective date for this extension that does not affect the applicability of the Act to other types of coverage.
THIRD PARTY ADMINISTRATOR ACT
(NAIC Guideline Version 2)

Drafting Note: This “version 2” guideline excludes workers’ compensation, while the “version 1” guideline includes workers’ compensation. A state that intends to adopt a TPA law should start with the version that is appropriate for its needs.

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Section 1. Definitions

For purposes of this Act:

A. “Affiliate or affiliated” means a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another specified person.

B. “Business entity” means a corporation, association, partnership, limited liability company or other legal entity.

Drafting Note: Many laws use very broad definitions of “entity” that include individuals. Provisions of this Act referring to business entities are specifically intended to exclude individuals, as the full scope of TPA responsibilities and requirements are not well-suited to licensure of an individual. In addition, an overbroad definition of entity or “business entity” could result in individuals working for TPAs being required to be individually licensed as TPAs.

C. “Collateral” means funds, letters of credit or any item with economic value owned by the payor but held by an insurer or TPA in case it needs to be used to fulfill premium or loss reimbursement obligations in accordance with a contract between the insurer or TPA and the payor. “Collateral” shall include anticipated loss prepayments made prior to the payment of losses, pursuant to arrangements where reimbursement is not due until after losses have been paid.

D. “Commissioner” means the Commissioner of Insurance of this state.

E. “Control” (including the terms “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly,
owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by [insert appropriate reference to state law regulating holding companies] that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

F. “GAAP” means United States generally accepted accounting principles consistently applied.

G. “Home state” means the United States jurisdiction that has adopted this Act or a substantially similar law governing TPAs and that has granted the TPA a home state TPA license.

H. “Insurer” means an entity licensed in a United States jurisdiction to provide life, annuity, health or stop-loss coverage as an insurance company, health maintenance organization, fraternal benefit society or prepaid hospital or medical care plan.

**Drafting Note:** States that license multiple employer welfare arrangements (MEWAs) or that authorize employee leasing companies or professional employer organizations (PEOs) to provide employee welfare benefits on a self-funded basis, will want to include these entities in the list of entities that are included in the definition of insurer for purposes of this Act, but only to the extent of their license or authorization.

I. “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

**Drafting Note:** States that use different terminology such as “agent” and/or “broker” should make appropriate adjustments to this language. In states that do not license business entities as insurance producers, use the following definition:

II. “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, and also includes a business entity whose primary activities are the sales, solicitation and negotiation of insurance.

J. “Nonresident TPA” means a TPA whose home state is any jurisdiction other than this state.

K. “Payor” means an insurer or an employer administering its employee benefit plan or the employee benefit plan of an affiliated employer under common management and control.

L. “Person” means an individual or a business entity.

M. “Stop-loss insurance” means insurance protecting an employer or other person responsible for an otherwise self-insured health or life benefit plan against obligations under the plan, but “stop-loss insurance” does not include reinsurance written for an insurance company.

**Drafting note:** The inclusion of the stop-loss definition and the inclusion of stop-loss throughout this law are not necessary in states where stop-loss is clearly stipulated to be health insurance and cannot be interpreted to be liability insurance or some other form of insurance. In such states, references to stop-loss may be deleted or – if retained – viewed as a clarification (as stop-loss is considered to be liability insurance in some states).

N. “Third party administrator” or “TPA” means a person who directly or indirectly underwrites, collects charges, collateral or premiums from, or adjusts or settles claims on residents of this state, in connection with life, annuity, health or stop-loss coverage, except that a person shall not be considered a TPA if that person’s only actions that would otherwise cause it to be considered a TPA are among the following:

1. A person working for a TPA to the extent that the person’s activities are subject to the supervision and control of the TPA;

2. An employer administering its employee benefit plan or the employee benefit plan of an affiliated employer under common management and control;

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(3) The administration of a bona fide employee benefit plan established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974, as the act existed on [an appropriate recent date should be selected];

(4) A union administering a benefit plan on behalf of its members;

(5) An insurer administering insurance coverage for its policyholders, subscribers or certificate holders, or those of an affiliated insurer under common management and control;

(6) An insurer directly or indirectly underwriting, collecting charges, collateral or premiums from, or adjusting or settling claims on behalf of a client that is not a policyholder, subscriber or certificate holder, and that has its United States headquarters or principal location of business in a jurisdiction in which the insurer is licensed to write that coverage;

(7) An insurer directly or indirectly underwriting, collecting charges, collateral or premiums, or adjusting or settling claims, provided that the insurer is licensed in this state to write that line of insurance coverage;

(8) An insurance producer selling insurance or engaged in related activities within the scope of the producer’s license;

(9) A creditor acting on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(10) A trust and its trustees and agents acting pursuant to such trust established in conformity with 29 U.S.C. Section 186;

(11) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code and its trustees acting pursuant to such trust, or a custodian and the custodian’s agents acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;

(12) A credit union or a financial institution that is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, when collecting or remitting premiums to licensed insurance producers or to limited lines producers or authorized payors in connection with loan payments;

(13) A credit card issuing company advancing or collecting insurance premiums or charges from its credit card holders who have authorized collection;

(14) An individual adjusting or settling claims in the normal course of that individual’s practice or employment as an attorney at law and who does not collect charges or premiums in connection with insurance coverage;

(15) A person licensed as a managing general agent in this state when acting within the scope of that license; or

(16) A business entity that is affiliated with a licensed insurer while acting as a TPA for the direct and assumed insurance business of an affiliated insurer;

O. “Underwrites” or “underwriting” means, but is not limited to, the acceptance of employer or individual applications for coverage of individuals and the overall planning and coordination of a benefits program.

P. “Uniform Application” means the current version of the NAIC Uniform Application for Third Party Administrators.
Section 2. Licensing Necessary

No person shall act as a TPA in this state unless that person is licensed as a TPA pursuant to this Act or unless the TPA is exempted from this Act’s licensing requirement pursuant to subsection G of section 13 of this Act. This prohibition shall not apply to a person while employed by, or when operating under contract to, a TPA that is licensed pursuant to this Act, or exempted from this Act’s licensing requirements pursuant to subsection G of section 13 of this Act.

Section 3. Payment to a TPA

If an insurer utilizes the services of a TPA, any premiums or charges for insurance paid to the TPA by or on behalf of the insured party, or any collateral furnished to the TPA by or on behalf of the insured party, shall be deemed to have been received by the insurer, and the return of collateral or the payment of return premiums or claim payments forwarded by the insurer to the TPA shall not be deemed to have been paid to the insured party or claimant until the payments are received by the insured party or claimant. Nothing in this section limits any right of the insurer against the TPA resulting from the failure of the TPA to make payments to the insurer, insured parties or claimants.

Section 4. Maintenance of Information

A. A TPA shall maintain and make available to the payor complete books and records of all transactions performed on behalf of the payor. The books and records shall be maintained in accordance with prudent standards of insurance record keeping and shall be maintained for a period of not less than five (5) years from the date of their creation.

B. The commissioner shall have access to books and records maintained by a TPA for the purposes of examination, audit and inspection. Any documents, materials or other information in the possession or control of the commissioner that are furnished by a TPA, payor, insurance producer or an employee or agent thereof acting on behalf of the TPA, payor or insurance producer, or obtained by the commissioner in an investigation shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be not subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use such documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner’s official duties.

C. Neither the commissioner nor any person who receives documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning confidential documents, materials, or information subject to Subsection B of this section.

F. In order to assist in the performance of his or her duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection B of this section, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or 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) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or 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) [OPTIONAL] May enter into agreements governing sharing and use of information consistent with this subsection.
Drafting Note: The language in Subsection D(1) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

G. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection D of this section.

F. Nothing in this Act shall prohibit the commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to [insert appropriate reference to state law] to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

G. Notwithstanding any contractual agreements between the payor and the TPA that operate to the contrary, the TPA shall retain the right to sufficient continuing access to books and records to permit the TPA to fulfill all of its contractual obligations to insured parties, claimants, and the payor.

H. In the event the payor or the TPA cancel their agreement; notwithstanding the provisions of Subsection A of this section, the TPA may, by written agreement with the payor, transfer all records to a new TPA rather than retain them for five (5) years. In such cases, the new TPA shall acknowledge, in writing, that it is responsible for retaining the records of the prior TPA as required in Subsection A of this section.

Section 5. Approval of Advertising

A TPA that advertises on behalf of its client may only use advertising that has been approved in writing by the client in advance of its use. A TPA that mentions any current or former client in its advertising must obtain the client’s prior written consent.

Section 6. Responsibilities of the Payor and TPA

A. No TPA shall act as such without a written agreement between the TPA and the payor. A copy of the agreement shall be retained by the TPA for the duration of the agreement and for five (5) years thereafter. The agreement shall contain all provisions required by this section, except insofar as the TPA does not perform all of the functions referenced in this section.

B. A payor that utilizes the services of a TPA shall retain responsibility for the benefits, premium rates, collateral and reimbursement procedures, underwriting criteria and claims payment procedures applicable to the coverage and for securing reinsurance or stop-loss insurance, if any. The rules pertaining to these matters, to the extent that they are relevant to the duties of the TPA, shall be agreed to in writing by the payor and the TPA.

C. An insurer utilizing the services of a TPA is responsible for the acts of the TPA and is responsible for providing the TPA’s books and records relevant to the insurer to the commissioner upon request.

D. The written agreement between the TPA and the payor shall provide that communications between the TPA and claimants shall avoid deceptive statements with regard to the responsibilities of the TPA, payor and any insurer with regard to claims or premiums.

E. In the event of a dispute between the payor and the TPA regarding which of them is to fulfill a lawful obligation with respect to a policy, certificate or claim subject to the written agreement, the payor shall fulfill such obligation.

F. The payor has the duty to provide for competent administration of its programs administered by a TPA and within the scope of this Act.

G. When a TPA administers benefits in connection with life, annuity, health and employee benefit stop-loss coverage for more than one hundred (100) certificate holders, subscribers, claimants or policyholders on
behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the TPA. At least one such review shall include an on-site audit of the operations of the TPA. The cost of such reviews or audits shall be borne by the insurer and not reimbursed by the TPA. The requirements of this subsection shall not apply when the TPA and the insurer are affiliated.

Section 7. Premium Collection and Payment of Claims

A. All insurance charges, premiums, collateral and loss reimbursements collected by a TPA on behalf of or for a payor, the return of premiums or collateral received from a payor, and any funds held by the TPA for the payment of claims, shall be held by the TPA in a fiduciary capacity. Funds shall be immediately remitted to the person entitled to them or shall be deposited promptly in a fiduciary account established and maintained by the TPA in a federally insured financial institution. The TPA shall render a periodic accounting to the payor detailing all transactions performed by the TPA pertaining to the business of the payor, and the written agreement between the payor and the TPA shall include the specifications of this reporting.

B. The TPA shall keep copies of all records of any fiduciary account maintained or controlled by the TPA, and, upon request of a payor, shall furnish the payor with copies of the records pertaining to the deposits and withdrawals made on behalf of the payor. If funds deposited in a fiduciary account have been collected on behalf of or for more than one payor, or for the payment of claims associated with more than one policy, the TPA shall keep records clearly recording the deposits in and withdrawals from the account on behalf of each payor and relating to each policyholder.

C. The TPA shall not pay any claim by withdrawals from a fiduciary account in which premiums or charges are deposited. Withdrawals from a fiduciary account shall be made as provided in the written agreement between the TPA and the payor, and only for the following purposes:

1. Remittance to a payor entitled to remittance;
2. Deposit in an account maintained in the name of the payor;
3. Transfer to and deposit in a claims-paying account, with claims to be paid as provided in Subsection D of this section;
4. Payment to a group policyholder for remittance to the payor entitled to such remittance;
5. Payment to the TPA of its earned commissions, fees or charges;
6. Remittance of return premium to the person or persons entitled to such return premium; and
7. Payment to other service providers as authorized by the payor.

D. All claims paid by the TPA from funds collected on behalf of or for a payor shall be paid only as authorized by the payor. Payments from an account maintained or controlled by the TPA for purposes including the payment of claims may be made only for the following purposes:

1. Payment of valid claims;
2. Payment of expenses associated with claims handling to the TPA or to other service providers approved by the payor;
3. Remittance to the payor, or transfer to a successor TPA as directed by the payor, for the purpose of paying claims and associated expenses; and
4. Return of funds held as collateral or prepayment, to the person entitled to those funds, upon a determination by the payor that those funds are no longer necessary to secure or facilitate the payment of claims and associated expenses.
Section 8. Compensation to the TPA

A. A TPA shall not enter into an agreement or understanding with a payor in which the effect is to make the amount of the TPA’s commissions, fees, or charges contingent upon savings effected in the payment of losses covered by the payor’s obligations. This provision shall not prohibit a TPA from receiving performance-based compensation for providing hospital or other auditing services, from providing managed care or related services, or from being compensated for subrogation expenses.

B. A payor shall not enter into an agreement with a TPA in violation of this section.

C. This section shall not prevent the compensation of a TPA from being based on premiums or charges collected or the number of claims paid or processed.

Section 9. Disclosure of Charges and Fees

A. When a TPA collects funds, the reason for collection of each item shall be identified to the insured party and each item shall be shown separately from any premium. Additional charges may not be made for services to the extent the services have been already paid for by the payor.

B. The TPA shall disclose to the payor all charges, fees and commissions that the TPA receives arising from services it provides for the payor, including any fees or commissions paid by payors providing reinsurance or stop-loss insurance.

Section 10. Delivery of Materials to Covered Individuals

Any policies, certificates, booklets, termination notices or other written communications delivered by the payor to the TPA for delivery to insured parties or covered individuals shall be delivered by the TPA promptly after receipt of instructions from the payor to deliver them.

Section 11. Home State TPA License

A. If a TPA is incorporated in this state or this state is its principal place of business within the United States, then the TPA may designate this state as its home state and apply to this state for licensure as a TPA. If neither the state in which a TPA is incorporated nor the state that is its principal place of business have adopted this Act or a substantially similar law governing TPAs, and if the TPA has not designated any other state that has adopted this Act or a substantially similar law governing TPAs as its home state, then the TPA may apply for licensure to this state as its home state.

B. A TPA applying to this state as its home state shall apply for licensure using the Uniform Application and designate an individual as the TPA’s contact person for department communications.

Drafting note: The contact person requirement in subsection B and the related part of the notification requirement in subsection J are recommended options for those states with computer systems or licensing and filing procedures for which the designation of a “responsible person” is necessary.

C. If a TPA designates this state as its home state because neither its state of incorporation nor the state that is its principal place of business within the United States have adopted this Act or a substantially similar law governing TPAs, but if one or both of these other jurisdictions have licensed the TPA, then the commissioner may consult with that state or states and may give due consideration to any relevant findings made by that state or states in order to avoid an unnecessarily duplicative review of the application.

D. The Uniform Application shall include or be accompanied by the following information and documents:

(2) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable documents and all amendments to such documents;
(2) The bylaws, rules, regulations or similar documents regulating the internal affairs of the applicant;

(3) NAIC Biographical Affidavit for the individuals who are responsible for the conduct of affairs of the applicant; including all members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholders or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the applicant; and any other person who exercises control or influence over the affairs of the applicant;

(4) Audited annual financial statements or reports for the two (2) most recent fiscal years that prove that the applicant has a positive net worth. If the applicant has been in existence for less than two (2) fiscal years, the Uniform Application shall include financial statements or reports, certified by an officer of the applicant and prepared in accordance with GAAP, for any completed fiscal years, and for any month during the current fiscal year for which such financial statements or reports have been completed. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following: a) amounts shown on the consolidated audited financial report shall be shown on the worksheet; b) amounts for each entity shall be stated separately, and c) explanations of consolidating and eliminating entries shall be included. The applicant shall also include such other information as the commissioner may require to review the current financial condition of the applicant.

(5) A statement describing the business plan including information on staffing levels and activities proposed in this state and nationwide. The plan shall provide details setting forth the applicant’s capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping and underwriting; and

(6) Such other pertinent information as may be required by the commissioner.

E. A TPA licensed or applying for licensure under this section shall make available for inspection by the commissioner copies of all contracts with payors or other persons utilizing the services of the TPA.

F. A TPA licensed or applying for licensure under this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the commissioner.

G. The commissioner may refuse to issue a license if the commissioner determines that the TPA or any individual responsible for the conduct of affairs of the TPA is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or a TPA certificate of authority or license denied or revoked for cause by any jurisdiction, or if the commissioner determines that any of the grounds set forth in Section 15 of this Act exists with respect to the TPA.

H. A license issued under this section shall remain valid, unless surrendered, suspended or revoked by the commissioner, for so long as the TPA continues in business in this state and remains in compliance with this Act.

I. An individual may not qualify for licensure under this section, except that an individual previously licensed as a TPA with this state as its home state shall retain that license, unless surrendered, suspended or revoked by the commissioner, for so long as the TPA continues in business in this state and remains in substantial compliance with this Act.

Drafting Note: The “grandfather” provision in Subsection I addresses situations where states amending their TPA Act may already have individuals licensed under their current TPA law. The old TPA model allowed (and ostensibly required) individuals fulfilling TPA functions to be licensed as TPAs. It was never the intent of the previous drafting to require that every individual employed by a TPA to be individually licensed, although it arguably may have been intended that an individual could form a TPA without incorporating and get a license for that operation. This subsection can be removed in

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states that have an existing TPA law, but where all current licensees qualify as “business entities.” States that are newly adopting a TPA law can also delete this subsection, as no entity could have previously held a license as a TPA.

J. A TPA licensed or applying for licensure under this section shall notify the commissioner within thirty days of any material change in its ownership, control, contact person for the TPA or other fact or circumstance affecting its qualification for a license in this state. The commissioner shall report any such changes to (insert name of the appropriate electronic database).

K. A TPA licensed or applying for a license under this section that administers or will administer governmental or church self-insured plans in this state or any other state shall maintain a surety bond for the use and benefit of the commissioner and the insurance regulatory authority of any additional state in which the TPA is authorized to conduct business and cover individuals and persons who have remitted premiums or insurance charges or other monies to the TPA in the course of the TPA’s business in the greater of the following amounts:

1. $100,000; or
2. Ten percent (10%) of the aggregate total amount of self-funded coverage under church plans or governmental plans handled in this state and all additional states in which the TPA is authorized to conduct business.

Section 12. Registration Requirement

A person who is not required to be licensed as a TPA under this Act and who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, only in connection with life, annuity or health coverage provided by a self-funded plan other than a governmental or church plan, shall register with the commissioner annually, verifying its status as herein described. This section shall not apply to an insurer or to an individual performing these actions as an employee of an insurer. This section shall also not apply to a person performing these actions under contract to or as an employee of a TPA.

Section 13. Nonresident TPA License

A. Unless a TPA has obtained a license in this state under Section 11, any TPA who performs TPA duties in this state shall obtain a nonresident TPA license in accordance with this section by filing with the commissioner the Uniform Application, accompanied by a letter of certification. In lieu of requiring a TPA to file a letter of certification with the Uniform Application, the commissioner may verify the nonresident TPA’s home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

B. A TPA shall not be eligible for a nonresident TPA license under this section if it does not hold a home state certificate of authority or license in a state that has adopted this Act or that applies substantially similar provisions as are contained in this Act to that TPA. If the Act in the TPA’s home state does not extend to stop-loss insurance, but if the home state otherwise applies substantially similar provisions as are contained in this Act to that TPA, then that omission shall not operate to disqualify the TPA from receiving a nonresident TPA license in this state.

C. Except as provided in Subsection B of this section and in section 15, the commissioner shall issue a nonresident TPA license to the TPA promptly upon receipt of a complete application.

D. Unless notified by the commissioner that the commissioner is able to verify the nonresident TPA’s home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, each nonresident TPA shall annually file a statement that its home state TPA certificate of authority or license remains in force and has not been revoked or suspended by its home state during the preceding year.

E. At the time of filing the statement required under Subsection D of this section or, if the commissioner has notified the nonresident TPA that the commissioner is able to verify the nonresident TPA’s home state
A TPA licensed or applying for licensure under this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the commissioner.

A nonresident TPA licensed in its home state is not required to hold a nonresident TPA license in this state if the TPA’s duties in this state are limited to the administration of group policies or plans of insurance and no more than one hundred (100) certificate holders for all such plans reside in this state.

Section 14. Annual Report and Filing Fee

A. Each TPA licensed under Section 11 shall file an annual report for the preceding calendar year with the commissioner on or before July 1 of each year, or within such extension of time as the commissioner for good cause may grant. The annual report shall include an audited financial statement performed by an independent certified public accountant. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following: (a) amounts shown on the consolidated audited financial report shall be shown on the worksheet; (b) amounts for each entity shall be stated separately, and (c) explanations of consolidating and eliminating entries shall be included. The report shall be in the form and contain such matters as the commissioner prescribes and shall be verified by at least two (2) officers of the TPA.

B. The annual report shall include the complete names and addresses of all payors with which the TPA had agreements during the preceding fiscal year.

C. At the time of filing its annual report, the TPA shall pay a filing fee as required by the commissioner.

D. The commissioner shall review the most recently filed annual report of each TPA on or before September 1 of each year. Upon completion of its review, the commissioner shall either:

1. Issue a certification to the TPA that the annual report shows that the TPA has a positive net worth as evidenced by audited financial statements and is currently licensed and in good standing, or noting any deficiencies found in that annual report and financial statements; or

2. Update any electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicating that the annual report shows that the TPA has a positive net worth as evidenced by audited financial statements and complies with existing law, or noting any deficiencies found in the annual report.

Section 15. Grounds for Denial, Suspension or Revocation of Licensure

A. The commissioner shall, deny, suspend or revoke the license of a TPA, or shall issue a cease and desist order should the TPA not have a license if, after notice and opportunity for hearing, the commissioner finds that the TPA:

1. Is in an unsound financial condition;

2. Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this state hazardous or injurious to insured persons or the public; or

3. Has failed to pay any judgment rendered against it in this state within sixty (60) days after the judgment has become final.
B. The commissioner may deny, suspend or revoke the license of a TPA, or may issue a cease and desist order should the TPA not have a license if, after notice and opportunity for hearing, the commissioner finds that the TPA:

1. Has violated any lawful rule or order of the commissioner or any provision of the insurance laws of this state;

2. Has refused to be examined or to produce its accounts, records and files for examination, or if any individual responsible for the conduct of affairs of the TPA, including members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholder or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the TPA; and any other person who exercises control or influence over the affairs of the TPA; has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to an examination, when required by the commissioner;

3. Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused covered individuals to accept less than the amount due them or caused covered individuals to employ attorneys or bring suit against the TPA or a payor which it represents to secure full payment or settlement of such claims;

4. Is required pursuant to this Act to have a license and fails at any time to meet any qualification for which issuance of a license could have been refused had the failure then existed and been known to the commissioner, unless the commissioner issued a license with knowledge of the ground for disqualification and had the authority to waive it;

5. If any of the individuals responsible for the conduct of its affairs, including members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholder or member holding directly or indirectly ten percent (10%) or more of its voting stock, voting securities or voting interest; and any other person who exercises control or influence over its affairs; has been convicted of, or has entered a plea of guilty or nolo contendere to, a felony without regard to whether adjudication was withheld;

6. Is under suspension or revocation in another state; or

7. Has failed to file a timely annual report pursuant to Section 14, if a resident TPA, or a timely statement and filing fee, as applicable, pursuant to Sections 13D and E, if a nonresident TPA.

C. The commissioner, in his or her discretion, without advance notice, and before a hearing, may issue an order immediately suspending the license of a TPA, or may issue a cease and desist order should the TPA not have a license, if the commissioner finds that one or more of the following circumstances exist:

1. The TPA is insolvent or impaired;

2. A proceeding for receivership, conservatorship, rehabilitation or other delinquency proceeding regarding the TPA has been commenced in any state; or

3. The financial condition or business practices of the TPA otherwise pose an imminent threat to the public health, safety or welfare of the residents of this state.

At the time an order has been issued by the commissioner in accordance with Paragraph (1) of this subsection, the commissioner shall serve notice to the TPA that the TPA may request a hearing within ten business days after the receipt of the order. If a hearing is requested, the commissioner
shall schedule a hearing within ten business days after receipt of the request. If a hearing is not requested and the commissioner orders none, the order shall remain in effect until modified or vacated by the commissioner.

D. If the commissioner finds that one or more grounds exist for the suspension or revocation of a license issued under this part, or for a cease and desist order, the commissioner may, in lieu of or in addition to the suspension, revocation or cease and desist order, impose a fine upon the TPA.

**Drafting Note:** States with disciplinary provisions of general applicability for regulated insurance entities may wish to incorporate such provisions by reference and should revise the provisions of this section to the extent inconsistent with the state’s general statutory scheme.

**Section 16. Effective Date**

**Drafting Note:** If a TPA act was already in effect, but is now being amended to include stop-loss insurance, it will be necessary to include a prospective effective date for this extension that does not affect the applicability of the Act to other types of coverage.
Title Agent Statistical Data Plan Implementation Guideline

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Part F. Suggested Statute Language
Part G. Suggested Regulation on Reporting Requirements

Part A. Introduction

The purpose of the Title Agent Statistical Data Plan (the “stat plan”) is to give information that is more useful to state regulators about the business of title insurance at the agency level. In the 2007 United States Government Accountability Office (GAO) Report on Title Insurance, Actions Needed to Improve Oversight of the Title Industry and Better Protect Consumers (GAO-07-401), it was noted that “large insurers [tend] to use local or regional title agents to conduct their business.” Additionally, the GAO stated “potentially understanding the relationship between costs and the amounts consumers pay could help regulators improve their ability to protect consumers.” Finally, the report recommended that:

state regulators take action to (1) improve consumers’ ability to shop for title insurance and (2) improve their oversight of title agents. As part of this process, we are recommending that these regulators consider evaluating the competitive benefits of publicizing complete title insurance cost information... including the collection of data on title agents’ operations...

While annual financial reporting by insurers (also called underwriters) captures the overall picture of premiums and losses, there are many factors of the business which are only experienced by the ground-level title agent, including actual operating costs and losses not typically paid by an underwriter. This lack of information about the role of agencies in providing title insurance products and related services makes the business of title insurance particularly susceptible to question about the amount of premium retained by agencies, profitability of the industry, and the value of title insurance in general.

Although the stat plan attempts to capture comprehensive information on the title agency experience, the plan in its current form does not capture all information regarding the daily experience of title agencies. In the course of searching and examining land records, title agencies fulfill their main role in the title insurance process of identifying actual and/or potential clouds or defects on the title that may lead to future losses. Agents may work to correct or eliminate the title defects that can be fixed, and inform the insured of which ones cannot be cured by the agent and will be listed as exceptions in the policy. Title agents may also cure defects at the direction of the buyer, the lending institution, or the title insurer. Depending on the state, this function may be performed by an escrow agent, a title agent, or another third party. Sometimes, an entity will spend numerous hours evaluating and eliminating risk before the premium is even paid. This statistical plan does not differentiate between the resources spent to correct or eliminate title defects and the resources spent to identify title defects and to perform other policy acquisition activities. This is one of the fundamental differences between title insurance and casualty insurance. While technology helps to some extent, automated land records do not eliminate the cost of searching for and addressing defects in title. In most jurisdictions, automated land records are no more than automated indices and images of documents.
Although these systems can reduce the time and effort necessary to search land records, the actual process is unchanged, and title insurance producers or abstractors still must search all records, find those related to a property, and manually examine each document. While some software systems collect and store information, they can be prohibitively expensive for many agencies. In an effort to keep the burden of completing the stat plan as low as possible, information on specific defects found and/or fixed in each search is not collected at this time. Therefore, the stat plan should not be viewed as a fully accurate picture of the profitability of title insurance agencies, but rather as a tool to better understand the economics of the industry.

**Part B. Mechanism for Reporting and Collection of Data/Implementation**

Although the actual data points collected in the stat plan are points that should be readily available to reporting entities, it is important to note that most have not been previously required to collect and report this data in the current form. Title insurance agencies will need time to develop and put in place systems for collecting and organizing the data, which may involve purchasing new or updating existing software systems, developing tracking mechanisms, and other administrative tasks involved with the collection of requested data.

Therefore, it is suggested that state regulatory agencies provide as much notice as possible prior to the actual expected dates for collecting required data for reporting in the following year. A regulator looking to implement the stat plan should provide sufficient notice prior to January 1 of the year that collection will begin, thereby ensuring enough time for agencies to adopt and adapt their systems before having to track and collect the data. After that, title agencies will track the data points through the year, and ongoing basis, enabling them to easily compile, prepare, and submit the data plan each year to their regulatory agency. The Task Force recommends a yearly reporting date of June 1 for the previous year’s data.

Prior to implementation, regulators should also examine the values, labels, and instructions in the stat plan and make any necessary modifications to conform the plan to local practices and customs. Although it is recommended that the plan remain substantially similar, it is recognized that not all terms and values in the plan will translate well from jurisdiction to jurisdiction.

If feasible, the regulator should establish a web-based reporting site for electronic collection of stat plan data, as well as to disseminate important information about the stat plan. A web-based reporting site should include anticipatory and experientially based FAQs. In the absence of a web-based reporting system, the regulator should develop a system for manually reporting data which can be used by all reporting entities, that prescribes a format and set parameters common to the industry and consistent with other data collection requirements.

The state’s data reporting and collection system should include controls that prevent the entry of data that are invalid or internally inconsistent. The system should be designed to meet the needs of various types of reporting entities, many of which have not been accustomed to reporting any kind of information to the commissioner.

The regulator should strive to be as clear as possible about the requirements of reporting, including by issuing FAQs and other formal guidance for reporting agents to rely upon when reporting data under the stat plan. To promote efficiency of reporting and quality of data, regulators should make the operation and format of the stat plan’s data reporting and collection system consistent with other uniform data collection conventions and those of other states. In order to facilitate uniformity among states, regulators are encouraged to share with other states any information available regarding the design and operation of each state’s system.

**Part C. Confidentiality of Data**

Due to the sensitive nature of individual agent data, including income, expense, and loss experience, it is strongly recommended that regulators keep individual responses on the stat plan confidential. While such data may already be protected as proprietary, financial, or other sensitive information, it is highly recommended that states determine whether they can hold the stat plan information confidential, and enact any statutory or regulatory amendments necessary to do so.
However, nothing herein should be construed as attempting to limit the sharing or publication of aggregate data, since such publication may in fact make important disclosures regarding the experience of title agents in a particular geographic area or business demographic (i.e. by county, state, or by agency type). Additionally, the sharing of data among regulators should be exempted from any confidential protections given to collected data.

**Part D. Uses of Data**

Because the data collected as part of the stat plan does not fully capture the agent experience as it pertains to items caught and corrected prior to issuance of policy, caution should be taken if regulators intend on using the stat plan to set rates or analyze entities’ justifications of rates and fees. Although rate and fee setting is a conceivable use of the data collected, regulators need to be aware of the shortcomings of the plan, and willing to accept data and justifications provided beyond the scope of the stat plan.

Other uses of the data collected include:

- Fulfilling GAO recommendations of increased title agent data collection
- Comparison of relationship of costs to title agents and prices consumers pay
- Quantitative analysis of differences between title insurance and other lines of insurance (particularly in operating costs vs. loss costs)
- Comparison of FTEs in agencies vs. total licensees in a jurisdiction
- Agent premium experience
- Market share analysis
- Marketing expense ratios (compared to market share)
- Premium vs. agency claims loss experience
- Agent experience by locality (county, city, etc.)
- Develop Market Conduct Base Line Market Analyses

**Part E. Insurance Department Outreach Efforts**

Under the stat plan, regulators are responsible for collecting data from entities not traditionally required to provide annual data statistics to insurance departments. To ensure efficient implementation and timely compliance with annual reporting requirements, regulators should engage in outreach and training initiatives. Some of the groups to contact during outreach efforts include:

**Industry Associations**

- State land title associations
- National land title associations
- National Title Insurance Computer System Providers
- Title Insurance Data Collection and Consulting firms

**Other Organizations**

- Title insurance underwriters’ state offices
- Other state departments of insurance
- National Association of Insurance Commissioners

The organizations listed above can help regulators make reporting entities aware of the state’s annual title agency statistical reporting requirements. Training programs conducted by regulators and accessibility to members of these organizations will improve the timeliness and quality of data submitted by reporting entities.
Part F. Suggested Statute Language

Title Agent Statistical Data Plan. (1) Every title agency doing business in this state, on or before the last day of May in each year, shall submit to the commissioner a report, signed and certified by an owner, officer, partner, or director of the agency, of the specific information listed in the NAIC Title Insurance Agent Statistical Data Plan.

(2) Information relating to the individual agencies filed with the commissioner under subsection (1) shall be kept confidential and not subject to public disclosure. However, nothing in this subsection (2) shall prohibit the commissioner from publishing data collected in an aggregate form, so as not to identify individual agencies’ data, or from sharing particular agency data with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the information.

(3) The commissioner may establish rules, including rules providing statistical plans, for use by all title insurers and title insurance agents in the collection and reporting of demographic, revenue, expense and loss experience data in such form and detail as is necessary to aid him or her in the evaluation of the title insurance industry at the agency level.

Drafting note: States that require the data to be submitted electronically should establish a method of electronic signature verification that is acceptable to the commissioner.

Part G. Suggested Regulation on Reporting Requirements

Drafting note: This is not a model regulation, but a suggested regulation/best practice for any necessary rules that may need to be promulgated for the implementation of the stat plan. When drafting regulations, take into account local statutes, practices, and customs and modify this regulation accordingly.

Section 1. Statement of Purpose
Section 2. Statutory Authority
Section 3. Applicability and Scope
Section 4. Definitions
Section 5. Data Required
Section 6. Due dates/Time Periods for Collection
Section 7. Method of Submission
Section 8. Confidentiality
Section 9. Enforcement
Section 10. Severability
Section 11. Effective Date

Section 1. Statement of Purpose

This regulation is intended to provide standards and direction for the collection and reporting of title agent data in accordance with the NAIC’s Title Agent Statistical Data Plan. The regulation specifies the data required, due dates and time periods for collection and submission of data, methods of submission, and addresses the confidentiality of the data submitted.

Section 2. Statutory Authority

This regulation is issued based upon the authority granted the commissioner under (cite any enabling legislation and state law corresponding to market analysis, market regulation, and/or title insurance regulation).
Section 3. Applicability and Scope

Under this regulation, all operating title insurance agencies and underwriter direct operations are required to provide yearly report of their policy issuance, business income and expense, and loss experience (excluding losses forwarded to or paid by an underwriter). Agencies include independent title agencies, affiliated business arrangement (AfBA) title agencies, attorney firms/title agencies, and underwriter direct operations.

Drafting note: Types of entities may vary by state.

Section 4. Definitions

1. Affiliated Business Arrangement (AfBA) – an arrangement in which a settlement producer, such as a real estate broker, developer, mortgage loan originator, or bank, or any other individual or entity that is in a position, directly or indirectly, to refer settlement business to a title entity, also maintains a direct or beneficial ownership interest in that title entity.

2. Affiliated title agency - a title agency that is owned, either wholly or in part, by a title insurance company/underwriter, but does not operate as an underwriter direct agency.

3. Attorney firm/title agency - a title agency that is owned and operated by an attorney or law firm.

4. Independent title agency - a title agency that is not part of an ownership arrangement with a real estate settlement producer, or with a title insurance company/underwriter.

5. NAIC title agent statistical data plan - also known as the "stat plan", this is the data reporting plan developed by the National Association of Insurance Commissioners Title Agent Statistical Data Plan Working Group, incorporated by reference herein.

6. Reporting entity - any title agency that is required to submit the information required under the stat plan, including independent, AfBA, attorney, and underwriter direct agencies.

7. Reporting period - the calendar year immediately preceding the current stat plan due date.

8. Stat plan due date - the due date for reporting entities to submit data to the commissioner. The standard due date under the stat plan is May 30 of each year.

9. Underwriter direct agency - a title agency that is wholly owned and operated by a title insurance company/underwriter.

Drafting note: Individual states may have different definitions for some of the above items, or may have more or fewer definitions to include. In addition, definitions under Real Estate Settlement Procedures Act (RESPA) may vary from those listed above. States should update, add, or delete definitions, as well as add relevant statutory citations as necessary.

Section 5. Data Required

Incorporate reference to stat plan here, rather than including the actual plan (to accommodate for future amendments to plan)
Section 6. Due Dates/Time Periods for Collection

All reporting entities are required to submit the data referenced in Section 5 of this regulation on or before May 30 for the immediately preceding reporting period.

Section 7. Method of Submission

All reporting entities shall submit the data in a manner prescribed by the commissioner.

Drafting Note: States should develop a method for collecting data electronically, either through a database in which entities can log in to report or through a dedicated email address, as well as methods of communicating requirements and any changes to the industry. Such method should be noted in Section 7.

Section 8. Confidentiality and Sharing

Information filed with the commissioner relating to the experience of a particular agent shall be kept confidential unless the commissioner finds it in the public interest to disclose the information required of title insurers or title insurance agents under this section.

In order to assist in the performance of the commissioner’s duties under this chapter, the commissioner may share data and information submitted by title insurance entities, including agencies, insurer direct operations, and title agent attorney firms, pursuant to Title Agent Statistical Plan data calls and collections, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the information. Additionally, nothing contained herein shall prohibit the commissioner from sharing or publishing data in an aggregate form with the above parties or any other stakeholder.

Drafting Note: States should ensure that the language that they use does not, nor can be construed as attempting to, limit the sharing or publication of aggregated data, since such publication may in fact make important disclosures regarding the experience of title agents in a particular geographic area or business demographic (i.e. by county, state or by agency type.)

Furthermore, States should contemplate whether or not they intend to publish aggregated data and the extent to which they are prepared to be required to publish or just may publish, etc.

Section 9. Enforcement

The commissioner may require that the information provided under this section be verified by oath of the insurer’s or agent’s president or vice president or secretary, as applicable. The commissioner may further require that the information required under this section be subject to an audit conducted by the commissioner. The commissioner shall have the authority to establish a minimum threshold level at which an audit would be required.

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions available in the (insert state) statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in (cite appropriate state laws concerning failure to respond, unfair business practices, etc.) may be applied.
Section 10. Severability

If any of the provisions of this regulation shall be held invalid or unenforceable, this regulation shall be construed as if not containing such provisions and the validity, legality, and enforceability of the remaining provisions shall not be affected or impaired in any way.

Section 11. Effective Date

This regulation is effective on [insert date] and applies to all transactions entered into after the effective date.
Report of the
Market Regulation and Consumer Affairs (D) Committee

The Market Regulation and Consumer Affairs (D) Committee met via conference call Sept. 12, 2011. During this meeting, the Committee:

1. Adopted annuity suitability examination standard revisions to be included in Chapter 19 of the Market Regulation Handbook.

2. Adopted a new examination standard regarding retained asset accounts to be included in the Market Regulation Handbook.

3. Received an update on the Committee’s policy direction regarding interstate collaboration.

4. Discussed the Complaint Reconciliation Proposal.

5. Adopted its task force and working group reports: Antifraud (D) Task Force; Market Information Systems (D) Task Force; Consumer Connections (D) Working Group; Consumer Disclosures (D) Working Group; Market Conduct Examination Standards (D) Working Group; Social Media in Insurance (D) Working Group; Limited Medical Benefits Plan (D) Working Group; and Market Actions (D) Working Group.
Report of the
Financial Condition (E) Committee

The Financial Condition (E) Committee met March 28 and Sept. 19, 2011. During these meetings, the Committee adopted or received the reports of its task forces and working groups. Many of these groups are technical in nature and involve ongoing work necessary to maintain and keep current the NAIC solvency framework. The details of those activities have not been provided in this report; rather, the details of items that were of a non-routine and/or significant nature are included in this report.

During its March 28 meeting, the Committee:

1. Adopted the minutes from its meetings of Dec. 8, 2010; Feb. 14, 2011; Feb. 18, 2011; and March 8, 2011. Included in its March 8 conference call was the Committee’s adoption of a “Life-Risk Based Capital Risk Mitigation” proposal. The adopted proposal provides life insurers with credit in the C-1 risk component of the RBC formula for basic and intermediate hedges that reduce the economic credit risk associated with such assets. Also adopted on the March 8 conference call were referral letters to the Financial Analysis Handbook (E) Working Group, the Capital Adequacy (E) Task Force and the Life Actuarial (A) Task Force on various issues related to broadening products that are being included in separate accounts. Finally, also adopted on the March 8 conference call was a proposed modification to the charge of the Separate Accounts Risk (E) Working Group as follows:

   Study the need to modify existing or develop new regulatory guidance requiring the establishment of risk charges for the risk assumed by the general account in support of individual related to separate accounts where in recent years various products and contract benefits have increased the risk to the general account products guaranteed by the general account. At the conclusion of such study, provide a recommendation to the Financial Condition Committee, including a request for Model Law Development/Change if the recommendation is for the NAIC to devote its resources to such an effort.

2. Received a status report from the Rating Agency (E) Working Group regarding the efforts by each of its applicable technical groups to address the Working Group’s recommendations for reducing reliance on rating agencies.

3. Adopted a request for extension regarding the model law development on fraternal RBC. The request was drafted by the Capital Adequacy (E) Task Force and suggests that, instead of developing a new model law to give regulators authority on these types of entities, changes be made to the existing Risk-Based Capital for Insurers Model Act (#315).

4. Adopted a model law development request on life RBC. The request contemplates raising the trend test from 250% to 300% for consistency with the property/casualty and health trend test. The Committee also agreed to request an exception to the Executive (EX) Committee model law procedures to allow for this simple change to the NAIC model to be adopted by the entire NAIC membership at the Summer National Meeting.

5. Adopted a new charge to the Financial Examiners Handbook (E) Technical Group as follows:

   Review current guidance in the Financial Condition Examiners Handbook regarding a review of insurer compliance with federal AML requirements and recommend appropriate revisions addressing the findings of the 2010 Financial Sector Assessment Program and the Financial Crimes Enforcement Network’s recommendations.

6. Received a letter from the Statutory Accounting Principles (E) Working Group regarding the statutory hierarchy and approved distribution of the letter to the Valuation of Securities (E) Task Force.

7. Referred an issue regarding audit opinions to the NAIC/AICPA (E) Working Group as highlighted from the industry to the Accounting Practices and Procedures (E) Task Force.

8. Approved a letter for distribution to all commissioners, directors and superintendents regarding waivers related to the Supplemental Health Care Exhibit.
9. Adopted new charges for the Examination Oversight (E) Task Force, as requested by the Executive (EX) Committee, dealing with climate change.

During its Sept. 19 meeting, the Committee:

1. Adopted its June 9 conference call minutes. During that call, the Committee changed the name of the Risk Assessment Implementation (E) Subgroup to the Risk-Focused Surveillance (E) Working Group and moved it within the committee structure to report directly to the Committee. The Committee also referred the issue of prospective risks and reduction in financial statement verification to this Working Group.

2. Adopted the Model Guideline for Implementation of State Orderly Liquidation Authority. This model guideline was developed by the Receivership and Insolvency (E) Task Force following adoption of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010, as part of a comprehensive review of how the state-based receivership community would respond in the event of a federal determination of systemic risk involving an insurance company or affiliate of an insurance company. The model guideline’s statutory language is not an amendment to the NAIC receivership models, but is intended as a guideline for use by those states seeking to review their authority under existing state law for purposes of initiating rehabilitation or liquidation proceedings in accordance with the federal statute.

3. Received a referral from the Receivership and Insolvency (E) Task Force regarding model law or guideline development to address collection of undisputed reinsurance recoverable balances. The item was referred to the Reinsurance (E) Task Force for consideration.

4. Adopted revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) as adopted by the Reinsurance (E) Task Force during its Sept. 19 meeting and as amended during the Committee discussion. The revisions to these models are intended to implement key elements of the Reinsurance Regulatory Modernization Framework, which was adopted by the NAIC in December 2008. Additional revisions are included with respect to the trustee surplus requirement for a multiple beneficiary trust account maintained by an assuming insurer in run-off.


6. Adopted two revisions to the current Risk-Based Capital for Insurers Model Act (#312): 1) include fraternal benefit societies in the life section of the model; and 2) update the RBC level where the RBC trend test could be triggered from 2.5 to 3.0 x Authorized Control Level RBC. The change in trend test levels would apply to both life and fraternal RBC, but only the life RBC requirements will be recommended for inclusion in the NAIC Financial Regulation Standards and Accreditation Program. Changes to the life and fraternal RBC formulas would need to be drafted once the changes to the model act are approved.

7. Received a proposal from the Group Solvency Issues (EX) Working Group regarding Accreditation Part A: Laws and Regulations, substantially similar elements for the revised Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation (#450). The proposal was referred to the Financial Regulation Standards and Accreditation (F) Committee for consideration.

8. Received a status report regarding its Financial Guaranty Insurance Guideline (E) Working Group. In light of the uncertainty concerning the future development, if any, of new financial guaranty insurance products, and the continued close supervision of financial guaranty insurers by their state insurance regulators, the Committee adopted a recommendation to place the Working Group in inactive status until there is more clarity and certainty in the market related to these insured products. At that time, the Committee will consider reactivating the Working Group.

9. Received a response memorandum from the Life Actuarial (A) Task Force on the referral regarding separate account issues. The Committee exposed the response document for a public comment period ending Oct. 19.

10. Discussed the use of captives for life and health reinsurance agreements. The Committee anticipates receiving a 2011 and 2012 charge to further analyze this issue.

11. Discussed the downgrade of the U.S. debt rating. The Committee will continue to monitor issues related to this item.
Report of the
Financial Regulation Standards and Accreditation (F) Committee

The Financial Regulation Standards and Accreditation (F) Committee met via conference call Oct. 3, 2011, in regulator-to-regulator session pursuant to the NAIC Policy Statement on Open Meetings #7. During this meeting, the Committee discussed state-specific accreditation issues and voted to award continued accreditation to the Alabama Department of Insurance.

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Report of the
International Insurance Relations (G) Committee

The International Insurance Relations (G) Committee met April 15 and August 24, 2011, via conference call. During these calls, the Committee:

1. Discussed proposed comments to be submitted on behalf of U.S. insurance regulators to the International Association of Insurance Supervisors (IAIS) on material related to their Insurance Core Principles (ICPs).

2. Adopted a motion to submit the comments on the ICPs as modified during the conference call to the IAIS.

3. Discussed proposed comments to be submitted on behalf of U.S. insurance regulators to the IAIS on the draft Concept Paper for the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame).

4. Adopted a motion via e-mail to submit the comments on ComFrame as modified during the conference call to the IAIS.