Chapter 17
Determination of Financial Condition

Part 1
General Provisions

31A-17-101 Scope.

Except as otherwise provided under this code, this chapter and the rules adopted to implement it apply to all insurers, including reinsurers, authorized to do business in this state.

Enacted by Chapter 242, 1985 General Session

31A-17-102 Standards for accounting rules.

When adopting accounting rules, the commissioner shall consider recommendations made by the National Association of Insurance Commissioners. Accounting rules shall follow generally accepted accounting principles, except as modified by statutory insurance accounting principles.

Enacted by Chapter 242, 1985 General Session

Part 2
Qualified Assets

31A-17-201 Qualified assets.

(1) Except as provided under Subsections (3) and (4), only the qualified assets listed in Subsection (2) may be used in determining the financial condition of an insurer, except to the extent an insurer has shown to the commissioner that the insurer has excess surplus, as defined in Section 31A-1-301.

(2) For purposes of Subsection (1), "qualified assets" means:

(a) any of the following acquired or held in accordance with Sections 31A-18-105 and 31A-18-106:

(i) an investment;

(ii) a security;

(iii) property; or

(iv) a loan;

(b) the income due and accrued on an asset listed in Subsection (2)(a);

(c) assets other than an asset listed in Subsection (2)(a) that are determined to be admitted in the Accounting Practices and Procedures Manual, published by the National Association of Insurance Commissioners; and

(d) other assets authorized by the commissioner by rule.

(3)

(a) Subject to Subsection (5) and even if the assets could not otherwise be counted under this chapter, assets acquired in the bona fide enforcement of creditors' rights may be counted for the purposes of Subsection (1) and Sections 31A-18-105 and 31A-18-106:

(i) for five years after the acquisition of the assets if the assets are real property; and

(ii) for one year if the assets are not real property.

(b)

(i) The commissioner may allow reasonable extensions of the periods described in Subsection (3)(a), if disposal of the assets within the periods given is not possible without substantial loss.

(ii) Extensions under Subsection (3)(b)(i) may not, as to any particular asset, exceed a total of five years.

(4) Subject to Subsection (5), and even though under this chapter the assets could not otherwise be counted, assets acquired in connection with mergers, consolidations, or bulk reinsurance, or as a dividend or distribution of assets, may be counted for the same purposes, in the same manner, and for the same periods as assets acquired under Subsection (3).

(5) Assets described under Subsection (3) or (4) may not be counted for the purposes of Subsection (1), except to the extent they are counted as assets in determining insurer solvency under the laws of the state of domicile of the creditor or acquired insurer.

Amended by Chapter 252, 2003 General Session

31A-17-202 Status of assets that are not "qualified assets."

(1)

(a) Except as provided in Subsection (1)(b), if an insurer owns assets that are not qualified assets under Section 31A-17-201, the assets shall be disregarded in determining and reporting the financial condition of the insurer.

(b) An insurer may invest its funds in investments that are permitted under Section 31A-18-105 but in excess of the limits under Sections 31A-18-103 and 31A-18-106 or other assets approved by the commissioner and these assets may be recognized and reported in the financial condition of the insurer to the extent the insurer has excess surplus, as defined under Section 31A-1-301.

(2) Insurers bear the burden of establishing the extent to which they have excess surplus.

Amended by Chapter 131, 1999 General Session

31A-17-203 Encumbering of assets.

(1) No domestic insurer may pledge, hypothecate, or otherwise encumber its assets to secure the debt, guaranty, or obligation of any other person. This prohibition does not apply to obligations of the insurer under surety bonds or insurance contracts issued in the regular course of business.

(2) No domestic insurer may pledge, hypothecate, or otherwise encumber its assets in an amount in excess of the amount of its capital and surplus, without the prior written consent of the commissioner.

(3) The commissioner may grant a domestic insurer an exception to Subsection (2) for a reinsurance agreement which may cause assets of the domestic insurer to be held, deposited, pledged, hypothecated, or otherwise encumbered in an amount in excess of capital and surplus to secure, offset, protect, or meet reserves or liabilities of the insurer that are established, incurred, or required under the provisions of the reinsurance agreement. The domestic insurer shall first file with the commissioner a written request for this exception, accompanied by a copy of the proposed reinsurance agreement and specifically stating its purpose and the reasons the exception should be granted.

(4) Any person that accepts a pledge, hypothecation, or encumbrance of any asset of an insurer not in accordance with the terms and limitations of this section is considered to have accepted that asset subject to a superior, preferential, and perfected lien in favor of owners, beneficiaries,

assignees, certificate holders, or third party claimants or beneficiaries of any insurance benefit or right arising out of and within the coverage of any insurance policy issued by the insurer. The commissioner may bring or participate in an action in any court of competent jurisdiction to protect the interests of insureds or claimants under this section.

Enacted by Chapter 204, 1986 General Session

Part 4
Valuation and Reserves

31A-17-401 Valuation of assets.

(1) The commissioner shall value the assets of insurers in accordance with then current insurance business practices, but not in a manner inconsistent with the provisions of this title. In valuing assets, the commissioner shall consider any method then current, formulated, or approved by the National Association of Insurance Commissioners.

(2) Assets that are not qualified assets under Subsection 31A-17-201(2) are considered to have no value in evaluating an insurer's compliance with Chapter 17, Part 6, Risk-Based Capital. Those assets may be used in evaluating the insurer's financial condition only to the extent the insurer has excess surplus.

(3)

(a) Insurance subsidiaries are valued on the books of a parent insurer as follows:

(i) Except as provided under Subsections (3)(a)(iii) and (iv), common stock of the subsidiary is valued on the basis of the parent insurer's percentage of ownership of the common stock multiplied by the total of the subsidiary's capital and surplus, less amounts needed to liquidate all claims to the capital and surplus which are senior to common stock. Subsection 31A-18-106(1)(k) provides applicable limitations on investments in subsidiaries.

(ii) The value of securities other than common stock issued by a subsidiary is the lesser of the present value of the future income to be derived under the securities or the amount the parent insurer would receive as a result of the securities if the subsidiary were liquidated and all creditors of the subsidiary and holders of the subsidiary's securities with senior priority were paid in full. The present value of future income derived from securities is determined by rule adopted by the commissioner. A parent insurer may attribute value to a security of its subsidiary only if the parent insurer is being paid dividends or interest on the security, and only if the parent insurer can reasonably anticipate that dividends or interest will continue to be paid on the security.

(iii) Except as provided under Subsection (3)(a)(iv), any portion of the subsidiary's value permitted under Subsection (3)(a) that is represented by assets other than assets listed under Section 31A-17-201, may only be classified as excess surplus of the parent insurer, and then only to the extent the parent insurer has established that it has excess surplus under Section 31A-17-202.

(iv) For the purposes of Subsection (3)(a)(iii), assets of a newly acquired subsidiary that are the equivalent of qualified assets in the subsidiary's domiciliary state, are, for the first five years after the subsidiary's acquisition, considered to be qualified assets under Section 31A-17-201. This assumption stands even if the assets are not otherwise qualified assets under Section 31A-17-201.

(b) A subsidiary formed or acquired to hold or manage investments that the parent insurance company might hold or manage directly, shall be valued as if the assets of the subsidiary were owned directly by the insurer in a percentage equal to the insurer's percentage of ownership of the subsidiary. The subsidiary investment limitation of Subsection 31A-18-106(1)(k) does not apply to these subsidiaries.
(c) Subsidiaries other than those described in Subsections (3)(a) and (b) shall be valued in accordance with Subsection (1). The subsidiary investment limitation under Subsection 31A-18-106(1)(k) applies to these subsidiaries in the same manner as to subsidiaries described in Subsection (3)(a).
(d) In determining an insurer's financial condition, no value is given to:
(i) any interest held by the insurer in its own stock, including debts due the insurer that are secured by the insurer's own stock; or
(ii) any proportionate interest in the insurer's own stock, including debts that are secured by the insurer's own stock, which is held by any corporation, partnership, business unit, firm, or person owned in whole or in part by the insurer.
(4) The commissioner shall adopt rules to implement the provisions of this section.

Amended by Chapter 116, 2001 General Session

31A-17-402 Valuation of liabilities.
(1) Subject to this section, the commissioner shall make rules:
(a) specifying the liabilities required to be reported by an insurer in a financial statement submitted under Section 31A-2-202; and
(b) the methods of valuing the liabilities described in Subsection (1)(a).
(2) For life insurance, the methods of valuing specified pursuant to Subsection (1)(b) shall be consistent with Part 5, Standard Valuation Law.
(3) Title insurance reserves are provided for under Section 31A-17-408.
(4) In determining the financial condition of an insurer, liabilities include:
(a) the estimated amount necessary to pay:
(i) all the insurer's unpaid losses and claims incurred on or before the date of statement, whether reported or unreported; and
(ii) the expense of adjustment or settlement of a loss or claim described in this Subsection (4)(a);
(b) for life, accident and health insurance, and annuity contracts:
(i) the reserves on life insurance policies and annuity contracts in force, valued according to appropriate tables of mortality and the applicable rates of interest;
(ii) the reserves for accident and health benefits, for both active and disabled lives;
(iii) the reserves for accidental death benefits; and
(iv) any additional reserves:
(A) that may be required by the commissioner by rule; or
(B) if no rule is applicable under Subsection (4)(b)(iv)(A), in a manner consistent with the practice formulated or approved by the National Association of Insurance Commissioners with respect to those types of insurance;
(c) subject to Subsection (6), for insurance other than life, accident and health, and title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed:
(i) on a daily or monthly pro rata basis; or
(ii) other basis approved by the commissioner;

(d) for ocean marine and other transportation insurance, reserves:
(i) equal to 50% of the amount of premiums upon risks covering not more than one trip or passage not terminated; and
(ii) computed:
(A) upon a pro rata basis; or
(B) with the commissioner's consent, in accordance with a method provided under Subsection (4)(c); and
(e) the insurer's other liabilities due or accrued at the date of statement including:
(i) taxes;
(ii) expenses; and
(iii) other obligations.
(5)
(a) Except to the extent provided in Subsection (5)(b), in determining the financial condition of an insurer of workers' compensation insurance, the insurer's liabilities do not include any liability based on the liability of the Employer's Reinsurance Fund under Section 34A-2-702 for industrial accidents or occupational diseases occurring on or before June 30, 1994.
(b) Notwithstanding Subsection (5)(a), the liability of an insurer of workers' compensation insurance includes any premium assessment:
(i) imposed under Section 59-9-101; and
(ii) due at the date of statement.
(6) After adopting a method for computing the reserves described in Subsection (4)(c), an insurer may not change the method without the commissioner's written consent.

Amended by Chapter 306, 2007 General Session

31A-17-404 Credit allowed a domestic ceding insurer against reserves for reinsurance.
(1)
(a) Subject to Subsections (1)(b) and (c), a domestic ceding insurer is allowed credit for reinsurance as either an asset or a reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of Subsection (3), (4), (5), (6), (7), (8), or (9).
(b) Credit is allowed under Subsection (3), (4), or (5) only with respect to a cession of a kind or class of business that the assuming insurer is licensed or otherwise permitted to write or assume:
(i) in the assuming insurer's state of domicile; or
(ii) in the case of a United States branch of an alien assuming insurer, in the state through which the assuming insurer is entered and licensed to transact insurance or reinsurance.
(c) Credit is allowed under Subsection (5) or (6) only if the applicable requirements of Subsection (11) are met.
(2) A domestic ceding insurer is allowed credit for reinsurance ceded:
(a) only if the reinsurance is payable in a manner consistent with Section 31A-22-1201;
(b) only to the extent that the accounting:
(i) is consistent with the terms of the reinsurance contract; and
(ii) clearly reflects:
(A) the amount and nature of risk transferred; and
(B) liability, including contingent liability, of the ceding insurer;
(c) only to the extent the reinsurance contract shifts insurance policy risk from the ceding insurer to the assuming reinsurer in fact and not merely in form; and

(d) only if the reinsurance contract contains a provision placing on the reinsurer the credit risk of all dealings with intermediaries regarding the reinsurance contract.

(3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(4)

(a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is accredited by the commissioner as a reinsurer in this state.

(b) An insurer is accredited as a reinsurer if the insurer:

(i) files with the commissioner evidence of the insurer's submission to this state's jurisdiction;

(ii) submits to the commissioner's authority to examine the insurer's books and records;

(iii)

(A) is licensed to transact insurance or reinsurance in at least one state; or

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

(iv) files annually with the commissioner a copy of the insurer's:

(A) annual statement filed with the insurance department of the insurer's state of domicile; and

(B) most recent audited financial statement; and

(v)

(A)

(I) has not had the insurer's accreditation denied by the commissioner within 90 days after the day on which the insurer submits the information required by this Subsection (4); and

(II) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; or

(B)

(I) has the insurer's accreditation approved by the commissioner; and

(II) maintains a surplus with regard to policyholders in an amount less than $20,000,000.

(c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation is revoked by the commissioner after a notice and hearing.

(5)

(a) A domestic ceding insurer is allowed a credit if:

(i) the reinsurance is ceded to an assuming insurer that is:

(A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or

(B) in the case of a United States branch of an alien assuming insurer, is entered through a state meeting the requirements of Subsection (5)(a)(ii);

(ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for reinsurance substantially similar to those applicable under this section; and

(iii) the assuming insurer or United States branch of an alien assuming insurer:

(A) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; and

(B) submits to the authority of the commissioner to examine the insurer's books and records.

(b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded and assumed pursuant to a pooling arrangement among insurers in the same holding company system.

(6)

(a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that maintains a trust fund:

(i) created in accordance with rules made by the commissioner pursuant to Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and
(ii) in a qualified United States financial institution for the payment of a valid claim of:
(A) a United States ceding insurer of the assuming insurer;
(B) an assign of the United States ceding insurer; and
(C) a successor in interest to the United States ceding insurer.
(b) To enable the commissioner to determine the sufficiency of the trust fund described in Subsection (6)(a), the assuming insurer shall:
(i) report annually to the commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by a licensed insurer; and
(ii)
(A) submit to examination of its books and records by the commissioner; and
(B) pay the cost of an examination.
(c)
(i) Credit for reinsurance may not be granted under this Subsection (6) unless the form of the trust and any amendment to the trust is approved by:
(A) the commissioner of the state where the trust is domiciled; or
(B) the commissioner of another state who, pursuant to the terms of the trust instrument, accepts principal regulatory oversight of the trust.
(ii) The form of the trust and an amendment to the trust shall be filed with the commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled.
(iii) The trust instrument shall provide that a contested claim is valid and enforceable upon the final order of a court of competent jurisdiction in the United States.
(iv) The trust shall vest legal title to the trust's assets in one or more of the trust's trustees for the benefit of:
(A) a United States ceding insurer of the assuming insurer;
(B) an assign of the United States ceding insurer; or
(C) a successor in interest to the United States ceding insurer.
(v) The trust and the assuming insurer are subject to examination as determined by the commissioner.
(vi) The trust shall remain in effect for as long as the assuming insurer has an outstanding obligation due under a reinsurance agreement subject to the trust.
(vii) No later than February 28 of each year, the trustee of the trust shall:
(A) report to the commissioner in writing the balance of the trust;
(B) list the trust's investments at the end of the preceding calendar year; and
(C)
(I) certify the date of termination of the trust, if so planned; or
(II) certify that the trust will not expire before the following December 31.
(d) The following requirements apply to the following categories of assuming insurer:
(i) For a single assuming insurer:
(A) the trust fund shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and
(B) the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in Subsection (6)(d)(ii).
(ii)
(A) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal

regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development.

(B) The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency.

(C) The minimum required trusteed surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(iii) For a group acting as assuming insurer, including incorporated and individual unincorporated underwriters:

(A) for reinsurance ceded under a reinsurance agreement with an inception, amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to an underwriter of the group;

(B) for reinsurance ceded under a reinsurance agreement with an inception date on or before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the other provisions of this chapter, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States;

(C) in addition to a trust described in Subsection (6)(d)(iii)(A) or (B), the group shall maintain in trust a trusteed surplus of which $100,000,000 is held jointly for the benefit of the one or more United States domiciled ceding insurers of a member of the group for all years of account;

(D) the incorporated members of the group:

(I) may not be engaged in a business other than underwriting as a member of the group; and

(II) are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members; and

(E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner:

(I) an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or

(II) if a certification is unavailable, a financial statement, prepared by an independent public accountant, of each underwriter member of the group.

(iv) For a group of incorporated underwriters under common administration, the group shall:

(A) have continuously transacted an insurance business outside the United States for at least three years immediately preceding the day on which the group makes application for accreditation;

(B) maintain aggregate policyholders' surplus of at least $10,000,000,000;

(C) maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to a member of the group pursuant to a reinsurance contract issued in the name of the group;

(D) in addition to complying with the other provisions of this Subsection (6)(d)(iv), maintain a joint trusteed surplus of which $100,000,000 is held jointly for the benefit of the one

or more United States domiciled ceding insurers of a member of the group as additional security for these liabilities; and

(E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner:

(I) an annual certification of each underwriter member's solvency by the member's domiciliary regulator; and

(II) a financial statement of each underwriter member of the group prepared by an independent public accountant.

(7) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that secures the assuming insurer's obligations in accordance with this Subsection (7):

(a) The insurer shall be certified by the commissioner as a reinsurer in this state.

(b) To be eligible for certification, the assuming insurer shall:

(i) be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to Subsection (7)(d);

(ii) maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(iii) maintain financial strength ratings from two or more rating agencies considered acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(iv) agree to:

(A) submit to the jurisdiction of this state;

(B) appoint the commissioner as the assuming insurer's agent for service of process in this state;

(C) provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if the assuming insurer resists enforcement of a final United States judgment;

(D) agree to meet applicable information filing requirements as determined by the commissioner including an application for certification, a renewal and on an ongoing basis; and

(E) any other requirements for certification considered relevant by the commissioner.

(c) An association, including incorporated and individual unincorporated underwriters, may be a certified reinsurer, if the association:

(i) satisfies the requirements of Subsections (7)(a) and (b);

(ii) satisfies the association's minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and the association's members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of the association's members in an amount determined by the commissioner to provide adequate protection;

(iii) does not have incorporated members of the association engaged in any business other than underwriting as a member of the association;

(iv) is subject to the same level of regulation and solvency control of the incorporated members of the association by the association's domiciliary regulator as are the unincorporated members; and

(v) within 90 days after the day on which the association's financial statements are due to be filed with the association's domiciliary regulator, provides to the commissioner:

(A) an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or

(B) if a certification described in Subsection (7)(c)(v)(A) is unavailable, financial statements prepared by independent public accountants, of each underwriter member of the association.

(d)

(i) The commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer.

(ii) To determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner:

(A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis;

(B) shall consider the rights, the benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States;

(C) shall require the qualified jurisdiction to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and

(D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards.

(iii) The commissioner may consider additional factors in determining a qualified jurisdiction.

(iv) A list of qualified jurisdictions shall be published through the National Association of Insurance Commissioners' Committee Process.

(v) The commissioner shall:

(A) consider the National Association of Insurance Commissioners' list of qualified jurisdictions in determining qualified jurisdictions; and

(B) if the commissioner approves a jurisdiction as qualified that does not appear on the National Association of Insurance Commissioners' list of qualified jurisdictions, provide thoroughly documented justification in accordance with criteria to be developed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(vi) United States jurisdictions that meet the requirement for accreditation under the National Association of Insurance Commissioners' financial standards and accreditation program shall be recognized as qualified jurisdictions.

(vii) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation.

(e) The commissioner shall:

(i) assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies considered acceptable to the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) publish a list of all certified reinsurers and their ratings.

(f) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this Subsection (7) at a level consistent with the certified reinsurer's rating, as specified in rules made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(i) For a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with Section 31A-17-404.1, or in a

multibeneficiary trust in accordance with Subsections (5), (6), and (9), except as otherwise provided in this Subsection (7).

(ii) If a certified reinsurer maintains a trust to fully secure the certified reinsurer's obligations subject to Subsections (5), (6), and (9), and chooses to secure the certified reinsurer's obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for the certified reinsurer's obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this Subsection (7) or comparable laws of other United States jurisdictions and for the certified reinsurer's obligations subject to Subsections (5), (6), and (9).

(iii) It shall be a condition to the grant of certification under this Subsection (7) that the certified reinsurer shall have bound itself:

(A) by the language of the trust and agreement with the commissioner with principal regulatory oversight of the trust account; and

(B) upon termination of the trust account, to fund, out of the remaining surplus of the trust, any deficiency of any other trust account.

(iv) The minimum trusteed surplus requirements provided in Subsections (5), (6), and (9) are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this Subsection (7), except that the trust shall maintain a minimum trusteed surplus of $10,000,000.

(v) With respect to obligations incurred by a certified reinsurer under this Subsection (7), if the security is insufficient, the commissioner:

(A) shall reduce the allowable credit by an amount proportionate to the deficiency; and

(B) may impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(vi)

(A) For purposes of this Subsection (7), a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100% of the certified reinsurer's obligations.

(B) As used in this Subsection (7), the term "terminated" refers to revocation, suspension, voluntary surrender, and inactive status.

(C) If the commissioner continues to assign a higher rating as permitted by other provisions of this section, the requirement under this Subsection (7)(f)(vi) does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(g) If an applicant for certification has been certified as a reinsurer in a National Association of Insurance Commissioners' accredited jurisdiction, the commissioner may:

(i) defer to that jurisdiction's certification;

(ii) defer to the rating assigned by that jurisdiction; and

(iii) consider such reinsurer to be a certified reinsurer in this state.

(h)

(i) A certified reinsurer that ceases to assume new business in this state may request to maintain the certified reinsurer's certification in inactive status in order to continue to qualify for a reduction in security for its in-force business.

(ii) An inactive certified reinsurer shall continue to comply with all applicable requirements of this Subsection (7).

(iii) The commissioner shall assign a rating to a reinsurer that qualifies under this Subsection (7)(h), that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(8)
(a) As used in this Subsection (8):
(i) "Covered agreement" means an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that:
(A) is currently in effect or in a period of provisional application; and
(B) addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.
(ii) "Reciprocal jurisdiction" means a jurisdiction that is:
(A) a non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union;
(B) a United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners' financial standards and accreditation program; or
(C) a qualified jurisdiction, as determined by the commissioner in accordance with Subsection (7)(d), that is not otherwise described in this Subsection (8)(a)(ii) and meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the commissioner in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(b)
(i) Credit is allowed when the reinsurance is ceded to an assuming insurer meeting each of the conditions set forth in this Subsection (8)(b).
(ii) The assuming insurer must have the assuming insurer's head office in or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction.
(iii)
(A) The assuming insurer shall have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of the assuming insurer's domiciliary jurisdiction, in an amount to be set forth in regulation.
(B) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, the assuming insurer shall have and maintain, on an ongoing basis, minimum capital and surplus equivalents (net of liabilities), calculated according to the methodology applicable in the assuming insurer's domiciliary jurisdiction, and a central fund containing a balance in amounts set forth in regulation.
(iv)
(A) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ration, as applicable, which will be set forth in regulation.
(B) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, the assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has the assuming insurer's head office or is domiciled, as applicable, and is also licensed.
(v) The assuming insurer must agree and provide adequate assurance to the commissioner, in a form specified by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as follows:
(A) the assuming insurer must provide prompt written notice and explanation to the commissioner if the assuming insurer falls below the minimum requirements set forth in

Subsection (8)(c) or (d), or if any regulatory action is taken against the assuming insurer for serious noncompliance with applicable law;

(B) the assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process, however the commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement and nothing in this provision shall limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

(C) the assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or the ceding insurer's legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(D) each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which the final judgement was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by the ceding insurer's legal successor on behalf of the ceding insurer's resolution estate; and

(E) the assuming insurer must confirm that the assuming insurer is not presently participating in any solvent scheme of arrangement which involved this state's ceding insurers, and agree to notify the ceding insurer and the commissioner and to provide security:

(I) in an amount equal to 100% of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement; and

(II) in a form consistent with the provisions of Subsections (7) and (10) and as specified by the commissioner in regulation.

(vi) The assuming insurer or the assuming insurer's legal successor must provide, if requested by the commissioner, on behalf of the assuming insurer and any legal predecessors, certain documentation to the commissioner, as specified by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(vii) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(viii) The assuming insurer's supervisory authority must confirm to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in Subsections (8)(c) and (d).

(ix) Nothing in this provision precludes an assuming insurer from providing the commissioner with information on a voluntary basis.

(c)

(i) The commissioner shall timely create and publish a list of reciprocal jurisdictions.

(ii)

(A) A list of reciprocal jurisdictions is published through the National Association of Insurance Commissioners' Committee Process.

(B) The commissioner's list of reciprocal jurisdictions shall include any reciprocal jurisdiction as defined in this Subsection (8), and shall consider any other reciprocal jurisdictions in

accordance with the criteria developed under rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(iii)

(A) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that the commissioner may not remove from the list a reciprocal jurisdiction.

(B) Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer whose home office or domicile is in that jurisdiction is allowed, if otherwise allowed under this chapter.

(d)

(i) The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions shall be granted credit in accordance with this Subsection (8).

(ii) The commissioner may add an assuming insurer to such list if a National Association of Insurance Commissioners accredited jurisdiction has added such assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under this Subsection (8) and complies with any additional requirements that the commissioner may impose by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except to the extent that they conflict with an applicable covered agreement.

(e)

(i) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this Subsection (8), the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this Subsection (8) in accordance with procedures established in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(ii)

(A) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the day on which the suspension is effective qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with Subsection (10).

(B) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the day on which the revocation is effective with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into before the day on which the revocation is effective, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of Subsection (10).

(f) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or the ceding insurer's representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(g) Nothing in this Subsection (8) limits or in any way alters the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this chapter or other applicable law or regulation.

(h)

(i) Credit may be taken under this Subsection (8) only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this Subsection (8), and only with respect to losses incurred and reserves reported on or after the later of:

(A) the day on which the assuming insurer has met all eligibility requirements pursuant to Subsection (8)(b); and

(B) the day on which the new reinsurance agreement, amendment, or renewal is effective.

(ii) This Subsection (8) does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this Subsection (8), as long as the reinsurance qualifies for credit under any other applicable provision of this chapter.

(iii) Nothing in this Subsection (8) authorizes an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

(iv) Nothing in this Subsection (8) limits, or in any way alters, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(9) If reinsurance is ceded to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7), or (8), a domestic ceding insurer is allowed credit only as to the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law or regulation of that jurisdiction.

(10)

(a) An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7), or (8) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer.

(b) The commissioner may adopt by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specific additional requirements relating to or setting forth:

(i) the valuation of assets or reserve credits;

(ii) the amount and forms of security supporting reinsurance arrangements; and

(iii) the circumstances pursuant to which credit will be reduced or eliminated.

(c)

(i) The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is:

(A) held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or

(B) in the case of a trust, held in a qualified United States financial institution.

(ii) The security described in this Subsection (10)(c) may be in the form of:

(A) cash;

(B) securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

(C) clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement;

(D) letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to

be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

(E) any other form of security acceptable to the commissioner.

(11) Reinsurance credit is not allowed a domestic ceding insurer unless the assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:

(a)

(i) being an admitted insurer; and

(ii) submitting to jurisdiction under Section 31A-2-309;

(b) having irrevocably appointed the commissioner as the domestic ceding insurer's agent for service of process in an action arising out of or in connection with the reinsurance, which appointment is made under Section 31A-2-309; or

(c) agreeing in the reinsurance contract:

(i) that if the assuming insurer fails to perform the assuming insurer's obligations under the terms of the reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

(A) submit to the jurisdiction of a court of competent jurisdiction in a state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of the court or of an appellate court in the event of an appeal; and

(ii) to designate the commissioner or a specific attorney licensed to practice law in this state as its attorney upon whom may be served lawful process in an action, suit, or proceeding instituted by or on behalf of the ceding company.

(12) Submitting to the jurisdiction of Utah courts under Subsection (11) does not override a duty or right of a party under the reinsurance contract, including a requirement that the parties arbitrate their disputes.

(13)

(a) If an assuming insurer does not meet the requirements of Subsection (3), (4), (5), or (8), the credit permitted by Subsection (6) or (7) may not be allowed unless the assuming insurer agrees in the trust instrument to the conditions described in Subsections (13)(b) through (e).

(b)

(i) Notwithstanding any other provision in the trust instrument, if an event described in Subsection (13)(b)(ii) occurs the trustee shall comply with:

(A) an order of the commissioner with regulatory oversight over the trust; or

(B) an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(ii) This Subsection (13)(b) applies if:

(A) the trust fund is inadequate because the trust contains an amount less than the amount required by Subsection (6)(d); or

(B) the grantor of the trust is:

(I) declared insolvent; or

(II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the laws of its state or country of domicile.

(c) The assets of a trust fund described in Subsection (13)(b) shall be distributed by and a claim shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of a domestic insurance company.

(d) If the commissioner with regulatory oversight determines that the assets of the trust fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United

States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust instrument.

(e) A grantor shall waive any right otherwise available to the grantor under United States law that is inconsistent with this Subsection (13).

(14)

(a) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification.

(b) The commissioner shall give the reinsurer notice and opportunity for hearing.

(c) The suspension or revocation may not take effect until after the day on which the commissioner issues an order after a hearing, unless:

(i) the reinsurer waives the reinsurer's right to hearing;

(ii) the commissioner's order is based on:

(A) regulatory action by the reinsurer's domiciliary jurisdiction; or

(B) the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state under Subsection (7)(g); or

(iii) the commissioner's finding that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(d) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with Section 31A-17-404.1.

(e) If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with Subsection (7)(f) or Section 31A-17-404.1.

(15)

(a) A ceding insurer shall take steps to manage the ceding insurer's reinsurance recoverables proportionate to the ceding insurer's own book of business.

(b)

(i) A domestic ceding insurer shall notify the commissioner within 30 days after the day on which reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers:

(A) exceeds 50% of the domestic ceding insurer's last reported surplus to policyholders; or

(B) after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding insurer's last reported surplus to policyholders.

(ii) The notification required by Subsection (15)(b)(i) shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(c) A ceding insurer shall take steps to diversify the ceding insurer's reinsurance program.

(d)

(i) A domestic ceding insurer shall notify the commissioner within 30 days after the day on which the ceding insurer cedes or is likely to cede more than 20% of the ceding insurer's gross written premium in the prior calendar year to any:

(A) single assuming insurer; or

(B) group of affiliated assuming insurers.

(ii) The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(16) A ceding insurer licensed under Chapter 5, Domestic Stock and Mutual Insurance Corporations, Chapter 7, Nonprofit Health Service Insurance Corporations, Chapter 8, Health Maintenance Organizations and Limited Health Plans, or Chapter 9, Insurance Fraternals, may be allowed credit if:

(a) the reinsurance is ceded to an assuming domestic captive insurer; and

(b) the assuming domestic captive insurer complies with:

(i) Sections 31A-2-202 through 31A-2-205;

(ii) Chapter 4, Insurers in General;

(iii) Chapter 16, Insurance Holding Companies;

(iv) Chapter 16a, Risk Management and Own Risk and Solvency Assessment Act;

(v) Chapter 17, Determination of Financial Condition;

(vi) Chapter 18, Investments; and

(vii) any other requirement that, in the commissioner's discretion, is necessary to promote the captive insurer's solvency.

Amended by Chapter 194, 2023 General Session

31A-17-404.1 Asset or reduction from liability for reinsurance ceded by a domestic insurer to other assuming insurers.

(1)

(a) An asset or a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer that does not meet the requirements of Section 31A-17-404 is allowed in an amount not exceeding the liabilities carried by the ceding insurer.

(b) A reduction described in Subsection (1)(a) shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer:

(i) that are held:

(A) under a reinsurance contract with the assuming insurer; and

(B) as security for the payment of obligations under the reinsurance contract; and

(ii) if the security is held:

(A) in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or

(B) in the case of a trust, in a qualified United States financial institution.

(2) Security described in Subsection (1) may be in the form of:

(a) cash;

(b) a security:

(i) listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those considered exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office; and

(ii) qualifying as an admitted asset;

(c) subject to Subsection (3), a clean, irrevocable, unconditional letter of credit, issued or confirmed by a qualified United States financial institution:

(i) effective no later than December 31 of the year for which the filing is being made; and

(ii) in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement; or

(d) another form of security acceptable to the commissioner.

(3) Notwithstanding an issuing or confirming institution's subsequent failure to meet an applicable standard of acceptability, a letter of credit described in Subsection (2) that meets the applicable standards of issuer acceptability as of the day on which it is issued or confirmed shall continue to be acceptable as security until the sooner of the day on which the letter of credit expires, is extended, is renewed, is modified, or is amended.

Amended by Chapter 138, 2016 General Session

31A-17-404.3 Rules.

(1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and this chapter, the commissioner may make rules prescribing:
  (a) the form of a letter of credit required under this chapter;
  (b) the requirements for a trust or trust instrument required by this chapter;
  (c) the procedures for licensing and accrediting;
  (d) minimum capital and surplus requirements;
  (e) additional requirements relating to calculation of credit allowed a domestic ceding insurer against reserves for reinsurance under Section 31A-17-404; and
  (f) additional requirements relating to calculation of asset reduction from liability for reinsurance ceded by a domestic insurer to other ceding insurers under Section 31A-17-404.1.

(2) A rule made pursuant to Subsection (1)(e) or (f) may apply to reinsurance relating to:
  (a) a life insurance policy with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;
  (b) a universal life insurance policy with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;
  (c) a variable annuity with guaranteed death or living benefits;
  (d) a long-term care insurance policy; or
  (e) such other life and health insurance or annuity product as to which the National Association of Insurance Commissioners adopts model regulatory requirements with respect for credit for reinsurance.

(3) A rule adopted pursuant to Subsection (1)(e) or (f) may apply to a treaty containing:
  (a) a policy issued on or after January 1, 2015; and
  (b) a policy issued before January 1, 2015, if risk pertaining to the policy is ceded in connection with the treaty, either in whole or in part, on or after January 1, 2015.

(4) A rule adopted pursuant to Subsection (1)(e) or (f) may require the ceding insurer, in calculating the amounts or forms of security required to be held under rules made under this section, to use the Valuation Manual adopted by the National Association of Insurance Commissioners under Section 11B(1) of the National Association of Insurance Commissioners Standard Valuation Law, including all amendments adopted by the National Association of Insurance Commissioners and in effect on the date as of which the calculation is made, to the extent applicable.

(5) A rule adopted pursuant to Subsection (1)(e) or (f) may not apply to cessions to an assuming insurer that:
  (a) meets the conditions established in Subsection 31A-17-404(8);
  (b) is certified in this state; or
  (c) maintains at least $250,000,000 in capital and surplus when determined in accordance with the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, including all amendments thereto adopted by the National Association of Insurance Commissioners, excluding the impact of any permitted or prescribed practices and is:

(i) licensed in at least 26 states; or
(ii) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.
(6) The authority to adopt rules pursuant to Subsection (1)(e) or (f) does not otherwise limit the commissioner's general authority to make rules pursuant to Subsection (1).

Amended by Chapter 32, 2020 General Session

31A-17-404.4 Transition -- Application to reinsurance agreement.

The amendments to this part made in Laws of Utah 2008, Chapter 257, apply to a cession made on or after July 1, 2008 under a reinsurance contract that has an inception, anniversary, or renewal date no sooner than January 1, 2009.

Enacted by Chapter 257, 2008 General Session

31A-17-405 Fraternal rates and reserves.

(1) A fraternal may be organized for the transaction of business on a plan set forth in the contract which provides for sufficient contributions by each member each year to pay the member's share of the actual death claims of the year, through advance payments graded according to a mortality table approved by the commissioner, without any reserve, or with a reserve which may accumulate from overpayments of individual members. If this type of reserve does accumulate, each member shall be informed each year of the member's credit and of the cost of the member's insurance.
(2) Each fraternal shall collect regular premiums for each coverage it provides at adequate rates that are approved by the commissioner or conform to standards set by rules adopted by the commissioner.
(3) The reserves of a fraternal are subject to the same requirements as those of Chapter 5, Domestic Stock and Mutual Insurance Corporations, insurers writing the same coverages, except that the commissioner may authorize the use of suitable fraternal mortality tables or other appropriate tables instead of the tables used by Chapter 5, Domestic Stock and Mutual Insurance Corporations, insurers.

Enacted by Chapter 242, 1985 General Session

31A-17-406 Adjustment of reserves.

The commissioner may order an insurer to adjust its reserves so the reserves bear a reasonable actuarial relationship to the insurer's obligations.

Enacted by Chapter 242, 1985 General Session

31A-17-407 Accounting for repurchased shares.

When a corporation acquires its own shares under Section 31A-5-306 or in any other way, the acquired shares are accounted as a deduction from capital and not as assets.

Enacted by Chapter 242, 1985 General Session

31A-17-408 Title insurance reserves.

(1) In addition to an adequate reserve for outstanding losses, a title insurance company shall either:

(a) maintain and segregate an unearned premium reserve fund of not less than 10 cents for each $1,000 face amount of retained liability under each title insurance contract or policy on a single insurance risk issued; or
(b) have the commissioner review and approve a contract of reinsurance applicable to the title insurance company's policies, which contract adequately covers the exposure or risk which the unearned premium reserve would serve.
(2) The fund shall be maintained for the protection of policyholders and is not subject to the claims of stockholders or creditors other than policyholders.
(3) The title insurance company may release the fund in accordance with the standards of the NAIC Accounting Practices and Procedures Manual.

Amended by Chapter 198, 2022 General Session

Part 5
Standard Valuation Law

31A-17-501 Standard Valuation Law -- Definitions.
(1) This part is known as the "Standard Valuation Law."
(2) As used in this part, the following definitions apply on or after the operative date of the valuation manual:
(a) Notwithstanding Section 31A-1-301, "accident and health insurance" means a contract that incorporates morbidity risk and provides protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.
(b) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in Subsection 31A-17-503(2).
(c) "Company" means an entity that:
(i) has written, issued, or reinsured a life insurance contract, accident and health insurance contract, or deposit-type contract in this state and has at least one such policy in force or on claim; or
(ii) has written, issued, or reinsured a life insurance contract, accident and health insurance contract, or deposit-type contract in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state.
(d) "Deposit-type contract" means a contract that does not incorporate mortality or morbidity risks and as may be specified in the valuation manual.
(e) Notwithstanding Section 31A-1-301, "life insurance" means a contract that incorporates mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.
(f) "Policyholder behavior" means an action that a policyholder, contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this part, including lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract, but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.
(g) "Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with Section 31A-17-515 as specified in the valuation manual.

(h) "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing the statements and who meets the requirements specified in the valuation manual.
(i) "Tail risk" means a risk that occurs either when the frequency of low probability events is higher than expected under a normal probability distribution or when there are observed events of very significant size or magnitude.
(j) "Valuation manual" means the manual of valuation instructions adopted in accordance with Section 31A-17-514.

Amended by Chapter 163, 2016 General Session

31A-17-502 Reserve valuation.

(1) The following apply to a policy or contract issued before the operative date of the valuation manual:
(a) The commissioner shall annually value, or cause to be valued, the reserve liabilities, also called "reserves" in this part, for outstanding life insurance policies and annuity and pure endowment contracts, of every life insurance company doing business in this state, issued before the operative date of the valuation manual. In calculating the reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required in this part of any foreign or alien company, the commissioner may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard provided in this part.
(b)
(i) Sections 31A-17-504, 31A-17-505, 31A-17-506, 31A-17-507, 31A-17-508, 31A-17-509, 31A-17-510, 31A-17-511, 31A-17-512, and 31A-17-513 apply to a policy or contract, as appropriate, subject to this part issued before the operative date of the valuation manual.
(ii) Sections 31A-17-514 and 31A-17-515 do not apply to a policy or contract described in Subsection (1)(b)(i).
(2) The following apply to a policy or contract issued on or after the operative date of the valuation manual:
(a) The commissioner shall annually value, or cause to be valued, the reserve liabilities, also called "reserves" in this part, for an outstanding life insurance contract, annuity and pure endowment contract, accident and health contract, and deposit-type contract of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserve liabilities required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this part.
(b) Sections 31A-17-514 and 31A-17-515 apply to a policy or contract issued on or after the operative date of the valuation manual.

Amended by Chapter 163, 2016 General Session

31A-17-503 Actuarial opinion of reserves.

(1)

(a) For an actuarial opinion before the operative date of the valuation manual, a life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commissioner by rule shall define the specifics of this opinion and add any other items considered to be necessary to its scope.

(b) The following apply to the actuarial analysis of reserves and assets supporting reserves:

(i) A life insurance company, except as exempted by or pursuant to rule, shall also annually include in the opinion required by Subsection (1)(a), an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including the benefits under the expenses associated with the policies and contracts.

(ii) The commissioner may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may consider necessary in order to render the opinion required by this section.

(c) An opinion required by Subsection (1)(b) shall be governed by the following provisions:

(i) A memorandum, in form and substance acceptable to the commissioner as specified by rule, shall be prepared to support each actuarial opinion.

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

(d) An opinion subject to this Subsection (1) shall be governed by the following provisions:

(i) The opinion shall be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, 1993.

(ii) The opinion shall apply to the business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rule.

(iii) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the commissioner may by rule prescribe.

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

(v) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth by department rule.

(vi) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(vii) Disciplinary action by the commissioner against the company or the qualified actuary shall be defined in rules by the commissioner consistent with Section 31A-2-308 and Title 63G, Chapter 4, Administrative Procedures Act.

(viii)

(A) Any memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the opinion, are considered protected records under Section 63G-2-305 and may not be made public and are not subject to subpoena under Subsection 63G-2-202(7), other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or rules made under this section.

(B) However, the memorandum or other material may otherwise be released by the commissioner with the written consent of the company, or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material.

(C) Once any portion of the confidential memorandum is cited in its marketing or is cited before any governmental agency other than the department or is released to the news media, all portions of the memorandum are no longer confidential.

(2) The following apply to an actuarial opinion of reserves after the operative date of the valuation manual:

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

(b) A company with an outstanding life insurance contract, accident and health insurance contract, or deposit-type contract in this state and subject to rule made by the commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by Subsection (2)(a) an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including the benefits under and expenses associated with the policies and contracts.

(c) An opinion required by Subsection (2)(b) shall be governed by the following provisions:

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

(ii) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or the commissioner

determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(d) An opinion subject to this Subsection (2) shall be governed by the following provisions:

(i) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the commissioner.

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

(iii) The opinion shall apply to the policies and contracts subject to Subsection (2)(b), plus other actuarial liabilities as may be specified in the valuation manual.

(iv) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual.

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

(vi) Except in cases of fraud or willful misconduct, the appointed actuary may not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion.

(vii) Disciplinary action by the commissioner against the company or the appointed actuary shall be defined in rules by the commissioner consistent with Section 31A-2-308 and Title 63G, Chapter 4, Administrative Procedures Act.

Amended by Chapter 163, 2016 General Session

31A-17-504 Computation of minimum standard.

Except as provided in Sections 31A-17-505, 31A-17-506, and 31A-17-513, the minimum standard for the valuation of the life insurance policies and annuity and pure endowment contracts issued before January 1, 1994, shall be that provided by the laws in effect immediately before that date. Except as otherwise provided in Sections 31A-17-505, 31A-17-506, and 31A-17-513, the minimum standard for the valuation of such policies and contracts issued on or after January 1, 1994, shall be the commissioner's reserve valuation methods defined in Sections 31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-513, 3.5% interest, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after June 1, 1973, 4% interest for such policies issued before April 2, 1980, 5.5% interest for single premium life insurance policies, and 4.5% interest for all other such policies issued on and after April 2, 1980, and the following tables:

(1) For an ordinary policy of life insurance issued on the standard basis, excluding any accident and health and accidental death benefits in the policy, the Commissioner's 1941 Standard Ordinary Mortality Table for such policies issued before the operative date of Subsection 31A-22-408(6)(a), the Commissioner's 1958 Standard Ordinary Mortality Table for such policies issued on or after the operative date of Subsection 31A-22-408(6)(a) and before the operative date of Subsection 31A-22-408(6)(d), provided that for any category of such policies issued on female risks, all modified net premiums and present values referred to in this section may be calculated according to an age not more than six years younger than the actual age of the

insured, and for such policies issued on or after the operative date of Subsection 31A-22-408(6)(d):

(a) the Commissioner's 1980 Standard Ordinary Mortality Table;

(b) at the election of the company for any one or more specified plans of life insurance, the Commissioner's 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(c) any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule made by the commissioner for use in determining the minimum standard of valuation for such policies.

(2) For an industrial life insurance policy issued on the standard basis, excluding any accident and health and accidental death benefits in the policy, the 1941 Standard Industrial Mortality Table for the policy issued before the operative date of Subsection 31A-22-408(6)(c), and for such policies issued on or after such operative date, the Commissioner's 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule made by the commissioner for use in determining the minimum standard of valuation for such policies.

(3) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies:

(a) the 1937 Standard Annuity Mortality Table;

(b) at the option of the company, the Annuity Mortality Table for 1949, Ultimate; or

(c) any modification of either of these tables approved by the commissioner.

(4) For group annuity and pure endowment contracts, excluding any accident and health and accidental death benefits in such policies:

(a) the Group Annuity Mortality Table for 1951, any modification of such table approved by the commissioner; or

(b) at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(5) For total and permanent disability benefits in or supplementary to ordinary policies or contracts:

(a)

(i) for a policy or contract issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rule made by the commissioner for use in determining the minimum standard of valuation for the policy;

(ii) for a policy or contract issued on or after January 1, 1961, and before January 1, 1966, either such tables or, at the option of the company, the Class (3) Disability Table (1926); and

(iii) for a policy issued before January 1, 1961, the Class (3) Disability Table (1926).

(b) A table described in this Subsection (5) shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(6) For accidental death benefits in or supplementary to policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule made by the commissioner for use in determining the minimum standard of valuation for such policies, for policies issued on or after January 1, 1961, and before January 1, 1966, either such table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table, and for policies issued before January 1, 1961, the Inter-Company Double Indemnity

Mortality Table. Either table shall be combined with a mortality table for calculating the reserves for life insurance policies.

(7) For group life insurance, life insurance issued on the substandard basis and other special benefits: such tables as may be approved by the commissioner.

Amended by Chapter 163, 2016 General Session

31A-17-505 Computation of minimum standard for annuities.

(1) Except as provided in Section 31A-17-506, the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of this section, as defined in Subsection (2), and for annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the commissioner's reserve valuation methods defined in Sections 31A-17-507 and 31A-17-508 and the following tables and interest rates:

(a) for individual annuity and pure endowment contracts issued before April 2, 1980, excluding any accident and health and accidental death benefits in the contracts:

(i)

(A) the 1971 Individual Annuity Mortality Table; or

(B) any modification of the 1971 Individual Annuity Mortality Table approved by the commissioner;

(ii) 6% interest for single premium immediate annuity contracts; and

(iii) 4% interest for all other individual annuity and pure endowment contracts;

(b) for individual single premium immediate annuity contracts issued on or after April 2, 1980, excluding any accident and health and accidental death benefits in the contracts:

(i)

(A) any individual annuity mortality table that is approved by rule made by the commissioner for use in determining the minimum standard of valuation for such contracts; or

(B) any modification of a table described in Subsection (1)(b)(i)(A) approved by the commissioner; and

(ii) 7.5% interest;

(c) for individual annuity and pure endowment contracts issued on or after April 2, 1980, other than single premium immediate annuity contracts, excluding any accident and health and accidental death benefits in the contracts:

(i)

(A) any individual annuity mortality table that is approved by rule made by the commissioner for use in determining the minimum standard of valuation for such contracts; or

(B) any modification of a table described in Subsection (1)(c)(i)(A) approved by the commissioner;

(ii) 5.5% interest for single premium deferred annuity and pure endowment contracts; and

(iii) 4.5% interest for all other such individual annuity and pure endowment contracts;

(d) for the annuities and pure endowments purchased before April 2, 1980, under group annuity and pure endowment contracts, excluding any accident and health and accidental death benefits purchased under the contracts:

(i)

(A) the 1971 Group Annuity Mortality Table; or

(B) any modification of the 1971 Group Annuity Mortality Table approved by the commissioner; and

(ii) 6.5% interest; and

(e) for the annuities and pure endowments purchased on or after April 2, 1980, under group annuity and pure endowment contracts, excluding any accident and health and accidental death benefits purchased under the contracts:

(i)

(A) any group annuity mortality table that is approved by rule made by the commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments; or

(B) any modification of a table described in Subsection (1)(e)(i)(A) approved by the commissioner; and

(ii) 7.5% interest.

(2)

(a) After June 1, 1973, any company may file with the commissioner a written notice of its election to comply with this section after a specified date before January 1, 1979, which shall be the operative date of this section for the company.

(b) If a company does not make an election under Subsection (2)(a), the operative date of this section for the company shall be January 1, 1979.

Amended by Chapter 163, 2016 General Session

31A-17-506 Computation of minimum standard by calendar year of issue.

(1) The interest rates used in determining the minimum standard for the valuation shall be the calendar year statutory valuation interest rates as defined in this section for:

(a) life insurance policies issued in a particular calendar year, on or after the operative date of Subsection 31A-22-408(6)(d);

(b) individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;

(c) annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts; and

(d) the net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts.

(2) Calendar year statutory valuation interest rates:

(a) The calendar year statutory valuation interest rates, "I," shall be determined as follows and the results rounded to the nearer 1/4 of 1%:

(i) for life insurance:

$$I = .03 + W(R1 - .03) + (W/2)(R2 - .09);$$

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

$$I = .03 + W(R - .03),$$

where R1 is the lesser of R and .09,
R2 is the greater of R and .09,
R is the reference interest rate defined in Subsection (4), and
W is the weighting factor defined in this section;

(iii) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in Subsection (2)(a)(ii), the formula for life insurance stated in Subsection (2)(a)(i) shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years, and the

formula for single premium immediate annuities stated in Subsection (2)(a)(ii) shall apply to annuities and guaranteed interest contracts with guarantee duration of 10 years or less;

(iv) for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in Subsection (2)(a)(ii) shall apply; and

(v) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in Subsection (2)(a)(ii) shall apply.

(b) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of 1% the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, using the reference interest rate defined in 1979, and shall be determined for each subsequent calendar year regardless of when Subsection 31A-22-408(6)(d) becomes operative.

(3) Weighting factors:

(a) The weighting factors referred to in the formulas stated in Subsection (2) are given in the following tables:

(i)

(A) Weighting factors for life insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less:	.50
More than 10, but less than 20:	.45
More than 20:	.35.

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

(ii) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: .80

(iii) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in Subsection (3)(a)(ii), shall be as specified in the tables in Subsections (3)(a)(iii)(A), (B), and (C), according to the rules and definitions in Subsection (3)(b):

(A) For annuities and guaranteed interest contracts valued on an issue year basis:

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

More than 20:	.45	.35	.35

	Plan Type		
	A	B	C
(B) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in Subsection (3)(a)(iii)(A) increased by:	.15	.25	.05

	Plan Type		
	A	B	C
(C) For annuities and guaranteed interest contracts valued on an issue year basis, other than those with no cash settlement options, which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in Subsection (3)(a)(iii)(A) or derived in Subsection (3)(a)(iii)(B) increased by:	.05	.05	.05.

(b)

(i) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guaranteed duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(ii) Plan type as used in the tables in this Subsection (3) is defined as follows:

(A) Plan Type A: At any time policyholder may withdraw funds only:

(I) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(II) without such adjustment but in installments over five years or more;

(III) as an immediate life annuity; or

(IV) no withdrawal permitted.

(B)

(I) Plan Type B: Before expiration of the interest rate guarantee, policyholder withdraw funds only:

(Aa) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(Bb) without such adjustment but in installments over five years or more; or

(Cc) no withdrawal permitted.

(II) At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

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

(I) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or

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

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

(4) Reference interest rate: "Reference interest rate" referred to in Subsection (2)(a) is defined as follows:

(a) For life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of the Monthly Average of the composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(b) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Subsection (4)(b), with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(d) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Subsection (4)(b), with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(e) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(f) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in Subsection (4)(b), the average over a period of 12 months, ending on June 30 of the calendar year of the

change in the fund, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(5) Alternative method for determining reference interest rates: In the event that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds is no longer published by Moody's Investors Service, Inc. or in the event that the National Association of Insurance Commissioners determines that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by rule made by the commissioner, may be substituted.

Amended by Chapter 163, 2016 General Session

31A-17-507 Reserve valuation method -- Life insurance and endowment benefits.

(1) Except as otherwise provided in Sections 31A-17-508, 31A-17-511, and 31A-17-513, reserves according to the commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of Subsection (1)(a) over Subsection (1)(b), as follows:

(a) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium may not exceed the net level annual premium on the 19 year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy.

(b) A net one year term premium for such benefits provided for in the first policy year.

(2)

(a) Provided that for any life insurance policy issued on or after January 1, 1997, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioner's reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined in this Subsection (2) as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in Section 31A-17-511, be the greater of the reserve as of such policy anniversary calculated as described in Subsection (1) and the reserve as of such policy anniversary calculated as described in that subsection, but with:

(i) the value defined in Subsection (1)(a) being reduced by 15% of the amount of such excess first year premium;

(ii) the present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date;

(iii) the policy being assumed to mature on such date as an endowment; and

(iv) the cash surrender value provided on such date being considered as an endowment benefit.

(b) In making the comparison described in Subsection (2)(a), the mortality and interest bases stated in Sections 31A-17-504 and 31A-17-506 shall be used.

(3) Reserves according to the commissioner's reserve valuation method for:

(a) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(b) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code;

(c) accident and health and accidental death benefits in all policies and contracts; and

(d) other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of Subsections (1) and (2).

Amended by Chapter 163, 2016 General Session

31A-17-508 Reserve valuation method -- Annuity and pure endowment benefits.

(1) This section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code.

(2) Reserves according to the commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any accident and health and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

Amended by Chapter 116, 2001 General Session

31A-17-509 Minimum reserves.

(1) In no event shall a company's aggregate reserves for life insurance policies, excluding accident and health and accidental death benefits, issued on or after January 1, 1994, be less than the aggregate reserves calculated in accordance with the methods set forth in Sections 31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-512 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(2) In no event shall the aggregate reserves for policies, contracts, and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by Section 31A-17-503.

Amended by Chapter 163, 2016 General Session

31A-17-510 Optional reserve calculation.

(1) Reserves for policies and contracts issued before January 1, 1994, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such policies and contracts than the minimum reserves required by the laws in effect immediately before that date. Reserves for any category of policies, contracts, or benefits as established by the commissioner, issued on or after January 1, 1994, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard provided in this part, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, may not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided in the policy or contract.

(2) Any such company which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this part may, with the approval of the commissioner, adopt any lower standard of valuation, but not lower than the minimum provided in this part, except that, for the purposes of this section, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required by Section 31A-17-503 may not be considered to be the adoption of a higher standard of valuation.

Amended by Chapter 163, 2016 General Session

31A-17-511 Reserve calculation -- Valuation net premium exceeding the gross premium charged.

(1) If in any contract year the gross premium charged by any company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in Sections 31A-17-504 and 31A-17-506.

(2) Provided that for any life insurance policy issued on or after January 1, 1997, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination of an endowment benefit and cash surrender value in an amount greater than such excess premium, this section shall be applied as if the method actually used in calculating the reserve for such policy were the method described in Section 31A-17-507, ignoring Subsection 31A-17-507(2). The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve

calculated in accordance with Section 31A-17-507, including Subsection 31A-17-507(2), and the minimum reserve calculated in accordance with this section.

Amended by Chapter 163, 2016 General Session

31A-17-512 Reserve calculation -- Indeterminate premium plans.

In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in Sections 31A-17-507, 31A-17-508, and 31A-17-511, the reserves which are held under any such plan shall:

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

(2) be computed by a method which is consistent with the principles of this part, as determined by rules promulgated by the commissioner.

Amended by Chapter 258, 2015 General Session

31A-17-513 Minimum standards for accident and health insurance contracts.

(1) For an accident and health insurance contract issued before the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the commissioner by rule.

(2) For an accident and health insurance contract issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under Subsection 31A-17-502(2).

Repealed and Re-enacted by Chapter 163, 2016 General Session

31A-17-514 Valuation manual for policies issued on or after the operative date of the valuation manual.

(1) For a policy issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under Subsection 31A-17-502(2), except as provided under Subsection (5) or (6).

(2) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(a) the valuation manual is adopted by the National Association of Insurance Commissioners by an affirmative vote of at least 42 members, or three-fourths of the members voting, whichever is greater;

(b) the Standard Valuation Law, as amended by the National Association of Insurance Commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than 75% of the direct premiums written as reported in the following annual statements submitted for 2008:

(i) life;

(ii) accident and health annual statements;

(iii) health annual statements; or

(iv) fraternal annual statements; and

(c) the Standard Valuation Law, as amended by the National Association of Insurance Commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions:

(i) the 50 states of the United States;
(ii) American Samoa;
(iii) the American Virgin Islands;
(iv) the District of Columbia;
(v) Guam; and
(vi) Puerto Rico.

(3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when the change to the valuation manual has been adopted by the National Association of Insurance Commissioners by an affirmative vote representing:

(a) at least three-fourths of the members of the National Association of Insurance Commissioners voting, but not less than a majority of the total membership; and

(b) members of the National Association of Insurance Commissioners representing jurisdictions totaling greater than 75% of the direct premiums written as reported in the following annual statements most recently available before the vote in Subsection (3)(a):

(i) life;
(ii) accident and health annual statements;
(iii) health annual statements; or
(iv) fraternal annual statements.

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

(a) minimum valuation standards for and definitions of a policy or contract subject to Subsection 31A-17-502(2), except such minimum valuation standards shall be:

(i) the commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to Subsection 31A-17-502(2);
(ii) the commissioner's annuity reserve valuation method for annuity contracts subject to Subsection 31A-17-502(2); and
(iii) minimum reserves for other policies or contracts subject to Subsection 31A-17-502(2);

(b) which policies or contracts or types of policies or contracts are subject to the requirements of a principle-based valuation in Subsection 31A-17-515(1) and the minimum valuation standards consistent with those requirements;

(c) for policies and contracts subject to a principle-based valuation under Section 31A-17-515:

(i) requirements for the format of reports to the commissioner under Subsection 31A-17-515(2)(c), which shall include information necessary to determine if the valuation is appropriate in compliance with this part;
(ii) prescribed assumptions for risks over which the company does not have significant control; and
(iii) procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures;

(d) for policies not subject to a principle-based valuation under Section 31A-17-515 the minimum valuation standard shall either:

(i) be consistent with the minimum standard of valuation before the operative date of the valuation manual; or
(ii) develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring;

(e) other requirements, including those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk

measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules, and internal controls; and

(f) the data and form of the data required under Section 31A-17-516, with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

(5) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this part, then the company shall, with respect to the requirement, comply with minimum valuation standards prescribed by the commissioner by rule.

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

(7) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or this part, and the company shall adjust the reserves as required by the commissioner. The commissioner may take other disciplinary action as permitted pursuant to Section 31A-2-308 and Title 63G, Chapter 4, Administrative Procedures Act.

Enacted by Chapter 163, 2016 General Session

31A-17-515 Requirements of a principle-based valuation.

(1) A company shall establish reserves using a principle-based valuation that meets the following conditions for a policy or contract as specified in the valuation manual:

(a) A company shall quantify the benefits and guarantees, and the funding, associated with the policy or contract and the policy's or contract's risks at a level of conservatism that reflects:

(i) conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the policies or contracts; and

(ii) for polices or contracts with significant tail risk, conditions appropriately adverse to quantify the tail risk.

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

(c) The company shall incorporate assumptions that are derived in one of the following manners:

(i) the assumption is prescribed in the valuation manual; and

(ii) for assumptions that are not prescribed, the assumptions shall:

(A) be established using the company's available experience, to the extent it is relevant and statistically credible; or

(B) to the extent that company data is not available, relevant, or statistically credible, be established using other relevant, statistically credible experience.

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

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

(a) establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;
(b) provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation:
(i) which controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual; and
(ii) the certification shall be based on the controls in place as of the end of the preceding calendar year; and
(c) develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.
(3) A principle-based valuation may include a prescribed formulaic reserve component.

Enacted by Chapter 163, 2016 General Session

31A-17-516 Experience reporting for policies in force on or after the operative date of the valuation manual.

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

Enacted by Chapter 163, 2016 General Session

31A-17-517 Confidentiality.

(1) For purposes of this section, "confidential information" means:
(a) a memorandum in support of an opinion submitted under Section 31A-17-503 and any other document, material, and other information, including working papers, and copies of a document, material, and other information, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the memorandum;
(b) a document, material, and other information, including working papers, and copies of a document, material, and other information created, produced, or obtained by or disclosed to the commissioner or any other person in the course of an examination made under Subsection 31A-17-514(6), except that if an examination report or other material prepared in connection with an examination made under Sections 31A-2-203 through 31A-2-205 is not held as private and confidential information under Sections 31A-2-203 through 31A-2-205, an examination report or other material prepared in connection with an examination made under Subsection 31A-17-514(6) may not be confidential information to the same extent as if the examination report or other material had been prepared under Sections 31A-2-203 through 31A-2-205;
(c) a report, document, material, or other information developed by a company in support of, or in connection with, an annual certification by the company under Subsection 31A-17-515(2)(b) evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other document, material, and other information, including working papers, and copies of the document, material, and other information, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such reports, documents, materials, and other information;
(d) any principle-based valuation report developed under Subsection 31A-17-515(2)(c) and any other document, material, and other information, including working papers, and copies of the

document, material, and other information, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such report; and

(e) any document, material, data, and other information submitted by a company under Section 31A-17-516, collectively, "experience data," and any other document, material, data, or other information, including working papers, and copies of the document, material, data, and information created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner, together with any "experience data," the "experience materials," and any other document, material, data, and other information, including working papers, and copies of the document, material, data, and other information created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such experience materials.

(2)

(a) Except as provided in this section, a company's confidential information is confidential, not public records, not open to public inspection, and not subject to Title 63G, Chapter 2, Government Records Access and Management Act.

(b) The commissioner is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties.

(c) In order to assist in the performance of the commissioner's duties, the commissioner may share confidential information:

(i) with other state, federal, and international regulatory agencies and with the National Association of Insurance Commissioners and its affiliates and subsidiaries;

(ii) in the case of confidential information specified in Subsections (1)(a) and (1)(d) only, with the Actuarial Board for Counseling and Discipline or its successor, upon request, stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal, and international law enforcement officials; and

(iii) in the case of Subsections (2)(c)(i) and (ii), provided that the recipient agrees, and has the legal authority to agree, to maintain the confidentiality of a document, material, data, and other information in the same manner and to the same extent as required for the commissioner.

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

(e) The commissioner may enter into agreements governing sharing and use of information consistent with this Subsection (2).

(f) No waiver of an applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection (2)(c).

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

(h) In this section "regulatory agency," "law enforcement agency," and the "National Association of Insurance Commissioners" include their employees, agents, consultants, and contractors.

(3) Notwithstanding Subsection (2), confidential information specified in Subsections (1)(a) and (1)(d):

(a) may be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary who submitted the related memorandum in support of an opinion submitted under Section 31A-17-503 or principle-based valuation report developed under Subsection 31A-17-515(2)(c) by reason of an action required by this part or by rules made under this part;

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

(c) once any portion of a memorandum in support of an opinion submitted under Section 31A-17-503 or a principle-based valuation report developed under Subsection 31A-17-515(2)(c) is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of the memorandum or report shall no longer be confidential.

Enacted by Chapter 163, 2016 General Session

31A-17-518 Single state exemption.

(1) The commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in Utah from the requirements of Section 31A-17-514 provided:

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

(b) the company computes reserves using assumptions and methods used before the operative date of the valuation manual in addition to any requirements established by the commissioner and made by rule.

(2) For any company granted an exemption under this section, Sections 31A-17-503, 31A-17-504, 31A-17-505, 31A-17-506, 31A-17-507, 31A-17-508, 31A-17-509, 31A-17-510, 31A-17-511, 31A-17-512, and 31A-17-513 are applicable. With respect to any company applying this exemption, any reference to Section 31A-17-514 found in Sections 31A-17-503, 31A-17-504, 31A-17-505, 31A-17-506, 31A-17-507, 31A-17-508, 31A-17-509, 31A-17-510, 31A-17-511, 31A-17-512, and 31A-17-513 is not applicable.

Enacted by Chapter 163, 2016 General Session

Part 6
Risk-Based Capital

31A-17-601 Definitions.

As used in this part:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with Subsection 31A-17-602(5).

(2) "Corrective order" means an order issued by the commissioner specifying corrective action that the commissioner determines is required.

(3) "Health organization" means:

(a) an entity that is authorized under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans; and
(b) that is:
(i) a health maintenance organization;
(ii) a limited health service organization;
(iii) a dental or vision plan;
(iv) a hospital, medical, and dental indemnity or service corporation; or
(v) other managed care organization.
(4) "Life or accident and health insurer" means:
(a) an insurance company licensed to write life insurance, accident and health insurance, or both; or
(b) a licensed property casualty insurer writing only disability insurance.
(5) "Property and casualty insurer" means any insurance company licensed to write lines of insurance other than life but does not include a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer.
(6) "RBC" means risk-based capital.
(7) "RBC instructions" means the RBC report including the National Association of Insurance Commissioner's risk-based capital instructions that govern the year for which an RBC report is prepared.
(8) "RBC level" means an insurer's or health organization's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC.
(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;
(b) "Company action level RBC" means the product of 2.0 and its authorized control level RBC;
(c) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC; and
(d) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.
(9)
(a) "RBC plan" means a comprehensive financial plan containing the elements specified in Subsection 31A-17-603(2).
(b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:
(i) the commissioner rejects the RBC plan; and
(ii) the plan is revised by the insurer or health organization, with or without the commissioner's recommendation.
(10) "RBC report" means the report required in Section 31A-17-602.

Amended by Chapter 198, 2022 General Session

31A-17-602 RBC reports -- RBC of life and accident and health insurers -- RBC of property and casualty insurers.

(1) Every domestic life or accident and health insurer, every domestic property and casualty insurer, and every domestic health organization shall:
(a) on or before March 1, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing the information as is required by the RBC instructions;
(b) file its RBC report with the insurance commissioner in any state in which the insurer or health organization is authorized to do business, if the insurance commissioner of that state notifies

the insurer or health organization of its request in writing, in which case the insurer or health organization may file its RBC report not later than the later of:
(i) 15 days from the receipt of notice to file its RBC report with that state; or
(ii) March 1; and
(c) file the documents described in Subsections (1)(a) and (b) with the National Association of Insurance Commissioners in accordance with RBC instructions.
(2) A life and accident and health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:
(a) the risk with respect to the insurer's assets;
(b) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;
(c) the interest rate risk with respect to the insurer's business; and
(d) all other business risks and other relevant risks as set forth in the RBC instructions.
(3) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account and may adjust for the covariance between:
(a) asset risk;
(b) credit risk;
(c) underwriting risk; and
(d) all other business risks and the other relevant risks as set forth in the RBC instructions.
(4) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account and may adjust for the covariance between:
(a) asset risk;
(b) credit risk;
(c) underwriting risk; and
(d) all other business risks and such other relevant risks as are set forth in the RBC instructions.
(5)
(a) If a domestic insurer files an RBC report that the commissioner determines is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment.
(b) The notice under Subsection (5)(a) shall contain a statement of the reason for the adjustment.
(6) The commissioner may make rules to assist in applying the provisions of this part to health organizations.

Amended by Chapter 116, 2001 General Session

31A-17-603 Company action level event.
(1) "Company action level event" means any of the following events:
(a) the filing of an RBC report by an insurer or health organization that indicates that:
(i) the insurer's or health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;
(ii) if a life insurer, accident and health insurer, or health organization, the insurer or health organization:
(A) has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the life, fraternal, or health RBC instructions; or

(iii) if a property and casualty insurer, the insurer has:

(A) total adjusted capital that is greater than or equal to its company action level RBC, but less than the product of its authorized control level RBC and 3.0; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the property and casualty RBC instructions;

(b) the notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates an event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607; or

(c) if, pursuant to Section 31A-17-607, an insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(2)

(a) In the event of a company action level event, the insurer or health organization shall prepare and submit to the commissioner an RBC plan that shall:

(i) identify the conditions that contribute to the company action level event;

(ii) contain proposals of corrective actions that the insurer or health organization intends to take and that are expected to result in the elimination of the company action level event;

(iii) provide projections of the insurer's or health organization's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of:

(A) statutory operating income;

(B) net income;

(C) capital;

(D) surplus; and

(E) RBC levels;

(iv) identify the key assumptions impacting the insurer's or health organization's projections and the sensitivity of the projections to the assumptions; and

(v) identify the quality of, and problems associated with, the insurer's or health organization's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(b) For purposes of Subsection (2)(a)(iii), the projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(3) The RBC plan shall be submitted:

(a) within 45 days of the company action level event; or

(b) if the insurer or health organization challenges an adjusted RBC report pursuant to Section 31A-17-607, within 45 days after notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(4)

(a) Within 60 days after the submission by an insurer or health organization of an RBC plan to the commissioner, the commissioner shall notify the insurer or health organization whether the RBC plan:

(i) shall be implemented; or

(ii) is unsatisfactory.

(b) If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer or health organization shall set forth the reasons for the determination, and may propose revisions that will render the RBC plan satisfactory. Upon notification from the commissioner, the insurer or health organization shall:
(i) prepare a revised RBC plan that incorporates any revision proposed by the commissioner; and
(ii) submit the revised RBC plan to the commissioner:
(A) within 45 days after the notification from the commissioner; or
(B) if the insurer challenges the notification from the commissioner under Section 31A-17-607, within 45 days after a notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.
(5) In the event of a notification by the commissioner to an insurer or health organization that the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may specify in the notification that the notification constitutes a regulatory action level event subject to the insurer's or health organization's right to a hearing under Section 31A-17-607.
(6) Every domestic insurer or health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer or health organization is authorized to do business if:
(a) the state has an RBC provision substantially similar to Subsection 31A-17-608(1); and
(b) the insurance commissioner of that state notifies the insurer or health organization of its request for the filing in writing, in which case the insurer or health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:
(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state; or
(ii) the date on which the RBC plan or revised RBC plan is filed under Subsections (3) and (4).

Amended by Chapter 168, 2017 General Session

31A-17-604 Regulatory action level event.
(1) "Regulatory action level event" means with respect to any insurer or health organization, any of the following events:
(a) the filing of an RBC report by the insurer or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;
(b) the notification by the commissioner to an insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607;
(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge;
(d) the failure of the insurer or health organization to file an RBC report by March 1, unless the insurer or health organization has:
(i) provided an explanation for the failure that is satisfactory to the commissioner; and
(ii) cured the failure within 10 days after March 1;

(e) the failure of the insurer or health organization to submit an RBC plan to the commissioner within the time period set forth in Subsection 31A-17-603(3);
(f) notification by the commissioner to the insurer or health organization that:
(i) the RBC plan or revised RBC plan submitted by the insurer or health organization is unsatisfactory; and
(ii) the notification constitutes a regulatory action level event with respect to the insurer or health organization, provided the insurer has not challenged the determination under Section 31A-17-607;
(g) if, pursuant to Section 31A-17-607, the insurer or health organization challenges a determination by the commissioner under Subsection (1)(f), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the challenge; or
(h) notification by the commissioner to the insurer or health organization that the insurer or health organization has failed to adhere to its RBC plan or revised RBC plan, but only if:
(i) the failure has a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan; and
(ii) the commissioner has so stated in the notification, provided the insurer or health organization has not challenged the determination under Section 31A-17-607; or
(iii) if, pursuant to Section 31A-17-607, the insurer or health organization challenges a determination by the commissioner under Subsection (1)(h), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the challenge.
(2) In the event of a regulatory action level event the commissioner shall:
(a) require the insurer or health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;
(b) perform any examination or analysis the commissioner considers necessary of the assets, liabilities, and operations of the insurer or health organization, including a review of its RBC plan or revised RBC plan; and
(c) subsequent to the examination or analysis, issue a corrective order specifying the corrective action the commissioner determines is required.
(3) In determining a corrective action, the commissioner may take into account such factors the commissioner considers relevant with respect to the insurer or health organization based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer or health organization, including the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:
(a) within 45 days after the occurrence of the regulatory action level event;
(b) if the insurer or health organization challenges an adjusted RBC report pursuant to Section 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45 days after the notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge; or
(c) if the insurer or health organization challenges a revised RBC plan pursuant to Section 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45 days after the notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

Amended by Chapter 116, 2001 General Session

31A-17-605 Authorized control level event.

(1) "Authorized control level event" means any of the following events:

(a) the filing of an RBC report by the insurer or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) the notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607;

(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge;

(d) the failure of the insurer or health organization to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the insurer or health organization has not challenged the corrective order under Section 31A-17-607; or

(e) if the insurer or health organization has challenged a corrective order under Section 31A-17-607 and the commissioner after a hearing rejects the challenge or modifies the corrective order, the failure of the insurer or health organization to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2)

(a) In the event of an authorized control level event with respect to an insurer or health organization, the commissioner shall:

(i) take any action required under Section 31A-17-604 regarding an insurer or health organization with respect to which a regulatory action level event has occurred; or

(ii) take any action as is necessary to cause the insurer or health organization to be placed under regulatory control under Chapter 27, Part 5, Administrative Actions, if the commissioner considers it to be in the best interests of:

(A) the policyholders or members;

(B) creditors of the insurer or health organization; and

(C) the public.

(b) If the commissioner takes an action described in Subsection (2)(a), the authorized control level event is sufficient grounds for the commissioner to take action under Chapter 27, Part 5, Administrative Actions, and the commissioner shall have the rights, powers, and duties with respect to the insurer or health organization set forth in Chapter 27, Part 5, Administrative Actions.

(c) If the commissioner takes an action under Subsection (2)(a) pursuant to an adjusted RBC report, the insurer or health organization is entitled to the protections afforded to an insurer or health organization under Section 31A-27-504 pertaining to an action by the commissioner.

Amended by Chapter 309, 2007 General Session

31A-17-606 Mandatory control level event.

(1) "Mandatory control level event" means any of the following events:

(a) the filing of an RBC report that indicates that the insurer's or health organization's total adjusted capital is less than its mandatory control level RBC;

(b) notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607; or

(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(2)

(a) In the event of a mandatory control level event with respect to an insurer or health organization, the commissioner shall take any actions necessary to place the insurer under regulatory control under Chapter 27, Part 5, Administrative Actions.

(b) The mandatory control level event is sufficient grounds for the commissioner to take action under Chapter 27, Part 5, Administrative Actions, and the commissioner shall have the rights, powers, and duties with respect to the insurer or health organization as are set forth in Chapter 27, Part 5, Administrative Actions.

(c) If the commissioner takes an action pursuant to an adjusted RBC report, the insurer or health organization is entitled to the protections of Section 31A-27-504 pertaining to summary proceedings.

(d) Notwithstanding the other provisions of Subsection (2), the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

Amended by Chapter 309, 2007 General Session

31A-17-607 Hearings.

(1)

(a) Following receipt of a notice described in Subsection (2), the insurer or health organization shall have the right to a confidential departmental hearing at which the insurer or health organization may challenge a determination or action by the commissioner.

(b) The insurer or health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under Subsection (2).

(c) Upon receipt of the insurer's or health organization's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than 30 days after the date of the insurer's or health organization's request.

(2) An insurer or health organization has the right to a hearing under Subsection (1) after:

(a) notification to an insurer or health organization by the commissioner of an adjusted RBC report;

(b) notification to an insurer or health organization by the commissioner that:

(i) the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer or health organization;

(c) notification to any insurer or health organization by the commissioner that the insurer or health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event with respect to the insurer or health organization in accordance with its RBC plan or revised RBC plan; or

(d) notification to an insurer or health organization by the commissioner of a corrective order with respect to the insurer or health organization.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

31A-17-608 Confidentiality -- Prohibition on announcements -- Prohibition on use in ratemaking.

(1)
(a) The commissioner shall keep confidential to the extent that information in a report or plan is not required to be included in a publicly available annual statement schedule, any detail in an RBC report or RBC plan including the results or report of any examination or analysis of an insurer or health organization performed pursuant to this part, that is filed by a domestic or foreign insurer or health organization with the commissioner or any corrective order issued by the commissioner pursuant to examination or analysis.
(b) Information kept confidential under Subsection (1)(a) may not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to this part or any other provision of the insurance laws of this state.

(2)
(a) Except as otherwise required under this part, any insurer or health organization, producer, or other person engaged in any manner in the insurance business may not publish, disseminate, circulate or place before the public, or cause, directly or indirectly, the publishing, disseminating, circulating or placing before the public including, in a newspaper, magazine, other publication, a notice, circular, pamphlet, letter, or poster, or over any radio or television station, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any insurer or health organization, or of any component derived in the calculation.
(b) If any materially false statement with respect to the comparison regarding an insurer's or health organization's total adjusted capital to its RBC levels, or an inappropriate comparison of any other amount to the insurer's or health organization's RBC levels is published in any written publication and the insurer or health organization is able to demonstrate to the commissioner with substantial proof the falsity of the statement or the inappropriateness, the insurer or health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement or inappropriate comparison.

(3) The commissioner may not use an RBC instruction, report, plan, or revised plan:
(a) for ratemaking;
(b) as evidence in any rate proceeding; or
(c) to calculate or derive any element of an appropriate premium level or rate of return for any line of insurance or coverage that an insurer or health organization or any affiliate is authorized to write or cover.

Amended by Chapter 298, 2003 General Session

31A-17-609 Alternate adjusted capital.

(1) Except as provided in Section 31A-17-602, an insurer or health organization licensed under Chapter 5, Domestic Stock and Mutual Insurance Corporations, Chapter 7, Nonprofit Health

Service Insurance Corporations, Chapter 8, Health Maintenance Organizations and Limited Health Plans, Chapter 9, Insurance Fraternals, and Chapter 14, Foreign Insurers, shall maintain total adjusted capital as defined in Section 31A-1-301 in an amount equal to the greater of:

(a) 175% of the minimum required capital, or of the minimum permanent surplus in the case of nonassessable mutuals, required by Section 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, or 31A-14-205; or

(b) the net total of:

(i) 10% of net insurance premiums earned during the year; plus

(ii) 5% of the admitted value of common stocks and real estate; plus

(iii) 2% of the admitted value of all other invested assets, exclusive of cash deposits, short-term investments, policy loans, and premium notes; less

(iv) the amount of any asset valuation reserve being maintained by the insurer or health organization, but not to exceed the sum of Subsections (1)(b)(ii) and (iii).

(2) As used in Subsection (1)(b), "premiums earned" means premiums and other consideration earned for insurance in the 12-month period ending on the date the calculation is made.

(3) The commissioner may consider an insurer or health organization to be financially hazardous under Subsection 31A-27a-207(1)(i), if the insurer or health organization does not have qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's liabilities and the total adjusted capital required by Subsection (1).

(4) The commissioner shall consider an insurer or health organization to be financially hazardous under Subsection 31A-27a-207(1)(i) if the insurer or health organization does not have qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's liabilities and 70% of the total adjusted capital required by Subsection (1).

Amended by Chapter 309, 2007 General Session

31A-17-610 Foreign insurers or health organizations.

(1)

(a) Any foreign insurer or health organization shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the most recent calendar year by the later of:

(i) the date an RBC report would be required to be filed by a domestic insurer or health organization under this part; or

(ii) 15 days after the request is received by the foreign insurer or health organization.

(b) Any foreign insurer or health organization shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(2)

(a) The commissioner may require a foreign insurer or health organization to file an RBC plan with the commissioner if:

(i) there is a company action level event, regulatory action level event, or authorized control level event with respect to the foreign insurer or health organization as determined under:

(A) the RBC statute applicable in the state of domicile of the insurer or health organization; or

(B) if no RBC statute is in force in that state, under this part; and

(ii) the insurance commissioner of the state of domicile of the foreign insurer or health organization fails to require the foreign insurer or health organization to file an RBC plan in the manner specified under:

(A) that state's RBC statute; or

(B) if no RBC statute is in force in that state, under Section 31A-17-603.

(b) If the commissioner requires a foreign insurer or health organization to file an RBC plan, the failure of the foreign insurer or health organization to file the RBC plan with the commissioner is grounds to order the insurer or health organization to cease and desist from writing new insurance business in this state.

(3) The commissioner may petition a court as permitted under Section 31A-27a-901 with respect to the liquidation of property of a foreign insurer or health organization found in this state if:

(a) a mandatory control level event occurs with respect to any foreign insurer or health organization; and

(b) no domiciliary receiver has been appointed with respect to the foreign insurer or health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer or health organization.

Amended by Chapter 401, 2023 General Session

31A-17-611 Immunity.

There may be no liability on the part of, and no cause of action may arise against, the commissioner or the insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under this part.

Enacted by Chapter 9, 1996 Special Session 2

Enacted by Chapter 9, 1996 Special Session 2

31A-17-612 Severability clause.

If any provision of this part, or the application of the part to any person or circumstance, is held invalid, the determination may not affect the provisions or applications of this part that can be given effect without the invalid provision or application, and to that end the provisions of this part are severable.

Enacted by Chapter 9, 1996 Special Session 2

Enacted by Chapter 9, 1996 Special Session 2

31A-17-613 Effective date of notice.

A notice by the commissioner to an insurer or health organization that may result in regulatory action under this chapter is effective the sooner of:

(1) the date the insurer or health organization receives the notice; or

(2) three days after mailing the notice.

Amended by Chapter 116, 2001 General Session