SENATE ENROLLED ACT No. 341

AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-1-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]:

Chapter 1.5. Incorporation by Reference in IC 27

Sec. 1. (a) This section applies only to a reference in this title that is published by the NAIC.

(b) If a document described in subsection (a) to which a provision of this title refers is amended after the later of:

(1) the date of publication of the version of the document that is referenced in this title; or

(2) January 1, 2018;

the commissioner shall, before implementing the amendment in the regulation of the business of insurance, report in an electronic format under IC 5-14-6 to the:

(1) legislative council; and

(2) standing committees of the house of representatives and the senate that consider insurance matters;

concerning the existence of the amendment.

(c) Upon reporting to the legislative council and standing committees under subsection (b), the commissioner may implement the reported amendment in the regulation of the business of insurance.

(d) Not later than October 31 of each year, the commissioner shall:

(1) compile a list of all amendments:

(A) described in subsection (b); and

(B) published after October 31 of the preceding year; and

(2) report the list to the legislative council and standing committees described in subsection (b) in an electronic format under IC 5-14-6.

Sec. 2. Except as otherwise provided in this title, a reference in this title to an Indiana statute is a reference to the statute:

(1) as added to the Indiana Code (or, in the case of a noncode statute, as enacted into law); or

(2) as amended;

whichever occurred most recently.

Sec. 3. Except as otherwise provided in this title, a reference in this title to an Indiana administrative rule is a reference to the rule:

(1) as added to the Indiana Administrative Code; or

(2) as amended;

whichever occurred most recently.

Sec. 4. Except as otherwise provided in this title, the following apply to a reference in this title to a federal statute or regulation:

(1) A reference that contains a citation to the:

(A) United States Code location of the federal statute; or

(B) Code of Federal Regulations location of the federal regulation;

is a reference to the federal statute or regulation as in effect on January 1, 2018.

(2) A reference that contains a citation to:

(A) the Public Law by which the federal statute was enacted; or

(B) the issue of the Federal Register that contains the final language of the federal regulation;

is a reference to the federal statute or regulation as in effect on the date of the Public Law or issue of the Federal Register.

Sec. 5. (a) Except as otherwise provided in this title or as reported under section 1 of this chapter, a reference:

(1) in this title; and

(2) to a document not described this chapter;

is a reference to the document as in effect on January 1, 2018.

(b) The department shall maintain, as a public record:

(1) an electronic version on the department's Internet web

site; and

(2) a paper copy;

of each document to which there is a reference in this title, including each version of a document that is amended over time.

Sec. 6. The references in this chapter and the definitions in this chapter apply throughout this title.

Sec. 7. "Accounting Practices and Procedures Manual" refers to the document entitled "Accounting Practices and Procedures Manual" that is:

(1) adopted by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 8. "AICPA Statements on Auditing Standards (SAS) 61, Communication with Audit Committees" refers to the provision entitled "Statement on Auditing Standards 61, Communication with Audit Committees" that is:

(1) published by the American Institute of Certified Public Accountants; and

(2) in effect on January 1, 2018.

Sec. 9. "American Cancer Society guidelines" refers to the guidelines published by the American Cancer Society that are in effect on January 1, 2018.

Sec. 10. "Annual Statement Blank" refers to the document entitled "Annual Statement Blank" that is:

(1) adopted by the NAIC;

(2) in effect on January 1, 2018; and

(3) applicable to the kind of insurance to which the information contained in the document applies.

Sec. 11. "Annual Statement Instructions" refers to the document entitled "Annual Statement Instructions" that is:

(1) adopted by the NAIC;

(2) in effect on January 1, 2018; and

(3) applicable to a particular Annual Statement Blank.

Sec. 12. "Current Dental Terminology" or "CDT" refers to the Current Dental Terminology coding system that is:

(1) published by the American Dental Association; and

(2) in effect on January 1, 2018.

Sec. 13. "Current Procedural Terminology" or "CPT" refers to the Current Procedural Terminology coding system that is:

(1) published by the American Medical Association; and

(2) in effect on January 1, 2018.

Sec. 14. "Diagnostic and Statistical Manual of Mental Disorders" or "DSM" refers to the document entitled "Diagnostic

and Statistical Manual of Mental Disorders of the American Psychiatric Association" that is in effect on January 1, 2018.

Sec. 15. "Financial Analysis Handbook" refers to the document entitled "Financial Analysis Handbook" that is:

(1) adopted by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 16. "Financial Condition Examiner's Handbook" refers to the document entitled "Financial Condition Examiner's Handbook" that is:

(1) adopted by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 17. "Financial Regulation Standards and Accreditation Program" refers to the accreditation program through which the NAIC certifies that state insurance departments have demonstrated compliance with legal, financial, organizational, licensing, and control standards established by the NAIC and described in the document entitled "Financial Regulation Standards and Accreditation Program" that is:

(1) adopted by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 18. "Healthcare Common Procedure Coding System" or "HCPCS" refers to the version of the Healthcare Common Procedure Coding System:

(1) the use of which is required by the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1301 et seq.); and

(2) that is in effect on January 1, 2018.

Sec. 19. "Insurance Regulatory Information System Ratios Manual" refers to the document entitled "Insurance Regulatory Information System Ratios Manual" that is:

(1) published by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 20. "International Classification of Diseases" or "ICD" refers to the International Classification of Diseases code book that is:

(1) published by the World Health Organization; and

(2) in effect on January 1, 2018.

Sec. 21. "Market Regulation Handbook" refers to the document entitled "Market Regulation Handbook" that is:

(1) adopted by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 22. "NAIC" refers to the National Association of Insurance

Commissioners.

Sec. 23. "NAIC Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix" refers to the document entitled "National Association of Insurance Commissioners Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix" that is:

(1) published by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 24. "National Committee on Quality Assurance standards or guidelines" refers to standards or guidelines for accreditation of health plans:

(1) that are published by the National Committee on Quality Assurance; and

(2) in effect on January 1, 2018.

Sec. 25. "Own Risk and Solvency Assessment Guidance Manual" or "ORSA Manual" refers to the document entitled "Own Risk and Solvency Assessment Guidance Manual" that is:

(1) adopted by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 26. "Purposes and Procedures Manual of the NAIC Investment Analysis Office" refers to the document entitled "Purposes and Procedures Manual of the NAIC Investment Analysis Office" that is:

(1) adopted by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 27. "Risk Based Capital Instructions" or "RBC Instructions" refers to the document entitled "Risk Based Capital Forecasting and Instructions" that is:

(1) adopted by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 28. "Securities Valuation Manual" refers to the document entitled "Securities Valuation Manual" that is:

(1) adopted by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 29. "Third party administrator" or "TPA" refers to the coding system that is:

(1) maintained by an applicable third party administrator; and

(2) in effect on January 1, 2018.

Sec. 30. "Uniform application" refers to the document entitled "Uniform Application for Individual Producer License/Registration" for resident and nonresident producer

licensing that is:

(1) published by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 31. "Uniform Application for Business Entity Adjusters" refers to the document entitled "Uniform Application for Business Entity Adjuster License/Registration" that is:

(1) published by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 32. "Uniform Application for Individual Adjusters" refers to the document entitled "Uniform Application for Individual Adjuster or Apprentice License/Registration" that is:

(1) published by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 33. "Uniform application for third party administrator license" refers to the document entitled "Uniform Application for Third Party Administrator License" that is:

(1) published by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 34. "Uniform business entity application" refers to the document entitled "Uniform Application for Business Entity License Renewal/Continuation" for resident and nonresident business entities that is:

(1) published by the NAIC; and

(2) in effect on January 1, 2018.

Sec. 35. "Valuation Manual" refers to the Valuation Manual that:

(1) was initially adopted by the NAIC on December 12, 2012; and

(2) is in effect on January 1, 2018.

SECTION 2. IC 27-1-3-13 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 13. (a) Each company authorized to conduct business in Indiana and required to file an annual statement with the department under IC 27-1-20-21 shall submit the company's statement on the ~~National Association of Insurance Commissioners (NAIC)~~ Annual Statement Blank prepared in accordance with ~~NAIC~~ Annual Statement Instructions, and following practices and procedures prescribed by the ~~most recent NAIC~~ Accounting Practices and Procedures Manual.

(b) To the extent that the ~~NAIC~~ Annual Statement Instructions require disclosure under subsection (a) of compensation paid to or on behalf of an insurer's officers, directors, or employees, the information may be filed with the department as an exhibit separate from the ~~annual~~

~~statement blank.~~ **Annual Statement Blank.** The compensation information described under this subsection shall be maintained by the department as confidential and may not be made public.

SECTION 3. IC 27-1-3.1-6 IS REPEALED [EFFECTIVE JULY 1, 2018]. ~~Sec. 6. As used in this chapter, "NAIC examiner's handbook" means the Examiners' Handbook adopted by the National Association of Insurance Commissioners.~~

SECTION 4. IC 27-1-3.1-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 8. (a) The commissioner or any of the commissioner's examiners:

(1) may conduct an examination under this chapter of any company as often as the commissioner, in the commissioner's sole discretion, considers appropriate; and

(2) shall, at a minimum, conduct an examination of every insurer licensed in Indiana at least once every five (5) years.

(b) In scheduling and determining the nature, scope, and frequency of the examinations, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the ~~NAIC examiner's handbook.~~ **Financial Condition Examiner's Handbook and the Market Regulation Handbook, whichever is applicable.**

(c) For purposes of completing an examination of any company under this chapter, the commissioner may examine or investigate any person, or the business of any person, in so far as such examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the company.

(d) In lieu of an examination under this chapter of any foreign or alien insurer licensed in Indiana, the commissioner may accept an examination report on such company as prepared by the insurance department of the company's state of domicile or port-of-entry state until January 1, 1994. After January 1, 1994, those reports may only be accepted if:

(1) the insurance department that prepared the report was at the time of the examination accredited under the ~~National Association of Insurance Commissioners'~~ Financial Regulation Standards and Accreditation Program; or

(2) the examination is performed with the participation of one (1) or more examiners who are employed by an accredited State Insurance Department and who after a review of the examination work papers and report state under oath that the examination was performed in a manner consistent with the standards and

procedures required by their insurance department.

SECTION 5. IC 27-1-3.1-9, AS AMENDED BY P.L.111-2008, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 9. (a) Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue an examination warrant appointing one (1) or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the ~~NAIC examiner's handbook.~~ **Financial Condition Examiner's Handbook and the Market Regulation Handbook.** The commissioner may also employ such other guidelines or procedures as the commissioner considers appropriate. The commissioner is not required to issue an examination warrant for a data call.

(b) Every company or person from whom information is sought, and the officers, directors, and agents of the company or person, must provide to the examiners appointed under subsection (a) timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company being examined. The officers, directors, employees, and agents of the company or person must facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees, or agents within the company's control, to submit to examination or to comply with any reasonable written request of the examiners, or the failure of any company to make a good faith effort to require compliance with such a request, is grounds for:

(1) suspension;

(2) refusal; or

(3) nonrenewal;

of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. The commissioner may proceed to suspend or revoke a license or authority upon the grounds set forth in this subsection under IC 27-1-3-10 or IC 27-1-3-19.

(c) The commissioner and the commissioner's examiners may issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to an examination conducted under this chapter. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter any order compelling the witness

to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

(d) When making an examination under this chapter, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners. The cost of retaining these examiners shall be borne by the company that is the subject of the examination.

(e) This chapter does not limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to this title. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

SECTION 6. IC 27-1-3.1-18 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 18. (a) The commissioner shall provide any financial analysis ratios computed by the Insurance Regulatory Information System ~~of the National Association of Insurance Commissioners~~ within five (5) business days after receiving a written request for those ratios.

(b) All examination synopses concerning insurance companies that are submitted to the department by the Insurance Regulatory Information System ~~of the National Association of Insurance Commissioners~~ are confidential and may not be disclosed by the department.

SECTION 7. IC 27-1-3.5-7, AS AMENDED BY P.L.146-2015, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 7. (a) The annual audited financial report filed by a domestic insurer under this chapter shall report:

(1) the financial position of the domestic insurer as of the end of the most recently ended calendar year; and

(2) the results of the domestic insurer's operations, cash flow, and changes in capital and surplus for that year;

in conformity with statutory accounting practices prescribed, or otherwise permitted, by the department of insurance.

(b) The financial statements included in the annual audited financial report filed by a domestic insurer under this chapter shall be examined by an independent auditor. The independent auditor shall conduct its examination of the domestic insurer's financial statements in accordance with generally accepted auditing standards, and shall consider such other procedures illustrated in the Financial Condition Examiner's Handbook ~~published by the National Association of Insurance Commissioners~~ as the independent auditor considers necessary.

(c) An annual audited financial report filed by a domestic insurer under this chapter must include the following:

(1) The report of the insurer's independent auditor.

(2) A balance sheet reporting admitted assets, liabilities, capital, and surplus.

(3) A statement of operations.

(4) A statement of cash flow.

(5) A statement of changes in capital and surplus.

(6) Notes to financial statements. The notes must be those required by the ~~National Association of Insurance Commissioners' annual statement instructions~~ **applicable Annual Statement Instructions** and any other notes required by statutory accounting practices, which must include a reconciliation of differences, if any, between the financial statements included in the audited financial report and the annual statement filed by the insurer under IC 27-1-20-21, including a written description of the nature of these differences.

(d) The financial statements included in a domestic insurer's audited financial report shall be prepared in the same form, and using language and groupings substantially the same, as the relevant sections of the annual statement of the insurer filed with the commissioner under IC 27-1-20-21.

(e) The financial statements included in a domestic insurer's audited financial report must be comparative, presenting the amounts as of December 31 of the year of the report and comparative amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an audited financial report under this chapter, the comparative data may be omitted.

SECTION 8. IC 27-1-3.5-12, AS AMENDED BY P.L.146-2015, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 12. (a) A domestic insurer required by this chapter to file an annual audited financial report with the commissioner shall also furnish the commissioner with a written communication describing any unremediated material weaknesses (as defined ~~by the NAIC Statement on Auditing Standard 60, Communication of Internal Control Related Matters Noted in an Audit)~~ **in the Accounting Practices and Procedures Manual)** in the domestic insurer's internal control over financial reporting as of the December 31 immediately preceding the audit (coinciding with the domestic insurer's annual audited financial report), noted during the audit. If no unremediated material weaknesses are noted during the audit, the communication must reflect that fact.

(b) The written communication required under subsection (a) must be prepared not later than sixty (60) days after the filing of the annual audited financial report.

(c) If a description of remedial actions taken or proposed to correct unremediated material weaknesses described under subsection (a) is not provided by the independent auditor, the domestic insurer shall provide a description of the remedial actions.

SECTION 9. IC 27-1-3.5-12.1, AS ADDED BY P.L.146-2015, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 12.1. (a) As used in this section, "independent", with respect to a member of an audit committee, means that the member, other than in the member's capacity as a member of the audit committee, the board of directors, or another board committee:

(1) does not accept a consulting fee, an advisory fee, or another compensatory fee from the domestic insurer or group of insurers; and

(2) is not an affiliate of the domestic insurer or group of insurers.

(b) This section does not apply to any of the following:

(1) A foreign insurer or an alien insurer that possesses a certificate of authority.

(2) A domestic insurer that is a SOX compliant entity.

(3) A wholly-owned subsidiary of a SOX compliant entity.

(c) The audit committee of a domestic insurer or group of insurers is directly responsible for the:

(1) appointment;

(2) compensation; and

(3) oversight of the work;

of the domestic insurer's or group of insurers' accountant, including resolution of disagreements between management and the accountant concerning financial reporting, for the purpose of preparing or issuing an annual audited financial report or related work under this chapter. Each accountant reports directly to the audit committee.

(d) The audit committee of a domestic insurer or group of insurers is responsible for:

(1) oversight of the domestic insurer's or group of insurers' internal audit function; and

(2) granting the person that performs the internal audit function suitable authority and resources to fulfill the person's responsibilities if required by section 12.3 of this chapter.

(e) The following apply to the membership of an audit committee:

(1) Each member shall be:

(A) a member of the board of directors of the domestic insurer;

or

(B) if the audit committee of the entity that controls a group of insurers serves as the audit committee of the domestic insurer or group of insurers, a member of the audit committee of the entity that controls the group of insurers.

(2) The percentage of independent members must meet the following minimum requirements:

(A) If the domestic insurer had direct written and assumed premiums during the immediately preceding calendar year of less than three hundred million dollars ($300,000,000), no minimum requirement applies.

(B) If the domestic insurer had direct written and assumed premiums during the immediately preceding calendar year of at least three hundred million dollars ($300,000,000) and less than five hundred million dollars ($500,000,000), at least fifty percent (50%) of the members must be independent members.

(C) If the domestic insurer had direct written and assumed premiums during the immediately preceding calendar year of at least five hundred million dollars ($500,000,000), at least seventy-five percent (75%) of the members must be independent members.

(f) If:

(1) state or federal law requires that a board of directors of a domestic insurer or group of insurers include otherwise nonindependent members; and

(2) an otherwise nonindependent member is not an officer or employee of the domestic insurer, group of insurers, or an affiliate of the domestic insurer or group of insurers;

the nonindependent member may serve as a member of an audit committee and be considered to be independent for audit committee purposes.

(g) If:

(1) a member of an audit committee of a domestic insurer ceases to be independent for reasons beyond the member's reasonable control; and

(2) the domestic insurer notifies the department of the cessation of independence;

the member may continue to serve as an audit committee member until the next annual meeting of the domestic insurer or one (1) year after the date on which the member's independence ceased, whichever occurs first.

(h) The ultimate controlling person of a domestic insurer may

designate the audit committee of the domestic insurer by providing written notice to each commissioner responsible for regulation of each affected insurer. The written notice must:

(1) be timely provided before the issuance of the annual audited financial report; and

(2) include a description of the basis for the designation.

(i) A designation:

(1) under subsection (h) may be changed with written notice from the domestic insurer to the commissioner, including a description of the basis for the designation; and

(2) under subsection (h) or this subsection remains in effect unless rescinded or changed.

(j) A domestic insurer's audit committee shall require the accountant that performs an audit required by this chapter to report to the audit committee in accordance with the requirements of AICPA Statements on Auditing Standards (SAS) 61, Communication with Audit Committees, ~~or its replacement,~~ including the following:

(1) All significant accounting policies and material permitted practices.

(2) All:

(A) material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the domestic insurer; and

(B) ramifications of the use of the alternative disclosures and treatments.

(3) The treatment described in subdivision (2) that is preferred by the accountant.

(4) Any other material written communication between the accountant and the management of the domestic insurer, including any management letter or schedule of unadjusted differences.

(k) If:

(1) a domestic insurer is a member of an insurance holding company system; and

(2) any substantial differences among insurers in the insurance holding company system are identified to the audit committee;

the reports required by subsection (j) may be provided to the audit committee on an aggregate basis for insurers in the holding company system.

(l) If a domestic insurer has direct written and assumed premiums (excluding premiums reinsured with the Federal Crop Insurance

Corporation and Federal Flood Program) of less than five hundred million dollars ($500,000,000), the domestic insurer may apply to the commissioner for a waiver from the audit committee requirements of this section based on hardship.

(m) A domestic insurer that receives a waiver under subsection (l) shall file the waiver, with the domestic insurer's annual statement filing, with the:

(1) commissioners of insurance in the states in which the domestic insurer is licensed or doing insurance business; and

(2) ~~National Association of Insurance Commissioners.~~ **NAIC.**

If another state has access to electronic filing with the ~~National Association of Insurance Commissioners,~~ **NAIC,** the domestic insurer shall file the waiver with the other state electronically in accordance with ~~National Association of Insurance Commissioners~~ **NAIC** electronic filing specifications.

SECTION 10. IC 27-1-4.1-6, AS ADDED BY P.L.146-2015, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 6. (a) An insurer or insurance group of which the insurer is a member shall, not later than June 1 of each calendar year, submit:

(1) to the commissioner; or

(2) if the insurer is a member of an insurance group, to the lead state commissioner of the insurance group (as determined by the procedures in the ~~most recent~~ Financial Analysis Handbook) ~~adopted by the NAIC)~~ according to the law of the lead state;

a CGAD.

(b) An insurer that is a member of an insurance group and not required to submit a CGAD to the commissioner under subsection (a) shall submit a CGAD to the commissioner upon the commissioner's request.

(c) A CGAD submitted under this section must include the signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting that to the best of the chief executive officer's or corporate secretary's knowledge the insurer has:

(1) implemented corporate governance procedures; and

(2) provided a copy of the CGAD to the insurer's board of directors or the appropriate committee of the board of directors.

SECTION 11. IC 27-1-4.1-8, AS ADDED BY P.L.146-2015, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 8. If a CGAD is submitted by an insurer as a member of an insurance group, the lead state commissioner of the insurance group (as determined by the procedures in the ~~most recent~~

Financial Analysis Handbook) ~~adopted by the NAIC)~~ shall:

(1) review a CGAD submitted under section 6 of this chapter; and

(2) make any requests for additional information.

SECTION 12. IC 27-1-12-2, AS AMENDED BY P.L.89-2011, SECTION 29, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. (a) The following definitions apply to this section:

(1) "Acceptable collateral" means, as to securities lending transactions:

(A) cash;

(B) cash equivalents;

(C) letters of credit; and

(D) direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, including the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation.

(2) "Acceptable collateral" means, as to lending foreign securities, sovereign debt that is rated:

(A) A- or higher by Standard & Poor's Corporation;

(B) A3 or higher by Moody's Investors Service, Inc.;

(C) A- or higher by Duff and Phelps, Inc.; or

(D) 1 by the Securities Valuation Office.

(3) "Acceptable collateral" means, as to repurchase transactions:

(A) cash;

(B) cash equivalents; and

(C) direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, including the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation.

(4) "Acceptable collateral" means, as to reverse repurchase transactions:

(A) cash; and

(B) cash equivalents.

(5) "Admitted assets" means assets permitted to be reported as admitted assets on the statutory financial statement of the life insurance company most recently required to be filed with the commissioner.

(6) "Business entity" means:

(A) a sole proprietorship;

(B) a corporation;

(C) a limited liability company;
(D) an association;
(E) a partnership;
(F) a joint stock company;
(G) a joint venture;
(H) a mutual fund;
(I) a trust;
(J) a joint tenancy; or
(K) other, similar form of business organization;
whether organized for-profit or not-for-profit.

(7) "Cash" means any of the following:
(A) United States denominated paper currency and coins.
(B) Negotiable money orders and checks.
(C) Funds held in any time or demand deposit in any depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(8) "Cash equivalent" means any of the following:
(A) A certificate of deposit issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.
(B) A banker's acceptance issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.
(C) A government money market mutual fund.
(D) A class one money market mutual fund.

(9) "Class one money market mutual fund" means a money market mutual fund that at all times qualifies for investment pursuant to the ~~"Purposes and Procedures of the Securities Valuation Office" or any successor publication~~ **Purposes and Procedures Manual of the NAIC Investment Analysis Office** either using the bond class one reserve factor or because it is exempt from asset valuation reserve requirements.

(10) "Dollar roll transaction" means two (2) simultaneous transactions that have settlement dates not more than ninety-six (96) days apart and that meet the following description:
(A) In one (1) transaction, a life insurance company sells to a business entity one (1) or both of the following:
(i) Asset-backed securities that are issued, assumed, or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation. ~~or the successor of an entity referred to in this item.~~

(ii) Other asset-backed securities referred to in Section 106 of Title I of the Secondary Mortgage Market Enhancement Act of 1984 (15 U.S.C. 77r-1). ~~as amended.~~

(B) In the other transaction, the life insurance company is obligated to purchase from the same business entity securities that are substantially similar to the securities sold under clause (A).

(11) "Domestic jurisdiction" means:

(A) the United States;

(B) any state, territory, or possession of the United States;

(C) the District of Columbia;

(D) Canada; or

(E) any province of Canada.

(12) "Earnings available for fixed charges" means income, after deducting:

(A) operating and maintenance expenses other than expenses that are fixed charges;

(B) taxes other than federal and state income taxes;

(C) depreciation; and

(D) depletion;

but excluding extraordinary nonrecurring items of income or expense appearing in the regular financial statements of a business entity.

(13) "Fixed charges" includes:

(A) interest on funded and unfunded debt;

(B) amortization of debt discount; and

(C) rentals for leased property.

(14) "Foreign currency" means a currency of a foreign jurisdiction.

(15) "Foreign jurisdiction" means a jurisdiction other than a domestic jurisdiction.

(16) "Government money market mutual fund" means a money market mutual fund that at all times:

(A) invests only in:

(i) obligations that are issued, guaranteed, or insured by the United States; or

(ii) collateralized repurchase agreements composed of obligations that are issued, guaranteed, or insured by the United States; and

(B) qualifies for investment without a reserve pursuant to the ~~"Purposes and Procedures of the Securities Valuation Office" or any successor publication.~~ **Purposes and Procedures**

Manual of the NAIC Investment Analysis Office.

(17) "Guaranteed or insured," when used in reference to an obligation acquired under this section, means that the guarantor or insurer has agreed to:

(A) perform or insure the obligation of the obligor or purchase the obligation; or

(B) be unconditionally obligated, until the obligation is repaid, to maintain in the obligor a minimum net worth, fixed charge coverage, stockholders' equity, or sufficient liquidity to enable the obligor to pay the obligation in full.

(18) "Investment company" means:

(A) an investment company as defined in Section 3(a) of the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.); ~~as amended;~~ or

(B) a person described in Section 3(c) of the Investment Company Act of 1940 **(15 U.S.C. 80a-1 et seq.).**

(19) "Investment company series" means an investment portfolio of an investment company that is organized as a series company to which assets of the investment company have been specifically allocated.

(20) "Letter of credit" means a clean, irrevocable, and unconditional letter of credit that is:

(A) issued or confirmed by; and

(B) payable and presentable at;

a financial institution on the list of financial institutions meeting the standards for issuing letters of credit under the ~~"Purposes and Procedures of the Securities Valuation Office" or any successor publication.~~ **Purposes and Procedures Manual of the NAIC Investment Analysis Office.** To constitute acceptable collateral for the purposes of paragraph 29 of subsection (b), a letter of credit must have an expiration date beyond the term of the subject transaction.

(21) "Market value" means the following:

(A) As to cash, the amount of the cash.

(B) As to cash equivalents, the amount of the cash equivalents.

(C) As to letters of credit, the amount of the letters of credit.

(D) As to a security as of any date:

(i) the price for the security on that date obtained from a generally recognized source, or the most recent quotation from such a source; or

(ii) if no generally recognized source exists, the price for the security as determined in good faith by the parties to a

transaction;

plus accrued but unpaid income on the security to the extent not included in the price as of that date.

(22) "Money market mutual fund" means a mutual fund that meets the conditions of 17 CFR 270.2a-7, under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(23) "Multilateral development bank" means an international development organization of which the United States is a member.

(24) "Mutual fund" means:

(A) an investment company; or

(B) in the case of an investment company that is organized as a series company, an investment company series;

that is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(25) "Obligation" means any of the following:

(A) A bond.

(B) A note.

(C) A debenture.

(D) Any other form of evidence of debt.

(26) "Person" means:

(A) an individual;

(B) a business entity;

(C) a multilateral development bank; or

(D) a government or quasi-governmental body, such as a political subdivision or a government sponsored enterprise.

(27) "Repurchase transaction" means a transaction in which a life insurance company purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the life insurance company at a specified price, either within a specified period of time or upon demand.

(28) "Reverse repurchase transaction" means a transaction in which a life insurance company sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

(29) "Securities lending transaction" means a transaction in which securities are loaned by a life insurance company to a business entity that is obligated to return the loaned securities or equivalent securities to the life insurance company, either within a specified

period of time or upon demand.

(30) "Securities Valuation Office" refers to

~~(A)~~ the Securities Valuation Office of the ~~National Association of Insurance Commissioners;~~ ~~or~~

~~(B) any successor of the office referred to in Clause (A) established by the National Association of Insurance Commissioners.~~ **NAIC.**

(31) "Series company" means an investment company that is organized as a series company (as defined in Rule 18f-2(a) adopted under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.)). ~~as amended).~~

(32) "Supported", when used in reference to an obligation, by whomever issued or made, means that:

(A) repayment of the obligation by:

(i) a domestic jurisdiction or by an administration, agency, authority, or instrumentality of a domestic jurisdiction; or

(ii) a business entity;

as the case may be, is secured by real or personal property of value at least equal to the principal amount of the obligation by means of mortgage, assignment of vendor's interest in one (1) or more conditional sales contracts, other title retention device, or by means of other security interest in such property for the benefit of the holder of the obligation; and

(B) the:

(i) domestic jurisdiction or administration, agency, authority, or instrumentality of the domestic jurisdiction; or

(ii) business entity;

as the case may be, has entered into a firm agreement to rent or use the property pursuant to which it is obligated to pay money as rental or for the use of such property in amounts and at times which shall be sufficient, after provision for taxes upon and other expenses of use of the property, to repay in full the obligation with interest and when such agreement and the money obligated to be paid thereunder are assigned, pledged, or secured for the benefit of the holder of the obligation. However, where the security for the repayment of the obligation consists of a first mortgage lien or deed of trust on a fee interest in real property, the obligation may provide for the amortization, during the initial, fixed period of the lease or contract, of less than one hundred percent (100%) of the obligation if there is pledged or assigned, as additional security for the obligation, sufficient rentals payable under the

lease, or of contract payments, to secure the amortized obligation payments required during the initial, fixed period of the lease or contract, including but not limited to payments of principal, interest, and taxes other than the income taxes of the borrower, and if there is to be left unamortized at the end of such period an amount not greater than the original appraised value of the land only, exclusive of all improvements, as prescribed by law.

(b) Investments of domestic life insurance companies at the time they are made shall conform to the following categories, conditions, limitations, and standards:

1. Obligations of a domestic jurisdiction or of any administration, agency, authority, or instrumentality of a domestic jurisdiction.

2. Obligations guaranteed, supported, or insured as to principal and interest by a domestic jurisdiction or by an administration, agency, authority, or instrumentality of a domestic jurisdiction.

3. Obligations issued under or pursuant to the Farm Credit Act of 1971 (12 U.S.C. 2001 through 2279aa-14) as in effect on December 31, 1990, or the Federal Home Loan Bank Act (12 U.S.C. 1421 through 1449) as in effect on December 31, 1990, interest bearing obligations of the FSLIC Resolution Fund or shares of any institution whose deposits are insured by the Federal Deposit Insurance Corporation to the extent that such shares are insured, obligations issued or guaranteed by a multilateral development bank, and obligations issued or guaranteed by the African Development Bank.

4. Obligations issued, guaranteed, or insured as to principal and interest by a city, county, drainage district, road district, school district, tax district, town, township, village, or other civil administration, agency, authority, instrumentality, or subdivision of a domestic jurisdiction, providing such obligations are authorized by law and are:

(a) direct and general obligations of the issuing, guaranteeing or insuring governmental unit, administration, agency, authority, district, subdivision, or instrumentality;

(b) payable from designated revenues pledged to the payment of the principal and interest thereof; or

(c) improvement bonds or other obligations constituting a first lien, except for tax liens, against all of the real estate within the improvement district or on that part of such real estate not discharged from such lien through payment of the assessment. The area to which such improvement bonds or other obligations relate shall be situated within the limits of a town or city and at least fifty percent (50%) of the properties within such area shall

be improved with business buildings or residences.

5. Loans evidenced by obligations secured by first mortgage liens on otherwise unencumbered real estate or otherwise unencumbered leaseholds having at least fifty (50) years of unexpired term, such real estate, or leaseholds to be located in a domestic jurisdiction. Such loans shall not exceed eighty percent (80%) of the fair value of the security determined in a manner satisfactory to the department, except that the percentage stated may be exceeded if and to the extent such excess is guaranteed or insured by:

(a) a domestic jurisdiction or by an administration, agency, authority, or instrumentality of any domestic jurisdiction; or

(b) a private mortgage insurance corporation approved by the department.

If improvements constitute a part of the value of the real estate or leaseholds, such improvements shall be insured against fire for the benefit of the mortgagee in an amount not less than the difference between the value of the land and the unpaid balance of the loan.

For the purpose of this section, real estate or a leasehold shall not be deemed to be encumbered by reason of the existence in relation thereto of:

(1) liens inferior to the lien securing the loan made by the life insurance company;

(2) taxes or assessment liens not delinquent;

(3) instruments creating or reserving mineral, oil, water or timber rights, rights-of-way, common or joint driveways, sewers, walls, or utility connections;

(4) building restrictions or other restrictive covenants; or

(5) an unassigned lease reserving rents or profits to the owner.

A loan that is authorized by this paragraph remains qualified under this paragraph notwithstanding any refinancing, modification, or extension of the loan. Investments authorized by this paragraph shall not in the aggregate exceed forty-five percent (45%) of the life insurance company's admitted assets.

6. Loans evidenced by obligations guaranteed or insured, but only to the extent guaranteed or insured, by a domestic jurisdiction or by any agency, administration, authority, or instrumentality of any domestic jurisdiction, and secured by second or subsequent mortgages or deeds of trust on real estate or leaseholds, provided the terms of the leasehold mortgages or deeds of trust shall not exceed four-fifths (4/5) of the unexpired lease term, including enforceable renewable options remaining at the time of the loan.

7. Real estate contracts involving otherwise unencumbered real

estate situated in a domestic jurisdiction, to be secured by the title to such real estate, which shall be transferred to the life insurance company or to a trustee or nominee of its choosing. For statement and deposit purposes, the value of a contract acquired pursuant to this paragraph shall be whichever of the following amounts is the least:

(a) eighty percent (80%) of the contract price of the real estate;

(b) eighty percent (80%) of the fair value of the real estate at the time the contract is purchased, such value to be determined in a manner satisfactory to the department; or

(c) the amount due under the contract.

For the purpose of this paragraph, real estate shall not be deemed encumbered by reason of the existence in relation thereto of: (1) taxes or assessment liens not delinquent; (2) instruments creating or reserving mineral, oil, water or timber rights, rights-of-way, common or joint driveways, sewers, walls or utility connections; (3) building restrictions or other restrictive covenants; or (4) an unassigned lease reserving rents or profits to the owner. Fire insurance upon improvements constituting a part of the real estate described in the contract shall be maintained in an amount at least equal to the unpaid balance due under the contract or the fair value of improvements, whichever is the lesser.

8. Improved or unimproved real property, whether encumbered or unencumbered, or any interest therein, held directly or evidenced by joint venture interests, general or limited partnership interests, trust certificates, or any other instruments, and acquired by the life insurance company as an investment, which real property, if unimproved, is developed within five (5) years. Real property acquired for investment under this paragraph, whether leased or intended to be developed for commercial or residential purposes or otherwise lawfully held, is subject to the following conditions and limitations:

(a) The real estate shall be located in a domestic jurisdiction.

(b) The admitted assets of the life insurance company must exceed twenty-five million dollars ($25,000,000).

(c) The life insurance company shall have the right to expend from time to time whatever amount or amounts may be necessary to conform the real estate to the needs and purposes of the lessee and the amount so expended shall be added to and become a part of the investment in such real estate.

(d) The value for statement and deposit purposes of an investment under this paragraph shall be reduced annually by amortization of the costs of improvement and development, less land costs, over the expected life of the property, which value and amortization

shall for statement and deposit purposes be determined in a manner satisfactory to the commissioner. In determining such value with respect to the calendar years in which an investment begins or ends with respect to a point in time other than the beginning or end of a calendar year, the amortization provided above shall be made on a proportional basis.

(e) Fire insurance shall be maintained in an amount at least equal to the insurable value of the improvements or the difference between the value of the land and the value at which such real estate is carried for statement and deposit purposes, whichever amount is smaller.

(f) Real estate acquired in any of the manners described and sanctioned under section 3 of this chapter, or otherwise lawfully held, except paragraph 5 of that section which specifically relates to the acquisition of real estate under this paragraph, shall not be affected in any respect by this paragraph unless such real estate at or subsequent to its acquisition fulfills the conditions and limitations of this paragraph, and is declared by the life insurance company in a writing filed with the department to be an investment under this paragraph. The value of real estate acquired under section 3 of this chapter, or otherwise lawfully held, and invested under this paragraph shall be initially that at which it was carried for statement and deposit purposes under that section.

(g) Neither the cost of each parcel of improved real property nor the aggregate cost of all unimproved real property acquired under the authority of this paragraph may exceed two percent (2%) of the life insurance company's admitted assets. For purposes of this paragraph, "unimproved real property" means land containing no structures intended for commercial, industrial, or residential occupancy, and "improved real property" consists of all land containing any such structure. When applying the limitations of subparagraph (d) of this paragraph, unimproved real property becomes improved real property as soon as construction of any commercial, industrial, or residential structure is so completed as to be capable of producing income. In the event the real property is mortgaged with recourse to the life insurance company or the life insurance company commences a plan of construction upon real property at its own expense or guarantees payment of borrowed funds to be used for such construction, the total project cost of the real property will be used in applying the two percent (2%) test. Further, no more than ten percent (10%) of the life insurance company's admitted assets may be invested in all

property, measured by the property value for statement and deposit purposes as defined in this paragraph, held under this paragraph at the same time.

9. Deposits of cash in a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation, or certificates of deposit issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

10. Bank and bankers' acceptances and other bills of exchange of kinds and maturities eligible for purchase or rediscount by federal reserve banks.

11. Obligations that are issued, guaranteed, assumed, or supported by a business entity organized under the laws of a domestic jurisdiction and that are rated:

(a) BBB- or higher by Standard & Poor's Corporation (or A-2 or higher in the case of commercial paper);

(b) Baa 3 or higher by Moody's Investors Service, Inc. (or P-2 or higher in the case of commercial paper);

(c) BBB- or higher by Duff and Phelps, Inc. (or D-2 or higher in the case of commercial paper); or

(d) 1 or 2 by the Securities Valuation Office.

Investments may also be made under this paragraph in obligations that have not received a rating if the earnings available for fixed charges of the business entity for the period of its five (5) fiscal years next preceding the date of purchase shall have averaged per year not less than one and one-half (1 1/2) times its average annual fixed charges applicable to such period and if during either of the last two (2) years of such period such earnings available for fixed charges shall have been not less than one and one-half (1 1/2) times its fixed charges for such year. However, if the business entity is a finance company or other lending institution at least eighty percent (80%) of the assets of which are cash and receivables representing loans or discounts made or purchased by it, the multiple shall be one and one-quarter (1 1/4) instead of one and one-half (1 1/2).

11.(A) Obligations issued, guaranteed, or assumed by a business entity organized under the laws of a domestic jurisdiction, which obligations have not received a rating or, if rated, have not received a rating that would qualify the obligations for investment under paragraph 11 of this section. Investments authorized by this paragraph may not exceed ten percent (10%) of the life insurance company's admitted assets.

12. Preferred stock of, or common or preferred stock guaranteed as to dividends by, any corporation organized under the laws of a

domestic jurisdiction, which over the period of the seven (7) fiscal years immediately preceding the date of purchase earned an average amount per annum at least equal to five percent (5%) of the par value of its common and preferred stock (or, in the case of stocks having no par value, of its issued or stated value) outstanding at date of purchase, or which over such period earned an average amount per annum at least equal to two (2) times the total of its annual interest charges, preferred dividends and dividends guaranteed by it, determined with reference to the date of purchase. No investment shall be made under this paragraph in a stock upon which any dividend is in arrears or has been in arrears for ninety (90) days within the immediately preceding five (5) year period.

13. Common stock of any solvent corporation organized under the laws of a domestic jurisdiction which over the seven (7) fiscal years immediately preceding purchase earned an average amount per annum at least equal to six percent (6%) of the par value of its capital stock (or, in the case of stock having no par value, of the issued or stated value of such stock) outstanding at date of purchase, but the conditions and limitations of this paragraph shall not apply to the special area of investment to which paragraph 23 of this section pertains.

13.(A) Stock or shares of any mutual fund that:

(a) has been in existence for a period of at least five (5) years immediately preceding the date of purchase, has assets of not less than twenty-five million dollars ($25,000,000) at the date of purchase, and invests substantially all of its assets in investments permitted under this section; or

(b) is a class one money market mutual fund or a class one bond mutual fund.

Investments authorized by this paragraph 13(A) in mutual funds having the same or affiliated investment advisers shall not at any one (1) time exceed in the aggregate ten percent (10%) of the life insurance company's admitted assets. The limitations contained in paragraph 22 of this subsection apply to investments in the types of mutual funds described in subparagraph (a). For the purposes of this paragraph, "class one bond mutual fund" means a mutual fund that at all times qualifies for investment using the bond class one reserve factor under the ~~"Purposes and Procedures of the Securities Valuation Office" or any successor publication.~~ **Purposes and Procedures Manual of the NAIC Investment Analysis Office.**

The aggregate amount of investments under this paragraph may be limited by the commissioner if the commissioner finds that investments under this paragraph may render the operation of the life insurance

company hazardous to the company's policyholders or creditors or to the general public.

14. Loans upon the pledge of any of the investments described in this section other than real estate and those qualifying solely under paragraph 20 of this subsection, but the amount of such a loan shall not exceed seventy-five percent (75%) of the value of the investment pledged.

15. Real estate acquired or otherwise lawfully held under the provisions of IC 27-1, except under paragraph 7 or 8 of this subsection, which real estate as an investment shall also include the value of improvements or betterments made thereon subsequent to its acquisition. The value of such real estate for deposit and statement purposes is to be determined in a manner satisfactory to the department.

15.(A) Tangible personal property, equipment trust obligations, or other instruments evidencing an ownership interest or other interest in tangible personal property when the life insurance company purchasing such property has admitted assets in excess of twenty-five million dollars ($25,000,000), and where there is a right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use of such personal property from a corporation whose obligations would be eligible for investment under the provisions of paragraph 11 of this subsection, provided that the aggregate of such payments together with the estimated salvage value of such property at the end of its minimum useful life, to be determined in a manner acceptable to the insurance commissioner, and the estimated tax benefits to the insurer resulting from ownership of such property, is adequate to return the cost of the investment in such property, and provided further, that each net investment in tangible personal property for which any single private corporation is obligated to pay rental, purchase, or other obligatory payments thereon does not exceed one-half of one percent (1/2%) of the life insurance company's admitted assets, and the aggregate net investments made under the provisions of this paragraph do not exceed five percent (5%) of the life insurance company's admitted assets.

16. Loans to policyholders of the life insurance company in amounts not exceeding in any case the reserve value of the policy at the time the loan is made.

17. A life insurance company doing business in a foreign jurisdiction may, if permitted or required by the laws of such jurisdiction, invest funds equal to its obligations in such jurisdiction in investments legal for life insurance companies domiciled in such

jurisdiction or doing business therein as alien companies.

17.(A) Investments in (i) obligations issued, guaranteed, assumed, or supported by a foreign jurisdiction or by a business entity organized under the laws of a foreign jurisdiction and (ii) preferred stock and common stock issued by any such business entity, if the obligations of such foreign jurisdiction or business entity, as appropriate, are rated:

(a) BBB- or higher by Standard & Poor's Corporation (or A-2 or higher in the case of commercial paper);

(b) Baa 3 or higher by Moody's Investors Service, Inc. (or P-2 or higher in the case of commercial paper);

(c) BBB- or higher by Duff and Phelps, Inc. (or D-2 or higher in the case of commercial paper); or

(d) 1 or 2 by the Securities Valuation Office.

If the obligations issued by a business entity organized under the laws of a foreign jurisdiction have not received a rating, investments may nevertheless be made under this paragraph in such obligations and in the preferred and common stock of the business entity if the earnings available for fixed charges of the business entity for a period of five (5) fiscal years preceding the date of purchase have averaged at least three (3) times its average fixed charges applicable to such period, and if during either of the last two (2) years of such period, the earnings available for fixed charges were at least three (3) times its fixed charges for such year. Investments authorized by this paragraph in a single foreign jurisdiction shall not exceed ten percent (10%) of the life insurance company's admitted assets. Subject to section 2.2(g) of this chapter, investments authorized by this paragraph denominated in foreign currencies shall not in the aggregate exceed ten percent (10%) of a life insurance company's admitted assets, and investments in any one (1) foreign currency shall not exceed five percent (5%) of the life insurance company's admitted assets. Investments authorized by this paragraph and paragraph 17(B) shall not in the aggregate exceed twenty percent (20%) of the life insurance company's admitted assets. This paragraph in no way limits or restricts investments which are otherwise specifically eligible for deposit under this section.

17.(B) Investments in:

(a) obligations issued, guaranteed, or assumed by a foreign jurisdiction or by a business entity organized under the laws of a foreign jurisdiction; and

(b) preferred stock and common stock issued by a business entity organized under the laws of a foreign jurisdiction;

which investments are not eligible for investment under paragraph 17.(A).

Investments authorized by this paragraph 17(B) shall not in the aggregate exceed five percent (5%) of the life insurance company's admitted assets. Subject to section 2.2(g) of this chapter, if investments authorized by this paragraph 17(B) are denominated in a foreign currency, the investments shall not, as to such currency, exceed two percent (2%) of the life insurance company's admitted assets. Investments authorized by this paragraph 17(B) in any one (1) foreign jurisdiction shall not exceed two percent (2%) of the life insurance company's admitted assets.

Investments authorized by paragraph 17(A) of this subsection and this paragraph 17(B) shall not in the aggregate exceed twenty percent (20%) of the life insurance company's admitted assets.

18. To protect itself against loss, a company may in good faith receive in payment of or as security for debts due or to become due, investments or property which do not conform to the categories, conditions, limitations, and standards set out above.

19. A life insurance company may purchase for its own benefit any of its outstanding annuity or insurance contracts or other obligations and the claims of holders thereof.

20. A life insurance company may make investments although not conforming to the categories, conditions, limitations, and standards contained in paragraphs 1 through 11, 12 through 19, and 29 through 31 of this subsection, but limited in aggregate amount to the lesser of:

(a) ten percent (10%) of the company's admitted assets; or

(b) the aggregate of the company's capital, surplus, and contingency reserves reported on the statutory financial statement of the insurer most recently required to be filed with the commissioner.

This paragraph 20 does not apply to investments authorized by paragraph 11.(A) of this subsection.

20.(A) Investments under paragraphs 1 through 20 and paragraphs 29 through 31 of this subsection are subject to the general conditions, limitations, and standards contained in paragraphs 21 through 28 of this subsection.

21. Investments in obligations (other than real estate mortgage indebtedness) and capital stock of, and in real estate and tangible personal property leased to, a single corporation, shall not exceed two percent (2%) of the life insurance company's admitted assets, taking into account the provisions of section 2.2(h) of this chapter. The conditions and limitations of this paragraph shall not apply to investments under paragraph 13(A) of this subsection or the special area of investment to which paragraph 23 of this subsection pertains.

22. Investments in:

(a) preferred stock; and

(b) common stock;

shall not, in the aggregate, exceed twenty percent (20%) of the life insurance company's admitted assets, exclusive of assets held in segregated accounts of the nature defined in class 1(c) of IC 27-1-5-1. These limitations shall not apply to investments for the special purposes described in paragraph 23 of this subsection nor to investments in connection with segregated accounts provided for in class 1(c) of IC 27-1-5-1.

23. Investments in subsidiary companies must be made in accordance with IC 27-1-23-2.6.

24. No investment, other than commercial bank deposits and loans on life insurance policies, shall be made unless authorized by the life insurance company's board of directors or a committee designated by the board of directors and charged with the duty of supervising loans or investments.

25. No life insurance company shall subscribe to or participate in any syndicate or similar underwriting of the purchase or sale of securities or property or enter into any transaction for such purchase or sale on account of said company, jointly with any other corporation, firm, or person, or enter into any agreement to withhold from sale any of its securities or property, but the disposition of its assets shall at all times be within its control. Nothing contained in this paragraph shall be construed to invalidate or prohibit an agreement by two (2) or more companies to join and share in the purchase of investments for bona fide investment purposes.

26. No life insurance company may invest in the stocks or obligations, except investments under paragraphs 9 and 10 of this subsection, of any corporation in which an officer of such life insurance company is either an officer or director. However, this limitation shall not apply with respect to such investments in:

(a) a corporation which is a subsidiary or affiliate of such life insurance company; or

(b) a trade association, provided such investment meets the requirements of paragraph 5 of this subsection.

27. Except for the purpose of mutualization provided for in section 23 of this chapter, or for the purpose of retirement of outstanding shares of capital stock pursuant to amendment of its articles of incorporation, or in connection with a plan approved by the commissioner for purchase of such shares by the life insurance company's officers, employees, or agents, no life insurance company

shall invest in its own stock.

28. In applying the conditions, limitations, and standards prescribed in paragraphs 11, 12, and 13 of this subsection to the stocks or obligations of a corporation which in the seven (7) year period preceding purchase of such stocks or obligations acquired its property or a substantial part thereof through consolidation, merger, or purchase, the earnings of the several predecessors or constituent corporations shall be consolidated.

29. A. Before a life insurance company may engage in securities lending transactions, repurchase transactions, reverse repurchase transactions, or dollar roll transactions, the life insurance company's board of directors must adopt a written plan that includes guidelines and objectives to be followed, including the following:

(1) A description of how cash received will be invested or used for general corporate purposes of the company.

(2) Operational procedures for managing interest rate risk, counterparty default risk, and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction.

(3) A statement of the extent to which the company may engage in securities lending transactions, repurchase transactions, reverse repurchase transactions, and dollar roll transactions.

B. A life insurance company must enter into a written agreement for all transactions authorized by this paragraph, other than dollar roll transactions. The written agreement:

(1) must require the termination of each transaction not more than one (1) year after its inception or upon the earlier demand of the company; and

(2) must be with the counterparty business entity, except that, for securities lending transactions, the agreement may be with an agent acting on behalf of the life insurance company if:

(A) the agent is:

(i) a business entity, the obligations of which are rated BBB- or higher by Standard & Poor's Corporation (or A-2 or higher in the case of commercial paper), Baa3 or higher by Moody's Investors Service, Inc. (or P-2 or higher in the case of commercial paper), BBB- or higher by Duff and Phelps, Inc. (or D-2 or higher in the case of commercial paper), or 1 or 2 by the Securities Valuation Office;

(ii) a business entity that is a primary dealer in United States government securities, recognized by the Federal Reserve Bank of New York; or

(iii) any other business entity approved by the

commissioner; and

(B) the agreement requires the agent to enter into with each counterparty separate agreements that are consistent with the requirements of this paragraph.

C. Cash received in a transaction under this paragraph shall be:

(1) invested:

(A) in accordance with this section 2; and

(B) in a manner that recognizes the liquidity needs of the transaction; or

(2) used by the life insurance company for its general corporate purposes.

D. For as long as a transaction under this paragraph remains outstanding, the life insurance company or its agent or custodian shall maintain, as to acceptable collateral received in the transaction, either physically or through book entry systems of the Federal Reserve, the Depository Trust Company, the Participants Trust Company, or another securities depository approved by the commissioner:

(1) possession of the acceptable collateral;

(2) a perfected security interest in the acceptable collateral; or

(3) in the case of a jurisdiction outside the United States:

(A) title to; or

(B) rights of a secured creditor to;

the acceptable collateral.

E. The limitations set forth in paragraphs 17 and 21 of this subsection do not apply to transactions under this paragraph 29. For purposes of calculations made to determine compliance with this paragraph, no effect may be given to the future obligation of the life insurance company to:

(1) resell securities, in the case of a repurchase transaction; or

(2) repurchase securities, in the case of a reverse repurchase transaction.

F. A life insurance company shall not enter into a transaction under this paragraph if, as a result of the transaction, and after giving effect to the transaction:

(1) the aggregate amount of securities then loaned, sold to, or purchased from any one (1) business entity under this paragraph would exceed five percent (5%) of the company's admitted assets (but in calculating the amount sold to or purchased from a business entity under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement); or

(2) the aggregate amount of all securities then loaned, sold to, or

purchased from all business entities under this paragraph would exceed forty percent (40%) of the admitted assets of the company (provided, however, that this limitation does not apply to a reverse repurchase transaction if the borrowing is used to meet operational liquidity requirements resulting from an officially declared catastrophe and is subject to a plan approved by the commissioner).

G. The following collateral requirements apply to all transactions under this paragraph:

(1) In a securities lending transaction, the life insurance company must receive acceptable collateral having a market value as of the transaction date at least equal to one hundred two percent (102%) of the market value of the securities loaned by the company in the transaction as of that date. If at any time the market value of the acceptable collateral received from a particular business entity is less than the market value of all securities loaned by the company to that business entity, the business entity shall be obligated to deliver additional acceptable collateral to the company, the market value of which, together with the market value of all acceptable collateral then held in connection with all securities lending transactions with that business entity, equals at least one hundred two percent (102%) of the market value of the loaned securities.

(2) In a reverse repurchase transaction, other than a dollar roll transaction, the life insurance company must receive acceptable collateral having a market value as of the transaction date equal to at least ninety-five percent (95%) of the market value of the securities transferred by the company in the transaction as of that date. If at any time the market value of the acceptable collateral received from a particular business entity is less than ninety-five percent (95%) of the market value of all securities transferred by the company to that business entity, the business entity shall be obligated to deliver additional acceptable collateral to the company, the market value of which, together with the market value of all acceptable collateral then held in connection with all reverse repurchase transactions with that business entity, equals at least ninety-five percent (95%) of the market value of the transferred securities.

(3) In a dollar roll transaction, the life insurance company must receive cash in an amount at least equal to the market value of the securities transferred by the company in the transaction as of the transaction date.

(4) In a repurchase transaction, the life insurance company must receive acceptable collateral having a market value equal to at least one hundred two percent (102%) of the purchase price paid by the company for the securities. If at any time the market value of the acceptable collateral received from a particular business entity is less than one hundred percent (100%) of the purchase price paid by the life insurance company in all repurchase transactions with that business entity, the business entity shall be obligated to provide additional acceptable collateral to the company, the market value of which, together with the market value of all acceptable collateral then held in connection with all repurchase transactions with that business entity, equals at least one hundred two percent (102%) of the purchase price. Securities acquired by a life insurance company in a repurchase transaction shall not be:

(A) sold in a reverse repurchase transaction;

(B) loaned in a securities lending transaction; or

(C) otherwise pledged.

30. A life insurance company may invest in obligations or interests in trusts or partnerships regardless of the issuer, which are secured by:

(a) investments authorized by paragraphs 1, 2, 3, 4, or 11 of this subsection; or

(b) collateral with the characteristics and limitations prescribed for loans under paragraph 5 of this subsection.

For the purposes of this paragraph 30, collateral may be substituted for other collateral if it is in the same amount with the same or greater interest rate and qualifies as collateral under subparagraph (a) or (b) of this paragraph.

31. A life insurance company may invest in obligations or interests in trusts or partnerships, regardless of the issuer, secured by any form of collateral other than that described in subparagraphs (a) and (b) of paragraph 30 of this subsection, which obligations or interests in trusts or partnerships are rated:

(a) A- or higher by Standard & Poor's Corporation or Duff and Phelps, Inc.;

(b) A 3 or higher by Moody's Investor Service, Inc.; or

(c) 1 by the Securities Valuation Office.

Investments authorized by this paragraph may not exceed ten percent (10%) of the life insurance company's admitted assets.

32. A. A life insurance company may invest in short-term pooling arrangements as provided in this paragraph.

B. The following definitions apply throughout this paragraph:

(1) "Affiliate" means, as to any person, another person that, directly or indirectly through one (1) or more intermediaries, controls, is controlled by, or is under common control with the person.

(2) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract (other than a commercial contract for goods or non-management services), or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten percent (10%) or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may determine, after furnishing all interested persons notice and an opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(3) "Qualified bank" means a national bank, state bank, or trust company that at all times is not less than adequately capitalized as determined by standards adopted by United States banking regulators and that is either regulated by state banking laws or is a member of the Federal Reserve System.

C. A life insurer may participate in investment pools qualified under this paragraph that invest only in:

(1) obligations that are rated BBB- or higher by Standard & Poor's Corporation (or A-2 or higher in the case of commercial paper), Baa 3 or higher by Moody's Investors Service, Inc. (or P-2 or higher in the case of commercial paper), BBB- or higher by Duff and Phelps, Inc. (or D-2 or higher in the case of commercial paper), or 1 or 2 by the Securities Valuation Office, and have:

(A) a remaining maturity of three hundred ninety-seven (397) days or less or a put that entitles the holder to receive the principal amount of the obligation which put may be exercised through maturity at specified intervals not exceeding three hundred ninety-seven (397) days; or

(B) a remaining maturity of three (3) years or less and a floating interest rate that resets not less frequently than quarterly on the basis of a current short-term index (for example, federal funds, prime rate, treasury bills, London InterBank Offered Rate (LIBOR) or commercial paper) and is

not subject to a maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(2) government money market mutual funds or class one money market mutual funds; or

(3) securities lending, repurchase, and reverse repurchase and dollar roll transactions that meet the requirements of paragraph 29 of this subsection and any applicable regulations of the department;

provided that the investment pool shall not acquire investments in any one (1) business entity that exceed ten percent (10%) of the total assets of the investment pool.

D. For an investment pool to be qualified under this paragraph, the investment pool shall not:

(1) acquire securities issued, assumed, guaranteed, or insured by the life insurance company or an affiliate of the company; or

(2) borrow or incur any indebtedness for borrowed money, except for securities lending, reverse repurchase, and dollar roll transactions that meet the requirements of paragraph 29 of this subsection.

E. A life insurance company shall not participate in an investment pool qualified under this paragraph if, as a result of and after giving effect to the participation, the aggregate amount of participation then held by the company in all investment pools under this paragraph and section 2.4 of this chapter would exceed thirty-five percent (35%) of its admitted assets.

F. For an investment pool to be qualified under this paragraph:

(1) the manager of the investment pool must:

(A) be organized under the laws of the United States, a state or territory of the United States, or the District of Columbia, and designated as the pool manager in a pooling agreement; and

(B) be the life insurance company, an affiliated company, a business entity affiliated with the company, or a qualified bank or a business entity registered under the Investment Advisors Act of 1940 (15 U.S.C. 80a-1 et seq.);

(2) the pool manager or an entity designated by the pool manager of the type set forth in subdivision (1) of this subparagraph F shall compile and maintain detailed accounting records setting forth:

(A) the cash receipts and disbursements reflecting each participant's proportionate participation in the investment pool;

(B) a complete description of all underlying assets of the investment pool (including amount, interest rate, maturity date

(if any) and other appropriate designations); and

(C) other records which, on a daily basis, allow third parties to verify each participant's interest in the investment pool; and

(3) the assets of the investment pool shall be held in one (1) or more accounts, in the name of or on behalf of the investment pool, under a custody agreement or trust agreement with a qualified bank, which must:

(A) state and recognize the claims and rights of each participant;

(B) acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its participation in the investment pool; and

(C) contain an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the qualified bank or any other person.

G. The pooling agreement for an investment pool qualified under this paragraph must be in writing and must include the following provisions:

(1) Insurers, subsidiaries, or affiliates of insurers holding interests in the pool, or any pension or profit sharing plan of such insurers or their subsidiaries or affiliates, shall, at all times, hold one hundred percent (100%) of the interests in the investment pool.

(2) The underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person.

(3) In proportion to the aggregate amount of each pool participant's interest in the investment pool:

(A) each participant owns an undivided interest in the underlying assets of the investment pool; and

(B) the underlying assets of the investment pool are held solely for the benefit of each participant.

(4) A participant or (in the event of the participant's insolvency, bankruptcy, or receivership) its trustee, receiver, or other successor-in-interest may withdraw all or any portion of its participation from the investment pool under the terms of the pooling agreement.

(5) Withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds shall occur within a reasonable and customary period thereafter. Payments upon withdrawals under this paragraph shall be calculated in each case net of all then applicable fees and

expenses of the investment pool. The pooling agreement shall provide for such payments to be made to the participants in one (1) of the following forms, at the discretion of the pool manager:

(A) in cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(B) in kind, a pro rata share of each underlying asset; or

(C) in a combination of cash and in kind distributions, a pro rata share in each underlying asset.

(6) The records of the investment pool shall be made available for inspection by the commissioner.

SECTION 13. IC 27-1-12-2.2, AS AMENDED BY P.L.81-2012, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2.2. (a) The following definitions apply to this section:

(1) "Acceptable collateral" means, as to over-the-counter derivatives transactions and for the purpose of calculating counterparty exposure amounts:

(A) cash;

(B) cash equivalents;

(C) letters of credit; and

(D) direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, including the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation.

(2) "Admitted assets" means the life insurance company's assets permitted to be reported as admitted assets on the statutory financial statement of the insurer most recently required to be filed with the commissioner.

(3) "Business entity" means:

(A) a sole proprietorship;

(B) a corporation;

(C) a limited liability company;

(D) an association;

(E) a partnership;

(F) a joint stock company;

(G) a joint venture;

(H) a mutual fund;

(I) a trust;

(J) a joint tenancy; or

(K) another, similar form of business organization;

whether organized for-profit or not-for-profit.

(4) "Cap" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one (1) or more underlying interests exceeds a predetermined number, sometimes called the strike rate or strike price.

(5) "Cash" means any of the following:

(A) United States denominated paper currency and coins.

(B) Negotiable money orders and checks.

(C) Funds held in any time or demand deposit in any depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(6) "Cash equivalent" means any of the following:

(A) A certificate of deposit issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(B) A banker's acceptance issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(C) A government money market mutual fund.

(D) A class one money market mutual fund.

(7) "Class one money market mutual fund" means a money market mutual fund that at all times qualifies for investment pursuant to the ~~"Purposes and Procedures of the Securities Valuation Office" or any successor publication~~ **Purposes and Procedures Manual of the NAIC Investment Analysis Office** either using the bond class one reserve factor or because it is exempt from asset valuation reserve requirements.

(8) "Collar" means two (2) derivatives transactions on the same underlying interest in which the insurer receives payments as the buyer of an option, cap, or floor in one (1) transaction and makes payments as the seller of a different option, cap, or floor in the second transaction.

(9) A. "Counterparty exposure amount" means the net amount of credit risk attributable to a derivative instrument that a life insurance company enters into with another business entity other than through a qualified exchange or a qualified foreign exchange, or cleared through a qualified clearing house ("over the counter derivative instrument"). The amount of credit risk equals:

(1) the market value of the over-the-counter derivative instrument, if the liquidation of the instrument would result in a final cash payment to the insurer; or

(2) zero (0), if the liquidation of the over-the-counter

derivative instrument would not result in a final cash payment to the insurer.

B. If a life insurance company enters into one (1) or more over-the-counter derivative instruments with another business entity under a written master agreement that provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counterparty is either within the United States or a foreign jurisdiction listed in the ~~"Purposes and Procedures of the Securities Valuation Office" or any successor publication~~ **Purposes and Procedures Manual of the NAIC Investment Analysis Office** as eligible for netting, the net amount of credit risk attributable to the counterparty is the greater of zero (0) or the remainder of:

(1) the market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer by the business entity; minus

(2) the market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

C. For open transactions involving over-the-counter derivative instruments, market value:

(1) shall be determined not less frequently than at the end of the most recent quarter of the insurer's fiscal year; and

(2) shall be reduced by the market value of acceptable collateral that is:

(A) held by the insurer; or

(B) placed in escrow by one (1) or both parties.

(10) "Covered" means, in the case of a call option, that:

(A) the life insurance company owns the instrument underlying the call option it has written (a "written call") during the entire period that the written call is outstanding; or

(B) pursuant to the exercise of options, warrants, or conversion rights already owned when the call option is written and held during the period that the written call is outstanding, the life insurance company can immediately acquire the instrument underlying the written call, if:

(1) the price at which the underlying instrument can be acquired is less than or equal to the strike price of the written call; or

(2) the life insurance company has placed in escrow or,

pursuant to a custodian agreement, has segregated during the entire period that the written call is outstanding, cash, cash equivalents, or securities with a market value equal to the difference between the price at which the underlying instrument can be acquired and the strike price of the written call.

(11) "Covered" means, in the case of a put option, that the life insurance company has placed in escrow or, pursuant to a custodian agreement, has segregated during the entire period that the put option it has sold (a "written put") is outstanding, cash, cash equivalents, or securities with a market value equal to the amount of the insurer's obligation under the written put.

(12) "Covered" means, in the case of a cap or floor, that the life insurance company holds in its portfolio, during the entire period that the cap or floor is outstanding, investments that generate sufficient cash flow to make all required payments under the cap or floor.

(13) "Derivative instrument" means an agreement (in the nature of a bilateral contract, option, or otherwise), an instrument, or a series or combination of agreements and instruments:

(A) to make or take delivery of, or assume or relinquish, a specified amount of one (1) or more of the interests underlying the derivative instrument, or to make a cash settlement in lieu thereof; or

(B) that has a price, performance, value, or cash flow based primarily upon the actual or expected price, level, performance, value, or cash flow of one (1) or more of the interests underlying the derivative instrument.

Derivative instruments include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, swaptions, forwards, futures, and any other agreements (in the nature of bilateral contracts, options, or otherwise) or substantially similar instruments, or any series or combination thereof, and any agreements (in the nature of bilateral contracts, options, or otherwise) or instruments permitted under rules adopted by the department.

(14) "Derivative transaction" means a transaction involving the use of one (1) or more derivative instruments. For purposes of this section, a derivative transaction may involve a requirement that the insurer, a counterparty, or both, are required to post collateral with the other party (or a designated third party) pursuant to an

agreement between the insurer and the counterparty.

(15) "Domestic jurisdiction" means the United States, any state, territory, or possession of the United States, the District of Columbia, Canada, or any province of Canada.

(16) "Floor" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a predetermined number, sometimes called the floor rate or price, exceeds a reference price or level or the performance or value of one or more underlying interests.

(17) "Foreign currency" means a currency other than that of a domestic jurisdiction.

(18) "Foreign jurisdiction" means a jurisdiction other than a domestic jurisdiction.

(19) "Forward" means an agreement (other than a future) to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance, or value of, one (1) or more underlying interests.

(20) "Future" means an agreement, traded on a qualified exchange or qualified foreign exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance, or value of, one or more underlying interests.

(21) "Government money market mutual fund" means a money market mutual fund that at all times:

(A) invests only in obligations issued, guaranteed, or insured by the United States or collateralized repurchase agreements composed of these obligations; and

(B) qualifies for investment without a reserve pursuant to the ~~"Purposes and Procedures of the Securities Valuation Office" or any successor publication.~~ **Purposes and Procedures Manual of the NAIC Investment Analysis Office.**

(22) "Guaranteed or insured," when used in connection with an obligation acquired under this section, means that the guarantor or insurer has agreed to:

(A) perform or insure the obligation of the obligor or purchase the obligation; or

(B) be unconditionally obligated until the obligation is repaid to maintain in the obligor a minimum net worth, fixed charge coverage, stockholders' equity, or sufficient liquidity to enable the obligor to pay the obligation in full.

(23) "Hedging transaction" means a derivative transaction that is entered into and maintained to manage:

(A) the risk of a change in the value, yield, price, cash flow, or

quantity of assets or liabilities (or a portfolio of assets, liabilities, or assets and liabilities) that the insurer has acquired or incurred or anticipates acquiring or incurring; or

(B) currency exchange rate risk or the degree of exposure to assets or liabilities (or a portfolio of assets, liabilities, or assets and liabilities) that the insurer has acquired or incurred or anticipates acquiring or incurring.

(24) "Income generation transaction" means a derivative transaction involving the writing of covered call options, covered put options, covered caps, or covered floors.

(25) "Investment company" means an investment company as defined in Section 3(a) of the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.) ~~as amended,~~ and a person described in Section 3(c) of the Investment Company Act of 1940.

(26) "Investment company series" means an investment portfolio of an investment company that is organized as a series company and to which assets of the investment company have been specifically allocated.

(27) "Letter of credit" means a clean, irrevocable, and unconditional letter of credit issued or confirmed by, and payable and presentable at, a financial institution on the list of financial institutions meeting the standards for issuing letters of credit under the ~~"Purposes and Procedures of the Securities Valuation Office" or any successor publication.~~ **Purposes and Procedures Manual of the NAIC Investment Analysis Office.**

(28) "Market value" means:

(A) as to cash, cash equivalents, and letters of credit, the amounts thereof;

(B) as to a security (other than a security that is an over-the-counter derivative instrument) as of any date, the price for the security on that date obtained from a generally recognized source or the most recent quotation from such a source or, to the extent no generally recognized source exists, the price for the security as determined in good faith by the parties to a transaction, plus accrued but unpaid income on the security to the extent not included in the price as of that date; and

(C) as to an over-the-counter derivative instrument as of any date, the amount that a life insurance company would have to pay or would receive for entering into an over-the-counter derivative transaction on substantially identical terms with another counterparty.

(29) "Money market mutual fund" means a mutual fund that meets the conditions of 17 CFR 270.2a-7, under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(30) "Mutual fund" means:

(A) an investment company; or

(B) in the case of an investment company that is organized as a series company, an investment company series;

that is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(31) "Obligation" means any of the following:

(A) A bond.

(B) A note.

(C) A debenture.

(D) Any other form of evidence of debt.

(32) "Option" means an agreement giving the buyer the right to buy or receive (a "call option"), sell or deliver (a "put option"), enter into, extend or terminate, or effect a cash settlement based on the actual or expected price, level, performance, or value of one or more underlying interests.

(33) "Qualified business entity" means a business entity that is:

(A) an issuer of obligations, preferred stock, or derivative instruments that are rated 1 or 2 or are rated the equivalent of 1 or 2 by the Securities Valuation Office or by a nationally recognized statistical rating organization recognized by the Securities Valuation Office; or

(B) a primary dealer in United States government securities, recognized by the Federal Reserve Bank of New York.

(34) "Qualified clearinghouse" means a clearinghouse:

(A) that is for, and subject to the rules of, a qualified exchange or qualified foreign exchange; and

(B) that provides clearing services, including acting as a counterparty to each of the parties to a transaction so that the parties no longer have credit risk as to each other.

(35) "Qualified exchange" means:

(A) a securities exchange registered as a national securities exchange, or a securities market regulated under the Securities Exchange Act of 1934 (15 U.S.C. 78 et seq.); ~~as amended;~~

(B) a board of trade or commodities exchange designated as a contract market by the Commodity Futures Trading Commission (CFTC); ~~or any successor of the CFTC;~~

(C) Private Offerings, Resales, and Trading through

Automated Linkages (PORTAL);

(D) a designated offshore securities market as defined in Securities Exchange Commission Regulation S (17 ~~C.F.R.~~ **CFR** Part 230); ~~as amended;~~ or

(E) a qualified foreign exchange.

(36) "Qualified foreign exchange" means a foreign exchange, board of trade, or contract market located outside the United States or its territories or possessions:

(A) that has received regulatory comparability relief under CFTC Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's Regulations (17 ~~C.F.R.~~ **CFR** Part 30));

(B) that is, or whose members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief under CFTC Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's Regulations (17 ~~C.F.R.~~ **CFR** Part 30)) as to futures transactions in the jurisdiction where the exchange, board of trade, or contract market is located; or

(C) upon which are listed foreign stock index futures contracts that are the subject of no-action relief issued by the CFTC's Office of the General Counsel, provided that an exchange, board of trade, or contract market that qualifies as a qualified foreign exchange only under this clause is a qualified foreign exchange only as to foreign stock index futures contracts that are the subject of no-action relief.

(37) "Replication transaction" means a derivative transaction that is intended to replicate the investment in one (1) or more assets that an insurer is authorized to acquire or sell under this section or section 2 of this chapter. A derivative transaction that is entered into as a hedging transaction shall not be considered a replication transaction.

(38) "Securities Valuation Office" refers to

~~(A)~~ the Securities Valuation Office of the ~~National Association of Insurance Commissioners;~~ ~~or~~

~~(B) any successor of the office referred to in Clause (A) established by the National Association of Insurance Commissioners.~~ **NAIC.**

(39) "Swap" means an agreement to exchange or to net payments at one (1) or more times based on the actual or expected price, level, performance, or value of one (1) or more underlying interests.

(40) "Swaption" means an agreement giving the buyer the right

(but not the obligation) to enter into a swap at a specified time in the future.

(41) "Underlying interest" means the assets, liabilities, other interests or a combination thereof underlying a derivative instrument, such as any one (1) or more securities, currencies, rates, indices, commodities, or derivative instruments.

(42) "Warrant" means an instrument that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, for example, as part of a merger or recapitalization agreement or to facilitate divestiture of the securities of another business entity.

(b) A life insurance company's board of directors shall do all the following:

(1) Before engaging in derivatives transactions, approve a written plan that specifies guidelines, systems, and objectives to be followed, such as:

(A) investment or, if applicable, underwriting objectives and risk constraints, such as credit risk limits;

(B) permissible transactions and the relationship of those transactions to the insurer's operations;

(C) internal control procedures;

(D) a system for determining whether a derivative instrument used for hedging has been effective;

(E) a credit risk management system for over-the-counter derivatives transactions that measures credit risk exposure using the counterparty exposure amount; and

(F) a mechanism for reviewing and auditing compliance with the guidelines, systems, and objectives specified in the written plan.

(2) Before engaging in derivatives transactions, make a determination that the insurer's investment managers have adequate professional personnel, technical expertise, and systems to implement the insurer's intended investment practices involving derivative instruments.

(3) Review whether derivatives transactions have been made in accordance with the approved guidelines and are consistent with stated objectives.

(4) Take action to correct any deficiencies in internal controls relating to derivatives transactions.

(c) A life insurance company may use derivative instruments under

this section to engage in hedging transactions, certain income generation transactions, and certain replication transactions, as these terms may be further defined in rules adopted by the department. For each hedging and replication transaction in which it engages, a life insurance company must be able to demonstrate to the commissioner:

(1) the intended characteristics; and

(2) the ongoing effectiveness;

of the derivative transaction or combination of the derivatives transactions through appropriate analyses.

(d) A life insurance company insurer may enter into a hedging transaction under this section if, as a result of the transaction, and after giving effect to the transaction:

(1) the aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed seven and one half percent (7.5%) of the insurer's admitted assets;

(2) the aggregate statement value of options, caps, and floors written in hedging transactions does not exceed three percent (3%) of the insurer's admitted assets; and

(3) the aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions does not exceed six and one-half percent (6.5%) of the insurer's admitted assets.

(e) A life insurance company may enter into the following types of income generation transactions:

(1) sales of covered call options on:

(A) non-callable fixed income securities;

(B) callable fixed income securities if the option expires by its terms before the end of the noncallable period; or

(C) derivative instruments based on fixed income securities or yields;

(2) sales of covered call options on equity securities;

(3) sales of covered puts on investments that the insurer is permitted to acquire under section 2 of this chapter; and

(4) sales of covered caps or floors;

only if, as a result of the transactions and after giving effect to the transactions, the aggregate statement value of the fixed income securities that are subject to call or that generate the cash flows for payments under the caps or floors, plus the face value of fixed income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the puts, does not exceed ten percent (10%) of the insurer's admitted assets.

(f) A life insurance company may enter into replication transactions.

For the purposes of this subsection, a replication transaction is subject to the limitations and restrictions set forth in section 2 of this chapter to which the replicated investments are subject.

(g) An investment of a life insurance company that is:

(1) permitted under section 2(b)(17A) or 2(b)(17B) of this chapter; and

(2) denominated in a foreign currency;

shall not be considered denominated in a foreign currency if the acquiring insurer enters into one (1) or more contracts permitted under this section in which the business entity counterparty agrees to exchange, or grants to the insurer the option to exchange, all payments made on the foreign currency denominated investment (or amounts equivalent to the payments that are or will be due to the insurer in accordance with the terms of such investment) for United States or Canadian dollars during the period that the contract or contracts are in effect, or other contracts with like effect, to insulate the insurer against loss caused by diminution of the value of payments owed to the insurer due to future changes in currency exchange rates.

(h) A life insurance company shall include all counterparty exposure amounts in determining compliance with the limitations set forth in section 2(b)(21) of this chapter.

(i) Upon the request of a life insurance company, the commissioner may approve additional transactions involving the use of derivative instruments that:

(1) exceed the limits set forth in subsections (d), (e), and (f); or

(2) are for other risk management purposes.

(j) A life insurance company shall maintain documentation and records relating to each derivative transaction. The documentation and records must record and include matters such as the following:

(1) The purpose or purposes of the transaction.

(2) The assets or liabilities to which the transaction relates.

(3) The specific derivative instrument used in the transaction.

(4) For collateralized derivatives transactions, a description of any collateral posted by the insurer or the counterparty, as well as records documenting any subsequent variations in the amount of the collateral.

(5) For over-the-counter derivative transactions, the name of the counterparty and the counterparty exposure amount.

(6) For exchange traded derivative instruments, the name of the exchange and the name of the firm that handled the trade.

(k) Each derivative instrument shall be:

(1) traded on a qualified exchange;

(2) entered into with, or guaranteed by, a business entity;

(3) issued or written by or entered into with the issuer of the underlying interest on which the derivative instrument is based; or

(4) entered into on a qualified foreign exchange.

SECTION 14. IC 27-1-12-2.4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2.4. (a) The following definitions apply to this section:

(1) "Admitted assets" means a life insurance company's assets permitted to be reported as admitted assets on the statutory financial statement of the insurer most recently required to be filed with the commissioner.

(2) "Affiliate" means, as to any person, another person that, directly or indirectly, through one (1) or more intermediaries:

(A) controls;

(B) is controlled by; or

(C) is under common control with;

the person.

(3) "Business entity" means:

(A) a sole proprietorship;

(B) a corporation;

(C) a limited liability company;

(D) an association;

(E) a partnership;

(F) a joint stock company;

(G) a joint venture;

(H) a mutual fund;

(I) a trust;

(J) a joint tenancy; or

(K) another, similar form of business organization;

whether organized for-profit or not-for-profit.

(4) "Cash" means any of the following:

(A) United States denominated paper currency and coins.

(B) Negotiable money orders and checks.

(C) Funds held in any time or demand deposit in any depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(5) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract (other than a commercial contract for goods or non-management services), or otherwise, unless the power is

the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten percent (10%) or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may determine, after furnishing all interested persons notice and an opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(6) "Fixed charges" includes interest on funded and unfunded debt, amortization of debt discount, and rentals for leased property.

(7) "Guaranteed or insured," when used in connection with an obligation acquired under this section, means that the guarantor or insurer has agreed to:

(A) perform or insure the obligation of the obligor or purchase the obligation; or

(B) be unconditionally obligated until the obligation is repaid to maintain in the obligor a minimum net worth, fixed charge coverage, stockholders' equity or sufficient liquidity to enable the obligor to pay the obligation in full.

(8) "Investment company" means an investment company as defined in Section 3(a) of the Investment Company Act of 1940 (15 U.S.C. 80a-1, et seq.) ~~as amended,~~ and a person described in Section 3(c) of the Investment Company Act of 1940 **(15 U.S.C. 80a-1 et seq.).**

(9) "Investment company series" means an investment portfolio of an investment company that is organized as a series company and to which assets of the investment company have been specifically allocated.

(10) "Market value" means:

(A) as to cash, cash equivalents, and letters of credit, the amounts thereof; and

(B) as to a security as of any date, the price for the security on that date obtained from a generally recognized source or the most recent quotation from such a source or, to the extent no generally recognized source exists, the price for the security as determined in good faith by the parties to a transaction, plus accrued but unpaid income on the security to the extent not included in the price as of that date.

(11) "Multilateral development bank" means an international

development organization of which the United States is a member.

(12) "Mutual fund" means:

(A) an investment company; or

(B) in the case of an investment company that is organized as a series company, an investment company series;

that is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(13) "Obligation" means any of the following:

(A) A bond.

(B) A note.

(C) A debenture.

(D) Any other form of evidence of debt.

(14) "Person" means an individual, a business entity, a multilateral development bank or a government or quasi-governmental body, such as a political subdivision or a government sponsored enterprise.

(15) "Qualified bank" means a national bank, state bank, or trust company that:

(A) at all times is not less than adequately capitalized, as determined by standards adopted by United States banking regulators; and

(B) is regulated by state banking laws or is a member of the Federal Reserve System.

(16) "Series company" means an investment company that is organized as a series company, as defined in ~~Rule 18f-2(a) adopted under the Investment Company Act of 1940 (15 U.S.C. 80a-1), as amended).~~ **17 CFR 270.18f-2(a).**

(b) In addition to the authority to participate in investment pools under section 2(b)(31) of this chapter, a life insurance company may participate in investment pools that:

(1) are qualified under this section; and

(2) invest only in investments that an insurer may acquire under section 2 of this chapter;

if the company's proportionate interest in the amount invested in these investments does not exceed the applicable limits of section 2 of this chapter.

(c) For an investment pool to be qualified under this section, the investment pool shall not:

(1) acquire securities issued, assumed, guaranteed, or insured by the insurer or an affiliate of the insurer; or

(2) borrow or incur any indebtedness for borrowed money, except for securities lending, reverse repurchase, and dollar roll transactions that meet the requirements of section 2(b)(29) of this chapter.

(d) A life insurance company shall not participate in an investment pool qualified under this section if, as a result of the participation and after giving effect to the participation, the aggregate amount of participation then held by the insurer in all investment pools under this section and under section 2(b)(31) of this chapter would exceed thirty-five percent (35%) of the admitted assets of the insurer.

(e) For an investment pool to be qualified under this section:

(1) the manager of the investment pool:

(A) must be organized under the laws of the United States, a state or territory of the United States, or the District of Columbia;

(B) must be designated as the pool manager in a pooling agreement; and

(C) must be:

(i) the insurer;

(ii) an affiliated insurer;

(iii) a business entity affiliated with the insurer;

(iv) a qualified bank; or

(v) a business entity registered under the Investment Advisors Act of 1940 ~~(15 U.S.C. 80a-1 et seq.);~~ **(15 U.S.C. 80b-1 et seq.);**

(2) the pool manager or an entity of the type referred to in subdivision (1)(C) that is designated by the pool manager must compile and maintain detailed accounting records setting forth:

(A) the cash receipts and disbursements reflecting each participant's proportionate participation in the investment pool;

(B) a complete description of all underlying assets of the investment pool (including the amount, interest rate, maturity date (if any) and other appropriate designations); and

(C) other records that, on a daily basis, allow third parties to verify each participant's interest in the investment pool; and

(3) the assets of the investment pool must be held in one (1) or more accounts, in the name of or on behalf of the investment pool, in a qualified bank under a custody agreement or trust agreement that:

(A) states and recognizes the claims and rights of each participant;

(B) acknowledges that the underlying assets of the investment

pool are held solely for the benefit of each participant in proportion to the aggregate amount of the participant's participation in the investment pool; and

(C) contains an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the qualified bank or the assets of any other person.

(f) The pooling agreement for an investment pool that is qualified under this section must be in writing and must provide the following:

(1) Insurers, subsidiaries, or affiliates of insurers holding interests in the pool, or any pension or profit sharing plan of the insurers or their subsidiaries or affiliates, must at all times hold one hundred percent (100%) of the interests in the investment pool.

(2) The underlying assets of the investment pool must not be commingled with the general assets of the pool manager or any other person.

(3) In proportion to the aggregate amount of each pool participant's interest in the investment pool:

(A) each participant owns an undivided interest in the underlying assets of the investment pool; and

(B) the underlying assets of the investment pool are held solely for the benefit of each participant.

(4) A participant or (in the event of the participant's insolvency, bankruptcy, or receivership) its trustee, receiver, or other successor-in-interest may withdraw all or any portion of its participation from the investment pool under the terms of the pooling agreement.

(5) Withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds shall occur within a reasonable and customary period thereafter. Payments upon withdrawals under this paragraph shall be calculated in each case net of all then applicable fees and expenses of the investment pool. The pooling agreement shall provide for such payments to be made to the participants in one (1) of the following forms, at the discretion of the pool manager:

(A) in cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(B) in kind, a pro rata share of each underlying asset; or

(C) in a combination of cash and in kind distributions, a pro rata share in each underlying asset.

(6) The records of the investment pool shall be made available for inspection by the commissioner.

SECTION 15. IC 27-1-12-4 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 4. (a) All bonds or other evidences of debt having a fixed term and rate of interest held by an insurer may, if amply secured and not in default as to principal or interest, be valued as follows: If purchased at par, at the par value; if purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made, or, instead of this method, according to an accepted method of valuation approved by the department. The purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage, or express charges paid in the acquisition of the securities. The department shall have full discretion in determining the method of calculating values according to the rules set forth in this subsection. However, no such method or valuation under this subsection may be inconsistent with any applicable method or valuation used by insurers in general or ~~any such~~ **the** method ~~then currently formulated or approved by the National Association of Insurance Commissioners or its successor organization.~~ **specified in the Accounting Practices and Procedures Manual.**

(b) Securities held by an insurer, other than those referred to in subsection (a), shall be valued, in the discretion of the department, at their market value or at their appraised value or at prices determined by the department as representing the fair market value of the securities. Preferred or guaranteed stocks or shares, while paying full dividends, may be carried at a fixed value in lieu of market value at the discretion of the department and in accordance with the method of valuation that the department approves. No valuation under this subsection may be inconsistent with ~~any~~ **the** applicable valuation or method ~~then currently formulated or approved by the National Association of Insurance Commissioners or its successor organization.~~ **specified in the Accounting Practices and Procedures Manual.**

SECTION 16. IC 27-1-12-7, AS AMENDED BY P.L.276-2013, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 7. (a) No policy of life insurance, except as stated in subsection (f) of this section, bearing a date of issue which is the same as or later than a transition date to be selected by the company pursuant to section 12 of this chapter, such transition date in no event to be later than January 1, 1948, shall be delivered or issued for delivery in this state, or issued by a company organized under the laws of this state, unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the department are at least as favorable to defaulting or surrendering

policyholders as are the minimum requirements specified in this section and are essentially in compliance with subsection (g) of this section:

(1) That, in the event of default in any premium payment after premiums have been paid for at least one (1) full year in the case of ordinary insurance or three (3) full years in the case of industrial insurance, the company will grant, upon proper request made not later than sixty (60) days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of an amount determined as specified in this section. In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty (60) days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits;

(2) That, upon surrender of the policy within sixty (60) days after the due date of any premium in default, after premiums have been paid for at least three (3) full years in the case of ordinary insurance or five (5) full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of a stated amount determined as specified in this section;

(3) That, if a request for a nonforfeiture benefit or surrender of the policy is not made or effected as contemplated in subdivisions (1) and (2) of this subsection, a designated paid-up nonforfeiture benefit shall become operative as specified in the policy;

(4) That, if the policy shall have become paid up by completion of all premium payments or if it continues in the form of a paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within thirty (30) days after any policy anniversary, a cash surrender value of such amount as may be determined in this section;

(5) In the case of policies which cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture

benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty (20) policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions to the credit of the policy and that there is no indebtedness to the company on account of or secured by the policy;

(6) A brief and general statement of the method to be used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy on the policy anniversaries beyond the last anniversary of those for which such values and benefits are consecutively shown in the table provided for in subdivision (5) of this subsection;

(7) An explanation of the manner in which the cash surrender value and the paid-up nonforfeiture benefit or benefits are affected by the existence of any paid-up additions to the policy or any indebtedness to the company on account of or secured by the policy.

Any of the provisions of this subsection not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The company shall reserve the right to defer the payment of any cash surrender value for a period of six (6) months after demand therefor and surrender of the policy.

(b) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy (including any existing paid-up additions) if there had been no default, over the sum of (1) the then present value of the adjusted premiums as defined in subsections (d) and (dd), corresponding to premiums which would have fallen due on and after such anniversary, and (2) the amount of any indebtedness to the company on account of or secured by the policy. However, for any policy issued on or after the operative date of subsection (dd) of this section which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value is an amount not less than the sum of the cash surrender value as defined in this paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in this paragraph for a policy which

provides only the benefits otherwise provided by such rider or supplemental policy provision.

For any family policy issued on or after the operative date of subsection (dd) of this section, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one (71), the cash surrender value referred to in the first paragraph of this subsection shall be an amount not less than the sum of the cash surrender value, as defined in that paragraph, for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value, as defined in that paragraph, for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse. Any cash surrender value available within thirty (30) days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by such paid-up policy (including any existing paid-up additions) decreased by any indebtedness to the company on account of or secured by the policy.

(c) Any paid-up nonforfeiture benefit available under a policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be not less than the cash surrender value then provided for by such policy or, if none is provided for, the minimum amount determinable in accordance with subsection (b) in the absence of the condition of subsection (a)(2) that premiums be paid for at least a specified period.

(d) This subsection does not apply to policies issued on or after the operative date of subsection (dd) of this section. Except as provided in the third paragraph of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) two per cent (2%) of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (iii) forty per cent (40%) of the adjusted premium for the first policy year; (iv) twenty-five per cent (25%) of either the adjusted premium for the first policy year or the

adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less; provided that for the sole purpose of computing the amounts of (iii) and (iv) above, no adjusted premiums in excess of four per cent (4%) of the amount of insurance or uniform amount equivalent thereto shall be used.

In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this subsection shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at date of issue as the benefits under the policy; provided that in the case of a policy for a varying amount of insurance issued on the life of a child under age ten (10), the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten (10) were the amount provided by such policy at age ten (10) or at expiry, if earlier.

The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (a) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (b) the adjusted premiums for such term insurance, the foregoing items (a) and (b) being calculated separately and as specified in the first two (2) paragraphs of this subsection except that, for the purposes of (ii), (iii) and (iv) of the first such paragraph, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a).

Except as otherwise provided in the succeeding paragraphs of this subsection, all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table, provided, that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six (6) years younger than the actual age of the insured, and such calculations for all policies of industrial

insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent (3 1/2%) per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided that in calculating the present value of any nonforfeiture benefits consisting of paid-up term insurance with or without pure endowment of a lesser amount, the rates of mortality assumed may be not more than one hundred and thirty per cent (130%) of the rates of the mortality according to such applicable table; and provided that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table or tables of mortality as may be specified by the company and approved by the department **in rules adopted under IC 4-22-2.**

In the case of ordinary policies bearing a date of issue which is the same as or later than the operative date of this paragraph as defined in the succeeding paragraph, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided, that such rate of interest shall not exceed three and one-half percent (3 1/2%) per annum, except that such rate of interest shall not exceed four percent (4%) per annum for policies bearing a date of issue of or later than September 1, 1973, and prior to September 1, 1979, and the interest rate may not exceed five and one-half percent (5 1/2%) per annum for policies bearing a date of issue after August 31, 1979; provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six (6) years younger than the actual age of the insured; provided that in calculating the present value of any nonforfeiture benefits consisting of paid-up term insurance with or without pure endowment of a lesser amount, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table; and provided that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table or tables of mortality as may be specified by the company and approved by the department **in rules adopted under IC 4-22-2.**

Any company may file with the department a written notice of its election to invoke the provisions of the preceding paragraph after a specified date before January 1, 1966. After the filing of such notice,

then upon such specified date (which shall be the operative date of the preceding paragraph for such company), the preceding paragraph shall become operative with respect to the ordinary policies issued by such company and bearing a date of issue which is the same as or later than such specified date. If a company makes no such election, the operative date of the preceding paragraph for such company shall be January 1, 1966.

In the case of policies of industrial insurance bearing a date of issue which is the same as or later than the operative date of this paragraph as defined in the succeeding paragraph, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided that such rate of interest shall not exceed three and one-half percent (3 1/2%) per annum, except that such rate of interest shall not exceed four percent (4%) per annum for policies bearing a date of issue of or later than September 1, 1973, and before September 1, 1979, and the rate of interest may not exceed five and one-half percent (5 1/2%) per annum for policies bearing a date of issue after August 31, 1979; provided, further, that in calculating the present value of any nonforfeiture benefits consisting of paid-up term insurance with or without pure endowment of a lesser amount, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table; and provided that for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table or tables of mortality as may be specified by the company and approved by the department **in rules adopted under IC 4-22-2.**

Any company may file with the department a written notice of its election to invoke the provisions of the preceding paragraph after a specified date before January 1, 1968. After the filing of such notice, then upon such specified date (which shall be the operative date of the preceding paragraph for such company), the preceding paragraph shall become operative with respect to the policies of industrial insurance issued by such company and bearing a date of issue which is the same as or later than such specified date. If a company makes no such election, the operative date of the preceding paragraph for such company shall be January 1, 1968.

(dd)(1) This subsection applies to all policies issued on or after the operative date of this subsection. Except as provided in subdivision (7) of this subsection, the adjusted premiums for any policy shall be

calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) one percent (1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and (iii) one hundred twenty-five percent (125%) of the nonforfeiture net level premium as defined in this subsection. Provided that in applying the percentage specified in (iii) no nonforfeiture net level premium may be considered to exceed four percent (4%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(2) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one (1) per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(3) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums, and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(4) Except as otherwise provided in subdivision (7) of this subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special

hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of: (A) the sum of (i) the then present value of the then future guaranteed benefits provided for by the policy and (ii) the additional expense allowance, if any, over (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(5) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (i) one percent (1%) of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten (10) policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten (10) policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (ii) one hundred twenty-five percent (125%) of the increase, if positive, in the nonforfeiture net level premium.

(6) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where:

(A) equals the sum of:

(i) the nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

(ii) the present value of the increase in future guaranteed benefits provided for by the policy; and

(B) equals the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(7) Notwithstanding any other provisions of this subsection to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, that policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(8) All adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of (i) the Commissioners 1980 Standard Ordinary Mortality Table or (ii) at the election of the company for any one (1) or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection, for policies issued in that calendar year. However:

(A) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year.

(B) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (a) of this section, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(C) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(D) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.

(E) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the tables referred to in this subdivision.

(F) For policies issued:

(i) before the operative date of the valuation manual specified in IC 27-1-12.8-34, any commissioners standard ordinary mortality tables, adopted after 1980 by the ~~National~~

~~Association of Insurance Commissioners,~~ **NAIC,** that are approved ~~by regulation promulgated~~ by the commissioner **in rules adopted under IC 4-22-2** for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table; or

(ii) on or after the operative date of the ~~valuation manual~~ **Valuation Manual** specified in IC 27-1-12.8-34, the ~~valuation manual~~ **Valuation Manual** must provide the commissioners standard ordinary mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the commissioner adopts a rule under IC 4-22-2 to approve any commissioners standard ordinary mortality table adopted by the ~~National Association of Insurance Commissioners~~ **NAIC** for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the ~~valuation manual,~~ **Valuation Manual,** that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the ~~valuation manual~~ **Valuation Manual.**

(G) For policies issued:

(i) before the operative date of the ~~valuation manual~~ **Valuation Manual** specified in IC 27-1-12.8-34, any commissioners standard industrial mortality tables, adopted after 1980 by the ~~National Association of Insurance Commissioners,~~ **NAIC,** that are approved ~~by regulation promulgated~~ by the commissioner **in rules adopted under IC 4-22-2** for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table; or

(ii) on or after the operative date of the ~~valuation manual~~ **Valuation Manual** specified in IC 27-1-12.8-34, the ~~valuation manual~~ **Valuation Manual** must provide the commissioners standard industrial mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961

Industrial Extended Term Insurance Table. If the commissioner adopts a rule under IC 4-22-2 to approve any commissioners standard industrial mortality table adopted by the ~~National Association of Insurance Commissioners~~ **NAIC** for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the ~~valuation manual,~~ **Valuation Manual,** that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the ~~valuation manual.~~ **Valuation Manual.**

(9) The nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be as follows:

(A) For policies issued before the operative date of the ~~valuation manual~~ **Valuation Manual** specified in IC 27-1-12.8-34, equal to one hundred twenty-five percent (125%) of the calendar year statutory valuation interest rate for such policy under IC 27-1-12.8, rounded to the nearer one quarter of one percent (1/4 of 1%).

(B) For policies issued on or after the operative date of the ~~valuation manual~~ **Valuation Manual** specified in IC 27-1-12.8-34, the nonforfeiture interest rate per annum for a policy issued in a particular calendar year must be provided by the ~~valuation manual.~~ **Valuation Manual.**

(10) Notwithstanding any other provision in this title to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(11) After September 1, 1981, any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for such company. If a company makes no such election, the operative date of this subsection for such company shall be January 1, 1989.

(e) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in subsections (b), (c), (d), and (dd) may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than

paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding the provisions of subsection (b), additional benefits payable (1) in the event of death or dismemberment by accident or accidental means, (2) in the event of total and permanent disability, (3) as reversionary annuity or deferred reversionary annuity benefits, (4) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply, (5) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six (26), is uniform in amount after the child's age is one (1), and has not become paid up by reason of the death of a parent of the child, and (6) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(f) This section shall not apply to any reinsurance, group insurance, pure endowment, annuity or reversionary annuity contract, nor to any term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy, nor to any term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections (d) and (dd), is less than the adjusted premium so calculated on a term policy of uniform amount, or renewal of it, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance, and for a term of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy, nor to any policy which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections (b), (c), (d), and (dd) of this section, exceeds two and one-half percent (2 1/2%) of the amount of insurance at the beginning of the same policy year, nor to any policy which shall be delivered outside this state through an agent or other representative of the company issuing the policy. For purposes of determining the applicability of this section, the age at expiry for a joint term life

insurance policy shall be the age at expiry of the oldest life.

(g) This subsection, in addition to all other applicable subsections of this section, applies to all policies issued on or after January 1, 1985. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be an amount which does not differ by more than two tenths of one percent (.2%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years, from the sum of (a) the greater of zero (0) and the basic cash value specified in this subsection and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as defined in this subsection, corresponding to premiums which would have fallen due on and after such anniversary. However, the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (b) or (d) of this section, whichever is applicable, shall be the same as are the effects specified in that subsection on the cash surrender values defined in that subsection.

The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (d) or (dd), whichever is applicable. Except as is required by the next succeeding sentence of this paragraph, such percentage:

(1) must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two tenths of one percent (.2%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and

(2) must be such that no percentage after the later of the two (2) policy anniversaries specified in the preceding item (a) may apply to fewer than five (5) consecutive policy years. No basic cash value may be less than the value which would be obtained if the

adjusted premiums for the policy, as defined in subsection (d) or (dd) of this section, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this section. The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy.

Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (a), (b), (c), (dd), and (e) of this section. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as subdivisions (1) through (6) in subsection (e) of this section shall conform with the principles of this subsection.

(h) 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 which is of such a nature that minimum values cannot be determined by the methods described in subsections (a), (b), (c), (d), or (dd) of this section then:

(1) the commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by subsection (a), (b), (c), (d), or (dd) of this section;

(2) the commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and

(3) the cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this section, as determined by regulations promulgated by the department.

SECTION 17. IC 27-1-12-10.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 10.5. The department shall adopt rules under IC 4-22-2 to prescribe minimum standards for the establishment of reserves as ~~required by the National Association of Insurance Commissioners or its successor organization~~ **specified in**

the Valuation Manual for insurers writing Class 1(a), Class 1(b), and Class 1(c) lines of business.

SECTION 18. IC 27-1-12.1-13, AS ADDED BY P.L.115-2011, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 13. (a) If approved by the commissioner, the following are considered to be and must be reported as admitted assets of a limited purpose subsidiary:

(1) Proceeds from a securitization, premiums, and other amounts payable by an affiliate to the limited purpose subsidiary.

(2) Letters of credit.

(3) Guarantees of the parent.

(4) Other assets.

(b) If the commissioner determines that the value of admitted assets that:

(1) were previously approved by the commissioner under subsection (a); and

(2) are not assets that are addressed by the Accounting Practices and Procedures Manual; ~~of the National Association of Insurance Commissioners;~~

has decreased, the commissioner may require the limited purpose subsidiary to provide additional security or collateral.

(c) The commissioner shall, at least thirty (30) days before taking action under subsection (b):

(1) notify the limited purpose subsidiary of the action; and

(2) provide to the limited purpose subsidiary an opportunity to remedy the issues identified by the commissioner.

SECTION 19. IC 27-1-12.3-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. As used in this chapter:

(a) "Published monthly average" means:

(1) Moody's corporate bond yield average-monthly average corporates as published by Moody's Investors Service, Inc.; ~~or any successor thereto;~~ or

(2) in the event that the Moody's corporate bond yield average-monthly average corporates is no longer published, a substantially similar average, established by regulation issued by the insurance commissioner.

(b) "Insurer" means an entity issuing a policy.

(c) "Policy loan" means:

(1) a loan secured by a policy of life insurance under ~~IC 27-1-12-6(8)~~ **IC 27-1-12-6(a)(8)** and IC 27-1-12-19;

(2) any premium loan made under a policy to pay one (1) or more

premiums that were not paid to the life insurer as they became due; or

(3) a loan secured by any certificate or annuity contract that provides loans on the security of the certificate or annuity contract.

(d) "Policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer.

(e) "Policy" means:

(1) a life insurance policy;

(2) a certificate issued by a fraternal benefit society; or

(3) an annuity contract;

that provides for policy loans.

(f) "Rate of interest" or "interest rate" means the rate of interest on policy loans, including the rate of interest charged on reinstatement of policy loans for the period during and after any lapse.

SECTION 20. IC 27-1-12.4-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. As used in this chapter, "Internal Revenue Code" means the Internal Revenue Code of 1986, as ~~amended and~~ in effect on January 1, 1994.

SECTION 21. IC 27-1-12.8-13, AS ADDED BY P.L.276-2013, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 13. On and after the operative date of the ~~valuation manual~~ **Valuation Manual** specified in section 34 of this chapter, as used in this chapter, "principal based valuation" means a reserve valuation that:

(1) uses at least one (1) method or assumption determined by the insurer; and

(2) is required to comply with section 35 of this chapter as specified in the ~~valuation manual.~~ **Valuation Manual.**

SECTION 22. IC 27-1-12.8-17 IS REPEALED [EFFECTIVE JULY 1, 2018]. ~~Sec. 17. As used in this chapter, "valuation manual" refers to the manual of valuation instructions adopted by the NAIC.~~

SECTION 23. IC 27-1-12.8-22, AS ADDED BY P.L.276-2013, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 22. (a) This section applies before the operative date of the ~~valuation manual.~~ **Valuation Manual.**

(b) Except as otherwise provided in this section, a supporting memorandum submitted by a company as required by section 21 of this chapter and material provided to the commissioner by the company in connection with the supporting memorandum:

(1) are confidential;

(2) are not subject to subpoena; and

(3) are not subject to discovery or admissible in evidence in a private civil action.

However, the commissioner may use the materials and information in connection with a regulatory or legal action brought as part of the commissioner's duties.

(c) The commissioner, or a person receiving documents, materials, or other information while acting under the authority of the commissioner, is not permitted or required to testify in a private civil action concerning information that is confidential as described in subsection (b).

(d) The commissioner may disclose documents, materials, and other information, including the information described in subsection (b), to:

(1) other state, federal, and international regulatory agencies;

(2) the NAIC and affiliates and subsidiaries of the NAIC; and

(3) state, federal, and international law enforcement authorities;

if the recipient agrees to maintain the confidential and privileged status of the documents, materials, and other information.

(e) The commissioner:

(1) may receive documents, materials, and other information, including confidential and privileged documents, materials, and information, from:

(A) other state, federal, and international regulatory agencies;

(B) the NAIC and affiliates and subsidiaries of the NAIC; and

(C) other state, federal, and international law enforcement authorities;

(2) shall maintain as confidential or privileged all documents, materials, and other information received with notice or the understanding that the documents, materials, and information are confidential or privileged under the law of the jurisdiction that is the source of the documents, materials, and information; and

(3) may enter into agreements governing sharing and use of information consistent with subsections (b) through (d).

(f) Any applicable privilege or claim of confidentiality in documents, materials, or information described in this section is not waived as a result of the disclosure or receipt of the documents, materials, or information by the commissioner as authorized by this section.

(g) A supporting memorandum described in section 21 of this chapter and other material provided by the company to the commissioner in connection with the supporting memorandum may:

(1) be subject to subpoena to defend an action seeking damages from the actuary who submitted the supporting memorandum

under section 21 of this chapter; and

(2) be released by the commissioner:

(A) with the written consent of the company; or

(B) to the American Academy of Actuaries in response to a written request that:

(i) states that the memorandum or other material is required for the purpose of professional disciplinary proceedings; and

(ii) sets forth procedures satisfactory to the commissioner for preserving the confidentiality of the supporting memorandum or other material.

(h) If any part of a supporting memorandum described in section 21 of this chapter is:

(1) cited by the company in the company's marketing;

(2) cited before a governmental agency other than a state insurance department; or

(3) released by the company to the news media;

all parts of the supporting memorandum are no longer confidential.

(i) The commissioner shall adopt rules under IC 4-22-2 containing the minimum standards for the valuation of accident and sickness insurance contracts.

SECTION 24. IC 27-1-12.8-23, AS ADDED BY P.L.276-2013, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 23. (a) This section applies on and after the operative date of the ~~valuation manual.~~ **Valuation Manual.**

(b) A company with outstanding life insurance contracts, accident and sickness insurance contracts, or deposit-type contracts in Indiana that is subject to regulation by the commissioner shall:

(1) annually submit the opinion of the appointed actuary concerning whether the reserves and related actuarial items held in support of the contracts:

(A) are computed appropriately;

(B) are based on assumptions that satisfy contractual provisions;

(C) are consistent with previously reported amounts; and

(D) comply with applicable Indiana law;

according to the specific requirements prescribed by the ~~valuation manual;~~ **Valuation Manual;** and

(2) except as exempted in the ~~valuation manual,~~ **Valuation Manual,** annually submit the opinion of the appointed actuary concerning whether the reserves and related actuarial items held in support of the contracts specified in the ~~valuation manual,~~ **Valuation Manual,** when considered with the assets held by the

company with respect to the reserves and related actuarial items including the:

(A) investment earnings on the assets; and

(B) considerations anticipated to be received and retained under the contracts;

make adequate provision for the company's obligations, including benefits under, expenses associated with, and any other obligations under the contracts.

(c) The following requirements apply to an opinion required by subsection (b)(2):

(1) A memorandum, in form and substance as specified in the ~~valuation manual~~ **Valuation Manual** and acceptable to the commissioner, must be prepared to support each actuarial opinion.

(2) If:

(A) the company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the ~~valuation manual;~~ **Valuation Manual;** or

(B) the commissioner determines that the supporting memorandum provided by the company fails to meet the standards prescribed by the ~~valuation manual~~ **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) The following requirements apply to an opinion prepared under subsection (b)(1) or (b)(2):

(1) The opinion must be in form and substance as specified in the ~~valuation manual~~ **Valuation Manual** and acceptable to the commissioner.

(2) The opinion must be submitted with the annual statement reflecting the valuation of the reserves for each year ending on or after the operative date of the ~~valuation manual.~~ **Valuation Manual.**

(3) The opinion must apply to all contracts subject to subsection (b)(2) plus other actuarial liabilities specified in the ~~valuation manual.~~ **Valuation Manual.**

(4) The opinion must be based on:

(A) standards adopted by the Actuarial Standards Board; ~~or a successor to the Actuarial Standards Board;~~ and

(B) additional standards prescribed in the ~~valuation manual.~~

Valuation Manual.

(5) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by the 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 Indiana.

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

(7) Disciplinary action by the commissioner against the company or the appointed actuary must be defined in rules adopted by the commissioner under IC 4-22-2.

SECTION 25. IC 27-1-12.8-24, AS ADDED BY P.L.276-2013, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 24. (a) Except as provided in sections 25, 26, and 33 of this chapter, the minimum standard for the valuation of contracts issued before the operative date of the ~~valuation manual~~ **Valuation Manual** specified in section 34 of this chapter and on or after the transition date selected by the company under IC 27-1-12-12, the transition date in no event to be later than January 1, 1948, is:

(1) the commissioners reserve valuation methods described in sections 27, 28, 31, and 33 of this chapter;

(2) three and one-half percent (3 1/2%) interest; or

(3) in the case of life insurance contracts (other than annuity and pure endowment contracts) issued after August 31, 1973:

(A) four percent (4%) interest for contracts issued before September 1, 1979;

(B) five and one-half percent (5 1/2%) interest for single premium life insurance contracts; and

(C) four and one-half percent (4 1/2%) interest for all other contracts issued after August 31, 1979.

(b) In addition to the minimum standards specified in subsection (a), the following tables apply:

(1) For ordinary contracts of life insurance issued on the standard basis, excluding disability and accidental death benefits in the contracts:

(A) the Commissioners 1941 Standard Ordinary Mortality Table for contracts issued before the operative date of the fifth paragraph of IC 27-1-12-7(d);

(B) for any category of contracts issued:

(i) on male risks; and

(ii) on or after the operative date of the fifth paragraph of IC 27-1-12-7(d) and before the operative date of IC 27-1-12-7(dd);

the Commissioners 1958 Standard Ordinary Mortality Table;

(C) for any category of contracts issued:

(i) on female risks; and

(ii) on or after the operative date of the fifth paragraph of IC 27-1-12-7(d) and before the operative date of IC 27-1-12-7(dd);

the Commissioners 1958 Standard Ordinary Mortality Table with all modified net premiums and present values referred to in sections 19 through 40 of this chapter calculated according to an age not more than six (6) years younger than the actual age of the insured; and

(D) for contracts issued on or after the operative date of IC 27-1-12-7(dd):

(i) the Commissioners 1980 Standard Ordinary Mortality Table;

(ii) at the election of the company for one (1) or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(iii) an ordinary mortality table, adopted after 1980 by the NAIC, which is approved by rule adopted by the department under IC 4-22-2 for use in determining the minimum standard of valuation for the contracts.

(2) For industrial life insurance contracts issued on the standard basis, excluding disability and accidental death benefits in the contracts:

(A) the 1941 Standard Industrial Mortality Table for contracts bearing a date of issue before the operative date of the seventh paragraph of IC 27-1-12-7(d); and

(B) for contracts bearing a date of issue that is the same as or later than the operative date described in clause (A), the Commissioners 1961 Standard Industrial Mortality Table or an industrial mortality table adopted after 1980 by the NAIC that is approved by rule adopted by the department under IC 4-22-2 for use in determining the minimum standard of valuation for the contracts.

(3) For individual annuity and pure endowment contracts,

excluding disability and accidental death benefits in the contracts:

(A) the 1937 Standard Annuity Mortality Table; or

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

(C) a modification of a table specified in clause (A) or (B) that is approved by the commissioner **in rules adopted under IC 4-22-2.**

(4) For group annuity and pure endowment contracts, excluding disability and accidental death benefits in the contracts:

(A) the Group Annuity Mortality Table for 1951;

(B) a modification of the table approved by the commissioner **in rules adopted under IC 4-22-2;** or

(C) 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 contracts:

(A) for contracts issued after December 31, 1965, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or tables of disablement rates and termination rates adopted after 1980 by the NAIC, that are approved by rule adopted by the department under IC 4-22-2 for use in determining the minimum standard of valuation for those contracts;

(B) for contracts issued after December 31, 1960, and before January 1, 1966:

(i) the tables described in clause (A); or

(ii) at the option of the company, the Class (3) Disability Table (1926); and

(C) for contracts issued before January 1, 1961, the Class (3) Disability Table (1926).

Any table described in this subdivision must, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance contracts.

(6) For accidental death benefits in or supplementary to contracts issued after December 31, 1965:

(A) the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the NAIC that is approved by rule adopted by the commissioner under IC 4-22-2 for use in determining the minimum standard of valuation for the contracts;

(B) for contracts issued after December 31, 1960, and before January 1, 1966:

(i) the table described in clause (A); or

(ii) at the option of the company, the Inter-Company Double Indemnity Mortality Table; and

(C) for contracts issued before January 1, 1961, the Inter-Company Double Indemnity Mortality Table.

A table described in this subdivision must be combined with a mortality table for calculating the reserves for life insurance contracts.

(7) For group life insurance, life insurance issued on the substandard basis, and other special benefits, tables approved by the commissioner **in rules adopted under IC 4-22-2.**

SECTION 26. IC 27-1-12.8-25, AS ADDED BY P.L.276-2013, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 25. (a) Except as provided in section 26 of this chapter, the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of this section, and for annuities and pure endowments purchased on or after the operative date of this section under group annuity and pure endowment contracts, and before the operative date of the ~~valuation manual~~ **Valuation Manual** specified in section 34 of this chapter, is the commissioners reserve valuation methods defined in sections 27 and 28 of this chapter and the following tables and interest rates:

(1) For individual annuity and pure endowment contracts issued before September 1, 1979, excluding disability and accidental death benefits in the contracts, both of the following:

(A) Either of the following:

(i) The 1971 Individual Annuity Mortality Table.

(ii) A modification of the table that is approved by the commissioner **in rules adopted under IC 4-22-2.**

(B) Either of the following:

(i) Six percent (6%) interest for single premium immediate annuity contracts.

(ii) Four percent (4%) interest for all other individual annuity and pure endowment contracts.

(2) For individual single premium immediate annuity contracts issued after August 31, 1979, excluding disability and accidental death benefits in the contracts, both of the following:

(A) One (1) of the following:

(i) The 1971 Individual Annuity Mortality Table.

(ii) An individual annuity mortality table adopted after 1980

by the NAIC that is approved by rule adopted by the commissioner under IC 4-22-2 for use in determining the minimum standard of valuation for the contracts.

(iii) A modification of a table described in item (i) or (ii) that is approved by the commissioner **in rules adopted under IC 4-22-2.**

(B) Seven and one-half percent (7 1/2%) interest.

(3) For individual annuity and pure endowment contracts issued after August 31, 1979, other than single premium immediate annuity contracts, excluding disability and accidental death benefits in the contracts, both of the following:

(A) One (1) of the following:

(i) The 1971 Individual Annuity Mortality Table.

(ii) An individual annuity mortality table adopted after 1980 by the NAIC that is approved by rule adopted by the commissioner under IC 4-22-2 for use in determining the minimum standard of valuation for the contracts.

(iii) A modification of a table described in item (i) or (ii) that is approved by the commissioner **in rules adopted under IC 4-22-2.**

(B) Either of the following:

(i) Five and one-half percent (5 1/2%) interest for single premium deferred annuity and pure endowment contracts.

(ii) Four and one-half percent (4 1/2%) interest for all other individual annuity and pure endowment contracts.

(4) For annuities and pure endowments purchased before September 1, 1979, under group annuity and pure endowment contracts, excluding disability and accidental death benefits purchased under the contracts, both of the following:

(A) Either of the following:

(i) The 1971 Group Annuity Mortality Table.

(ii) A modification of the table that is approved by the commissioner **in rules adopted under IC 4-22-2.**

(B) Six percent (6%) interest.

(5) For annuities and pure endowments purchased after August 31, 1979, under group annuity and pure endowment contracts, excluding disability and accidental death benefits purchased under the contracts, both of the following:

(A) One (1) of the following:

(i) The 1971 Group Annuity Mortality Table.

(ii) A group annuity mortality table adopted after 1980 by the NAIC that is approved by rule adopted by the

commissioner under IC 4-22-2 for use in determining the minimum standard of valuation for annuities and pure endowments.

(iii) A modification of a table described in item (i) or (ii) that is approved by the commissioner **in rules adopted under IC 4-22-2.**

(B) Seven and one-half percent (7 1/2%) interest.

(b) After September 1, 1973, a company may file with the commissioner a written notice of the company's election to comply with this section after a specified date before January 1, 1979, which is the operative date of this section for the company. If a company makes no election, the operative date of this section for the company is January 1, 1979.

SECTION 27. IC 27-1-12.8-34, AS ADDED BY P.L.276-2013, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 34. (a) Except as provided in subsections (e) and (g), for contracts issued on or after the operative date of the ~~valuation manual,~~ **Valuation Manual,** the standard prescribed in the ~~valuation manual~~ **Valuation Manual** is the minimum standard of valuation required under section 20 of this chapter.

(b) The operative date of the ~~valuation manual~~ **Valuation Manual** is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(1) The ~~valuation manual~~ **Valuation Manual** has been adopted by the NAIC by an affirmative vote of at least forty-two (42) members, or three-fourths (3/4) of the members voting, whichever is greater.

(2) ~~The "Standard Valuation Law" of the NAIC, as amended by the NAIC in 2009, or~~ Legislation ~~including~~ **containing** substantially similar terms and provisions **as the terms and provisions contained in this chapter** has been enacted by states representing greater than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements submitted for 2008:

(A) Life, accident, and health annual statements.

(B) Health annual statements.

(C) Fraternal annual statements.

(3) ~~The "Standard Valuation Law" of the NAIC, as amended by the NAIC in 2009, or~~ Legislation ~~including~~ **containing** substantially similar terms and provisions **as the terms and provisions contained in this chapter** has been enacted by at least forty-two (42) of the following fifty-five (55) jurisdictions:

(A) The fifty (50) states of the United States.

(B) American Samoa.

(C) The American Virgin Islands.

(D) The District of Columbia.

(E) Guam.

(F) Puerto Rico.

(c) Unless a change in the ~~valuation manual~~ **Valuation Manual** specifies a later effective date, changes to the ~~valuation manual~~ **Valuation Manual** are effective on the January 1 following the date when the change to the ~~valuation manual~~ **Valuation Manual** has been adopted by the NAIC by an affirmative vote representing:

(1) at least three-fourths (3/4) of the members of the NAIC voting, but not less than a majority of the total membership; and

(2) members of the NAIC representing jurisdictions totaling greater than seventy-five percent (75%) of the direct premiums written, as reported in the following annual statements most recently available before the vote:

(A) Life, accident, and health annual statements.

(B) Health annual statements.

(C) Fraternal annual statements.

(d) The ~~valuation manual~~ **Valuation Manual** must specify all of the following:

(1) Minimum valuation standards for contracts that are subject to section 20 of this chapter are the following:

(A) The commissioners reserve valuation method for life insurance contracts, other than annuity contracts.

(B) The commissioners annuity reserve valuation method for annuity contracts.

(C) Minimum reserves for all other contracts.

(2) The contracts or types of contracts that are subject to the requirements of a principle based valuation under section 35 of this chapter and the minimum valuation standards consistent with the requirements.

(3) For contracts that are subject to a principle based valuation under section 35 of this chapter, the following:

(A) Requirements for:

(i) the format of the reports to the commissioner under section 35(c)(3) of this chapter; and

(ii) which certifications described in item (i) must include information necessary to determine whether the valuation is appropriate and in compliance with sections 19 through 40 of this chapter.

(B) Assumptions prescribed for risks over which the company does not have significant control or influence.

(C) Procedures for corporate governance and oversight of the actuarial function and a process for appropriate waiver or modification of the procedures.

(4) For contracts that are not subject to a principle-based valuation under section 35 of this chapter, the minimum valuation standard must:

(A) be consistent with the minimum standard of valuation before the operative date of the ~~valuation manual;~~ **Valuation Manual;** or

(B) develop reserves that quantify:

(i) the benefits, guarantees, and funding associated with the contracts; and

(ii) the contracts' risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(5) Other requirements, including requirements relating to:

(A) Reserve methods.

(B) Models for measuring risk.

(C) Generation of economic scenarios.

(D) Assumptions.

(E) Margins.

(F) Use of company experience.

(G) Risk measurement.

(H) Disclosure.

(I) Certifications.

(J) Reports.

(K) Actuarial opinions and memorandums.

(L) Transition rules.

(M) Internal controls.

(6) The data and form of the data required under section 36 of this chapter, including:

(A) the person to whom the data must be submitted;

(B) data analyses; and

(C) reporting of analyses.

(e) If:

(1) there is no specific valuation requirement; or

(2) a specific valuation requirement in the ~~valuation manual~~ **Valuation Manual** is not, in the opinion of the commissioner, in compliance with sections 19 through 40 of this chapter;

a company shall, with respect to the specific valuation requirements,

comply with minimum valuation standards prescribed by the commissioner in rules adopted under IC 4-22-2.

(f) The commissioner may employ or contract with a qualified actuary, at the expense of a company, to:

(1) perform an actuarial examination of the company and provide an opinion concerning the appropriateness of any reserve assumption or method used by the company; or

(2) review and provide an opinion concerning the company's compliance with a requirement of this chapter. The commissioner may rely upon an opinion of a qualified actuary engaged by the commissioner of another state, district, or territory of the United States concerning sections 19 through 40 of this chapter.

(g) The commissioner may:

(1) require a company to change an assumption or method that in the opinion of the commissioner is necessary to comply with the requirements of the ~~valuation manual~~ **Valuation Manual** or sections 19 through 40 of this chapter; and

(2) take other disciplinary action allowed by law.

A company described in subdivision (1) shall adjust reserves as required by the commissioner.

SECTION 28. IC 27-1-12.8-35, AS ADDED BY P.L.276-2013, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 35. (a) This section applies on and after the operative date of the ~~valuation manual~~ **Valuation Manual** specified in section 34 of this chapter.

(b) A company shall, using a principle based valuation, establish reserves that meet the following conditions for contracts, as specified in the ~~valuation manual.~~ **Valuation Manual:**

(1) The reserves quantify the benefits, guarantees, and funding associated with the contracts and the contracts' risks at a level of conservatism that:

(A) reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts; and

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

(2) The reserves incorporate assumptions, risk analysis methods, and financial models and management techniques that are consistent with the assumptions, risk analysis methods, and financial models and management techniques used within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and

prescribed assumptions or methods.

(3) The reserves incorporate assumptions that are derived in one (1) of the following manners:

(A) The assumption is prescribed in the ~~valuation manual.~~ **Valuation Manual.**

(B) For an assumption that is not prescribed in the ~~valuation manual,~~ **Valuation Manual,** the assumption must:

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

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

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

(c) A company using a principle based valuation for at least one (1) contract that is subject to this section, as specified in the ~~valuation manual,~~ **Valuation Manual,** shall do the following:

(1) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with the procedures described in the ~~valuation manual.~~ **Valuation Manual.**

(2) 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. The internal controls must be designed to assure that:

(A) all material risks inherent in the liabilities and associated assets that are subject to the valuation are included in the valuation; and

(B) valuations are made in accordance with the ~~valuation manual.~~ **Valuation Manual.**

The certification must be based on the controls in place as of the end of the preceding calendar year.

(3) Develop, and file with the commissioner upon request, a principle based valuation report that complies with standards prescribed in the ~~valuation manual.~~ **Valuation Manual.**

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

SECTION 29. IC 27-1-12.8-37, AS ADDED BY P.L.276-2013, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 37. (a) Except as provided in this section and section 38 of this chapter, a company's confidential information is:

(1) confidential by law and privileged;

(2) not subject to subpoena; and

(3) not subject to discovery or admissible in evidence in a private civil action.

However, the commissioner may use confidential information in the furtherance of a regulatory or legal action brought against the company as a part of the commissioner's duties.

(b) The commissioner, or a person receiving confidential information while acting under the authority of the commissioner, is not permitted or required to testify in a private civil action concerning confidential information.

(c) The commissioner may disclose confidential information to:

(1) other state, federal, and international regulatory agencies;

(2) the NAIC and affiliates and subsidiaries of the NAIC;

(3) only in the case of confidential information specified in section 5(1) and 5(4) of this chapter, the Actuarial Board for Counseling and Discipline ~~or the successor to the Actuarial Board for Counseling and Discipline~~ upon request stating that the confidential information is required for professional disciplinary proceedings; and

(4) state, federal, and international law enforcement authorities;

if the recipient agrees, and has the legal authority to agree, to maintain the confidential and privileged status of the confidential information in the same manner and to the same extent as required for the commissioner.

(d) The commissioner:

(1) may receive confidential information, including privileged confidential information, from:

(A) other state, federal, and international regulatory agencies;

(B) the NAIC and affiliates and subsidiaries of the NAIC;

(C) the Actuarial Board for Counseling and Discipline; ~~or the successor to the Actuarial Board for Counseling and Discipline;~~ and

(D) other state, federal, and international law enforcement authorities; and

(2) shall maintain as confidential or privileged all confidential information received with notice or the understanding that the confidential information is confidential or privileged under the law of the jurisdiction that is the source of the confidential information.

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

(f) Any applicable privilege or claim of confidentiality in confidential information described in this section is not waived as a result of the disclosure or receipt of the confidential information by the commissioner under this section.

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

(h) For purposes of this section, "regulatory agency", "law enforcement agency", and "NAIC" include employees, agents, consultants, and contractors of a regulatory agency, law enforcement agency, and NAIC.

SECTION 30. IC 27-1-13-3, AS AMENDED BY P.L.81-2012, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 3. (a) The following definitions apply throughout this section:

(1) "Acceptable collateral" means the following:

(A) As to securities lending transactions and for the purpose of calculating counterparty exposure:

(i) cash;

(ii) cash equivalents;

(iii) letters of credit; and

(iv) direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, including the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation.

(B) As to lending foreign securities, sovereign debt rated 1 by the Securities Valuation Office.

(C) As to repurchase transactions:

(i) cash;

(ii) cash equivalents; and

(iii) direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, including the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation.

(D) As to reverse repurchase transactions:

(i) cash; and

(ii) cash equivalents.

(2) "Admitted assets" means assets permitted to be reported as admitted assets on the statutory financial statement of the insurer

most recently required to be filed with the commissioner.

(3) "Business entity" means any of the following:

(A) A sole proprietorship.

(B) A corporation.

(C) A limited liability company.

(D) An association.

(E) A general partnership.

(F) A limited partnership.

(G) A limited liability partnership.

(H) A joint stock company.

(I) A joint venture.

(J) A trust.

(K) A joint tenancy.

(L) Any other similar form of business organization, whether for profit or nonprofit.

(4) "Cash" means any of the following:

(A) United States denominated paper currency and coins.

(B) Negotiable money orders and checks.

(C) Funds held in any time or demand deposit in any depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(5) "Cash equivalent" means any of the following:

(A) A certificate of deposit issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(B) A banker's acceptance issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(C) A government money market mutual fund.

(D) A class one (1) money market mutual fund.

(6) "Class one (1) money market mutual fund" means a money market mutual fund that at all times qualifies for investment using the bond class one (1) reserve factor pursuant to the Purposes and Procedures **Manual** of the ~~Securities Valuation Office of the National Association of Insurance Commissioners. or any successor publication.~~ **NAIC Investment Analysis Office.**

(7) "Derivative transaction" has the meaning set forth in IC 27-1-12-2.2(a)(14).

(8) "Government money market mutual fund" means a money market mutual fund that at all times:

(A) invests only in obligations issued, guaranteed, or insured by the United States or collateralized repurchase agreements

composed of these obligations; and

(B) qualifies for investment without a reserve pursuant to the Purposes and Procedures **Manual** of the ~~Securities Valuation~~ **NAIC Investment Analysis** Office. ~~of the National Association of Insurance Commissioners or any successor publication.~~

(9) "Money market mutual fund" means a mutual fund that meets the conditions of 17 CFR 270.2a-7, under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(10) "Mutual fund" means:

(A) an investment company; or

(B) in the case of an investment company that is organized as a series company, an investment company series;

that is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(11) "Obligation" means any of the following:

(A) A bond.

(B) A note.

(C) A debenture.

(D) Any other form of evidence of debt.

(12) "Qualified business entity" means a business entity that is:

(A) an issuer of obligations or preferred stock that is rated one (1) or two (2) or is rated the equivalent of one (1) or two (2) by the Securities Valuation Office or by a nationally recognized statistical rating organization recognized by the Securities Valuation Office; or

(B) a primary dealer in United States government securities, recognized by the Federal Reserve Bank of New York.

(13) "Securities Valuation Office" refers to the Securities Valuation Office of the ~~National Association of Insurance Commissioners or any successor of the Office established by the National Association of Insurance Commissioners.~~ **NAIC.**

(b) Any company, other than one organized as a life insurance company, organized under the provisions of IC 27-1 or any other law of this state and authorized to make any or all kinds of insurance described in class 2 or class 3 of IC 27-1-5-1 shall invest its capital or guaranty fund as follows and not otherwise:

(1) In cash.

(2) In:

(A) direct obligations of the United States; or

(B) obligations secured or guaranteed as to principal and

interest by the United States.

(3) In:

(A) direct obligations; or

(B) obligations secured by the full faith and credit;

of any state of the United States or the District of Columbia.

(4) In obligations of any county, township, city, town, village, school district, or other municipal district within the United States which are a direct obligation of the county, township, city, town, village, or district issuing the same.

(5) In obligations secured by mortgages or deeds of trust or unencumbered real estate or perpetual leases thereon in the United States not exceeding eighty percent (80%) of the fair value of the security determined in a manner satisfactory to the department, except that the percentage stated may be exceeded if and to the extent such excess is guaranteed or insured by the United States, any state, territory, or possession of the United States, the District of Columbia, Canada, any province of Canada, or by an administration, agency, authority, or instrumentality of any such governmental units. Where improvements on the land constitute a part of the value on which the loan is made, the improvements shall be insured against fire and tornado for the benefit of the mortgagee. For the purposes of this section, real estate may not be deemed to be encumbered by reason of the existence of taxes or assessments that are not delinquent, instruments creating or reserving mineral, oil, or timber rights, rights-of-way, joint driveways, sewer rights, rights-in-walls, nor by reason of building restrictions, or other restrictive covenants, nor when such real estate is subject to lease in whole or in part whereby rents or profits are reserved to the owner. The restrictions contained in this subdivision do not apply to loans or investments made under section 5 of this chapter.

(c) Any company organized under the provisions of this article or any other law of this state and authorized to make any or all of the kinds of insurance described in class 2 or class 3 of IC 27-1-5-1 shall invest its funds over and above its required capital stock or required guaranty fund as follows, and not otherwise:

(1) In cash or cash equivalents. However, not more than ten percent (10%) of admitted assets may be invested in any single government money market mutual fund or class one (1) money market mutual fund.

(2) In direct obligations of the United States or obligations secured or guaranteed as to principal and interest by the United

States.

(3) In obligations issued, guaranteed, or insured as to principal and interest by a city, county, drainage district, road district, school district, tax district, town, township, village or other civil administration, agency, authority, instrumentality or subdivision of a state, territory, or possession of the United States, the District of Columbia, Canada, or any province of Canada, providing such obligations are authorized by law and are either:

(A) direct and general obligations of the issuing, guaranteeing, or insuring governmental unit, administration, agency, authority, district, subdivision, or instrumentality;

(B) payable from designated revenues pledged to the payment of the principal and interest of the obligations; or

(C) improvement bonds or other obligations constituting a first lien, except for tax liens, against all of the real estate within the improvement district or on that part of such real estate not discharged from such lien through payment of the assessment.

The area to which the improvement bonds or other obligations under clause (C) relate must be situated within the limits of a town or city and at least fifty percent (50%) of the properties within that area must be improved with business buildings or residences.

(4) In:

(A) direct obligations; or

(B) obligations secured by the full faith and credit;

of any state of the United States, the District of Columbia, or Canada or any province thereof.

(5) In obligations guaranteed, supported, or insured as to principal and interest by the United States, any state, territory, or possession of the United States, the District of Columbia, Canada, any province of Canada, or by an administration, agency, authority, or instrumentality of any of the political units listed in this subdivision. An obligation is "supported" for the purposes of this subdivision when repayment of the obligation is secured by real or personal property of value at least equal to the principal amount of the indebtedness by means of mortgage, assignment of vendor's interest in one (1) or more conditional sales contracts, other title retention device, or by means of other security interest in the property for the benefit of the holder of the obligation, and one (1) of the political units listed in this subdivision, or an administration, agency, authority, or instrumentality listed in this subdivision, has entered into a firm agreement to rent or use the

property pursuant to which entity is obligated to pay money as rental or for the use of the property in amounts and at times that are sufficient, after provision for taxes upon and for other expenses of the use of the property, to repay in full the indebtedness, both principal and interest, and when the firm agreement and the money obligated to be paid under the agreement are assigned, pledged, or secured for the benefit of the holder of the obligation. However, where the security consists of a first mortgage lien or deed of trust on a fee interest in real property, the obligation may provide for the amortization, during the initial fixed period of the lease or contract of less than one hundred percent (100%) of the indebtedness if there is pledged or assigned, as additional security for the obligation, sufficient rentals payable under the lease, or of contract payments, to secure the amortized obligation payments required during the initial, fixed period of the lease or contract, including but not limited to payments of principal, interest, and taxes other than the income taxes of the borrower, and if there is to be left unamortized at the end of the period an amount not greater than the original appraised value of the land only, exclusive of all improvements, as prescribed by law.

(6) In obligations secured by mortgages or deeds of trust or unencumbered real estate or perpetual leases thereon, in any state in the United States, the District of Columbia, Canada, or any province of Canada, not exceeding eighty percent (80%) of the fair value of the security determined in a manner satisfactory to the department, except that the percentage stated may be exceeded if and to the extent that the excess is guaranteed or insured by the United States, any state, territory, or possession of the United States, the District of Columbia, Canada, any province of Canada, or by an administration, agency, authority, or instrumentality of any of such governmental units. The value of the real estate must be determined by a method and in a manner satisfactory to the department. The restrictions contained in this subdivision do not apply to loans or investments made under section 5 of this chapter.

(7) In obligations issued under or pursuant to the Farm Credit Act of 1971 (12 U.S.C. 2001 through 2279aa-14) as in effect on December 31, 1990, or the Federal Home Loan Bank Act (12 U.S.C. 1421 through 1449) as in effect on December 31, 1990, interest bearing obligations of the FSLIC Resolution Fund and shares of any institution that is insured by the Federal Deposit

Insurance Corporation to the extent that the shares are insured, obligations issued or guaranteed by the International Bank for Reconstruction and Development, obligations issued or guaranteed by the Inter-American Development Bank, and obligations issued or guaranteed by the African Development Bank.

(8) In any mutual fund that:

(A) has been registered with the Securities and Exchange Commission for a period of at least five (5) years immediately preceding the date of purchase;

(B) has net assets of at least twenty-five million dollars ($25,000,000) on the date of purchase; and

(C) invests substantially all of its assets in investments permitted under this subsection.

The amount invested in any single mutual fund shall not exceed ten percent (10%) of admitted assets. The aggregate amount of investments under this subdivision may be limited by the commissioner if the commissioner finds that investments under this subdivision may render the operation of the company hazardous to the company's policyholders, to the company's creditors, or to the general public. This subdivision in no way limits or restricts investments that are otherwise specifically permitted under this section.

(9) In obligations payable in United States dollars and issued, guaranteed, assumed, insured, or accepted by a foreign government or by a solvent business entity existing under the laws of a foreign government, if the obligations of the foreign government or business entity meet at least one (1) of the following criteria:

(A) The obligations carry a rating of at least A3 conferred by Moody's Investor Services, Inc.

(B) The obligations carry a rating of at least A- conferred by Standard & Poor's Corporation.

(C) The earnings available for fixed charges of the business entity for a period of five (5) fiscal years preceding the date of purchase have averaged at least three (3) times the average fixed charges of the business entity applicable to the period, and if during either of the last two (2) years of the period, the earnings available for fixed charges were at least three (3) times the fixed charges of the business entity for the year. As used in this subdivision, the terms "earnings available for fixed charges" and "fixed charges" have the meanings set forth in

IC 27-1-12-2(a).

Foreign investments authorized by this subdivision shall not exceed twenty percent (20%) of the company's admitted assets. This subdivision in no way limits or restricts investments that are otherwise specifically permitted under this section. Canada is not a foreign government for purposes of this subdivision.

(10) In the obligations of any solvent business entity existing under the laws of the United States, any state of the United States, the District of Columbia, Canada, or any province of Canada, provided that interest on the obligations is not in default.

(11) In the preferred or guaranteed shares of any solvent business entity, so long as the business entity is not and has not been for the preceding five (5) years in default in the payment of interest due and payable on its outstanding debt or in arrears in the payment of dividends on any issue of its outstanding preferred or guaranteed stock.

(12) In the shares, other than those specified in subdivision (7), of any solvent business entity existing under the laws of any state of the United States, the District of Columbia, Canada, or any province of Canada, and in the shares of any institution wherever located which has the insurance protection provided by the Federal Deposit Insurance Corporation. Except for the purpose of mutualization or for the purpose of retirement of outstanding shares of capital stock pursuant to amendment of its articles of incorporation, or in connection with a plan approved by the commissioner for purchase of such shares by the insurance company's officers, employees, or agents, or for the elimination of fractional shares, no company subject to the provisions of this section may invest in its own stock.

(13) In loans upon the pledge of any mortgage, stocks, bonds, or other evidences of indebtedness, acceptable as investments under the terms of this chapter, if the current value of the mortgage, stock, bond, or other evidences of indebtedness is at least twenty-five percent (25%) more than the amount loaned on it.

(14) In real estate, subject to subsections (d) and (e).

(15) In securities lending, repurchase, and reverse repurchase transactions with business entities, subject to the following requirements:

(A) The company's board of directors shall adopt a written plan that specifies guidelines and objectives to be followed, such as:

(i) a description of how cash received will be invested or

used for general corporate purposes of the company;

(ii) operational procedures to manage interest rate risk, counterparty default risk, and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

(iii) the extent to which the company may engage in these transactions.

(B) The company shall enter into a written agreement for all transactions authorized in this subdivision. The written agreement shall require the termination of each transaction not more than one (1) year from its inception or upon the earlier demand of the company. The agreement shall be with the counterparty business entity but, for securities lending transactions, the agreement may be with an agent acting on behalf of the company if the agent is a qualified business entity and if the agreement:

(i) requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

(ii) prohibits securities lending transactions under the agreement with the agent or its affiliates.

(C) Cash received in a transaction under this section shall be invested in accordance with this section and in a manner that recognizes the liquidity needs of the transaction or used by the company for its general corporate purposes. For as long as the transaction remains outstanding, the company or its agent or custodian shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company, or other securities depositories approved by the commissioner:

(i) possession of the acceptable collateral;

(ii) a perfected security interest in the acceptable collateral; or

(iii) in the case of a jurisdiction outside the United States, title to, or rights of a secured creditor to, the acceptable collateral.

(D) For purposes of calculations made to determine compliance with this subdivision, no effect may be given to the company's future obligation to resell securities in the case of a repurchase transaction, or to repurchase securities in the case of a reverse repurchase transaction. A company shall not

enter into a transaction under this subdivision if, as a result of and after giving effect to the transaction:

(i) the aggregate amount of securities then loaned, sold to, or purchased from any one (1) business entity pursuant to this subdivision would exceed five percent (5%) of its admitted assets (but, in calculating the amount sold to or purchased from a business entity pursuant to repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement); or

(ii) the aggregate amount of all securities then loaned, sold to, or purchased from all business entities under this subdivision would exceed forty percent (40%) of its admitted assets.

(E) In a securities lending transaction, the company shall receive acceptable collateral having a market value as of the transaction date at least equal to one hundred two percent (102%) of the market value of the securities loaned by the company in the transaction as of that date. If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals one hundred two percent (102%) of the market value of the loaned securities.

(F) In a reverse repurchase transaction, the company shall receive acceptable collateral having a market value as of the transaction date at least equal to ninety-five percent (95%) of the market value of the securities transferred by the company in the transaction as of that date. If at any time the market value of the acceptable collateral is less than ninety-five percent (95%) of the market value of the securities so transferred, the business entity shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, equals at least ninety-five percent (95%) of the market value of the transferred securities.

(G) In a repurchase transaction, the company shall receive as acceptable collateral transferred securities having a market value equal to at least one hundred two percent (102%) of the purchase price paid by the company for the securities. If at any

time the market value of the acceptable collateral is less than one hundred percent (100%) of the purchase price paid by the company, the business entity shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, equals at least one hundred two percent (102%) of the purchase price. Securities acquired by a company in a repurchase transaction shall not be sold in a reverse repurchase transaction, loaned in a securities lending transaction, or otherwise pledged.

(16) In mortgage backed securities, including collateralized mortgage obligations, mortgage pass through securities, mortgage backed bonds, and real estate mortgage investment conduits, adequately secured by a pool of mortgages, which mortgages are fully guaranteed or insured by the government of the United States or any agency of the United States, including the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation.

(17) In mortgage backed securities, including collateralized mortgage obligations, mortgage pass through securities, mortgage backed bonds, and real estate mortgage investment conduits, adequately secured by a pool of mortgages, if the securities carry a rating of at least:

(A) A3 conferred by Moody's Investor Services, Inc.; or

(B) A- conferred by Standard & Poor's Corporation.

The amount invested in any one (1) obligation or pool of obligations described in this subdivision shall not exceed five percent (5%) of admitted assets. The aggregate amount of all investments under this subdivision shall not exceed ten percent (10%) of admitted assets.

(18) Any other investment acquired in good faith as payment on account of existing indebtedness or in connection with the refinancing, restructuring, or workout of existing indebtedness, if taken to protect the interests of the company in that investment.

(19) In obligations or interests in trusts or partnerships in which a life insurance company may invest as described in paragraph 31 of IC 27-1-12-2(b). Investments authorized by this paragraph may not exceed ten percent (10%) of the company's admitted assets.

(20) In any other investment. The total of all investments under this subdivision, except for investments in subsidiary companies under IC 27-1-23-2.6, may not exceed an aggregate amount of ten percent (10%) of the insurer's admitted assets. Investments are not

permitted under this subdivision:

(A) if expressly prohibited by statute; or

(B) in an insolvent organization or an organization in default with respect to the payment of principal or interest on its obligations.

(d) Any company subject to the provisions of this section shall have power to acquire, hold, or convey real estate, or an interest therein, as described below, and no other:

(1) Leaseholds, provided the mortgage term shall not exceed four-fifths (4/5) of the unexpired lease term, including enforceable renewable options, remaining at the time of the loan, such real estate or leaseholds to be located in the United States, any territory or possession of the United States, or Canada, the value of such leasehold for statement purposes shall be determined in a manner and form satisfactory to the department. At the time the leasehold is acquired and approved by the department, a schedule of annual depreciation shall be set up by the department in which the value of said leasehold is to be depreciated, and said depreciation is to be averaged out over not exceeding a period of fifty (50) years.

(2) The building in which it has its principal office and the land on which it stands.

(3) Such as shall be necessary for the convenient transaction of its business.

(4) Such as shall have been acquired for the accommodation of its business.

(5) Such as shall have been mortgaged to it in good faith by way of security for loans previously contracted or for money due.

(6) Such as shall have been conveyed to it in connection with its investments in real estate contracts or its investments in real estate under lease or for the purpose of leasing or such as shall have been acquired for the purpose of investment under any law, order, or regulation authorizing such investment, for statement purposes, the value of such real estate shall be determined in a manner satisfactory to the department.

(7) Such as shall have been conveyed to it in satisfaction of debts previously contracted in the course of its dealings, or in exchange for real estate so conveyed to it.

(8) Such as it shall have purchased at sales on judgments, decrees, or mortgages obtained or made for such debts.

(e) All real estate described in subsection (d)(4) through (d)(8) which is not necessary for the convenient transaction of its business

shall be sold by said company and disposed of within ten (10) years after it acquired title to the same, or within five (5) years after the same has ceased to be necessary for the accommodation of its business, unless the company procures the certificate of the commissioner that its interests will suffer materially by a forced sale of the real estate, in which event the time for the sale may be extended to such time as the commissioner directs in the certificate.

(f) The board of directors of a company, other than a company organized as a life insurance company, shall do all the following:

(1) Before engaging in derivatives transactions, approve a written plan that specifies guidelines, systems, and objectives to be followed, such as:

(A) investment of or, if applicable, underwriting objectives and risk constraints, such as credit risk limits;

(B) permissible transactions and the relationship of those transactions to the insurer's operations;

(C) internal control procedures;

(D) a system for determining whether a derivative instrument used for hedging has been effective;

(E) a credit risk management system for over-the-counter derivatives transactions that measures credit risk exposure using the counterparty exposure amount; and

(F) a mechanism for reviewing and auditing compliance with the guidelines, systems, and objectives specified in the written plan.

(2) Before engaging in derivatives transactions, make a determination that the insurer's investment managers have adequate professional personnel, technical expertise, and systems to implement the insurer's intended investment practices involving derivative instruments.

(3) Review whether derivatives transactions have been made in accordance with the approved guidelines and are consistent with stated objectives.

(4) Take action to correct any deficiencies in internal controls relating to derivatives transactions.

SECTION 31. IC 27-1-13-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 4. (a) All bonds or other evidences of debt having a fixed term and rate of interest held by an insurer may, if amply secured and not in default as to principal or interest, be valued as follows: If purchased at par, at the par value; if purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in

the meantime the effective rate of interest at which the purchase was made, or, instead of this method, according to an accepted method of valuation as is approved by the department. The purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage, or express charges paid in the acquisition of the securities. The department shall have full discretion in determining the method of calculating values according to the rules set forth in this subsection. However, no such method or valuation under this subsection may be inconsistent with any applicable method or valuation used by insurers in general or ~~any such~~ **the** method ~~then currently formulated or approved by the National Association of Insurance Commissioners or its successor organization.~~ **specified in the Accounting Practices and Procedures Manual.**

(b) Securities held by an insurer, other than those referred to in subsection (a), shall be valued, in the discretion of the department, at their market value or at their appraised value or at prices determined by the department as representing the fair market value of the securities. Preferred or guaranteed stocks or shares, while paying full dividends, may be carried at a fixed value in lieu of market value at the discretion of the department and in accordance with the method of valuation that the department approves. No valuation under this subsection may be inconsistent with ~~any~~ **the** applicable valuation or method ~~then currently formulated or approved by the National Association of Insurance Commissioners or its successor organization.~~ **specified in the Accounting Practices and Procedures Manual.**

SECTION 32. IC 27-1-13-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 8. In estimating the condition of any company which makes insurance comprised within class 2 or class 3 of IC 27-1-5-1, the department shall allow only such investments as assets as are authorized by the laws of this state at the date of the investigation, but unpaid premiums on policies or renewals written within three (3) months shall be admitted as available resources. It shall charge as liabilities in addition to all other outstanding indebtedness of the company the capital stock, if any, and the following:

(a) The premium reserve on policies in force equal to fifty percent (50%) of the gross premiums charged for covering risks, less the reserve computed by the same method, on reinsurance in force. However, the department may, in its discretion, charge a premium reserve equal to the unearned portions of the gross premium charged by computing on each respective risk from the date of the issuance of the policy, less the reserve, computed by the same method, on

reinsurance in force.

(b) In the case of policies of marine or inland navigation or transportation insurance it shall charge as a liability fifty percent (50%) of the amount of the premiums written in such policies upon yearly risks and upon risks covering not more than one (1) passage not terminated and the full amount of premiums written in policies upon all other such risks not terminated.

(c) The reserve for outstanding losses at least equal to the aggregate estimated amounts due or to become due on account of all losses or claims of which the company has received notice. However, the loss reserve shall also include the estimated liability on any notices received by the company of the occurrence of any event which may result in a loss and the estimated liability for all losses which have occurred but on which no notice has been received. For the purpose of such reserves, the company shall keep a complete and itemized record showing all losses and claims on which it has received notice, including all notices received by it of the occurrence of any event which may result in a loss.

(d) Any other reserves as are required by or provided for in the ~~annual statement blanks adopted by the National Association of Insurance Commissioners and~~ **applicable Annual Statement Blanks** furnished to companies under IC 27-1-3-13.

(e) Whenever, in the judgment of the department, the loss reserves calculated in accordance with subsections (a), (b), (c), and (d) are inadequate, it may in its discretion require a company to maintain additional reserves.

SECTION 33. IC 27-1-13-8.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 8.5. The department shall adopt rules under IC 4-22-2 to prescribe minimum standards for the establishment of reserves as required by the ~~National Association of Insurance Commissioners or its successor organization~~ **Accounting Practices and Procedures Manual** for insurers writing Class 2 and Class 3 lines of business.

SECTION 34. IC 27-1-15.6-2, AS AMENDED BY P.L.146-2015, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. The following definitions apply throughout this chapter, IC 27-1-15.7, and IC 27-1-15.8:

(1) "Bureau" refers to the child support bureau established by IC 31-25-3-1.

(2) "Business entity" means a corporation, an association, a partnership, a limited liability company, a limited liability partnership, or another legal entity.

(3) "Commissioner" means the insurance commissioner appointed

under IC 27-1-1-2.

(4) "Consultant" means a person who:

(A) holds himself or herself out to the public as being engaged in the business of offering; or

(B) for a fee, offers;

any advice, counsel, opinion, or service with respect to the benefits, advantages, or disadvantages promised under any policy of insurance that could be issued in Indiana.

(5) "Delinquent" means the condition of being at least:

(A) two thousand dollars ($2,000); or

(B) three (3) months;

past due in the payment of court ordered child support.

(6) "Designated home state license" means a license issued by the commissioner to an insurance producer who:

(A) maintains the insurance producer's principal place of residence or principal place of business in a state that does not license insurance producers for the line of authority for which the insurance producer seeks licensure in Indiana; and

(B) is permitted by the commissioner to designate Indiana as the insurance producer's nonresident home state.

(7) "FINRA" refers to the independent Financial Industry Regulatory Authority.

(8) "Home state" means the District of Columbia or any state or territory of the United States in which an insurance producer:

(A) maintains the insurance producer's principal place of residence or principal place of business; and

(B) is licensed to act as an insurance producer.

(9) "Insurance producer" means a person required to be licensed under the laws of Indiana to sell, solicit, or negotiate insurance.

(10) "License" means a document issued by the commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit an insurance carrier.

(11) "Limited line credit insurance" includes the following:

(A) Credit life insurance.

(B) Credit disability insurance.

(C) Credit property insurance.

(D) Credit unemployment insurance.

(E) Involuntary unemployment insurance.

(F) Mortgage life insurance.

(G) Mortgage guaranty insurance.

(H) Mortgage disability insurance.

(I) Guaranteed automobile protection (gap) insurance.

(J) Any other form of insurance:

(i) that is offered in connection with an extension of credit and is limited to partially or wholly extinguishing that credit obligation; and

(ii) that the insurance commissioner determines should be designated a form of limited line credit insurance.

(12) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one (1) or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(13) "Limited lines insurance" means any of the following:

(A) The lines of insurance defined in section 18 of this chapter.

(B) Any line of insurance the recognition of which is considered necessary by the commissioner for the purpose of complying with section 8(e) of this chapter.

(C) For purposes of section 8(e) of this chapter, any form of insurance with respect to which authority is granted by a home state that restricts the authority granted by a limited lines producer's license to less than total authority in the associated major lines described in section 7(a)(1) through 7(a)(6) of this chapter.

(14) "Limited lines producer" means a person authorized by the commissioner to sell, solicit, or negotiate limited lines insurance.

(15) "Limited lines travel insurance producer" means a person designated by an insurer to sell, solicit, or negotiate a travel insurance policy. The term includes the following:

(A) A managing general underwriter.

(B) A managing general agent.

(C) A limited lines producer.

(16) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(17) "Person" means an individual or a business entity.

(18) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of a company.

(19) "Solicit" means attempting to sell insurance or asking or

urging a person to apply for a particular kind of insurance from a particular company.

(20) "Surplus lines producer" means a person who sells, solicits, negotiates, or procures from an insurance company not licensed to transact business in Indiana an insurance policy that cannot be procured from insurers licensed to do business in Indiana.

(21) "Terminate" means:

(A) the cancellation of the relationship between an insurance producer and the insurer; or

(B) the termination of a producer's authority to transact insurance.

(22) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including the following:

(A) Interruption or cancellation of a trip or an event.

(B) Loss of baggage or personal effects.

(C) Damage to accommodations or rental vehicles.

(D) Sickness, accident, disability, or death that occurs during travel.

The term does not include a major medical plan that provides comprehensive medical insurance for a traveler on a trip that lasts at least six (6) months, including a traveler who is an individual who works overseas as an expatriot or is deployed as a member of the military.

(23) "Travel retailer" means a business entity that offers and delivers travel insurance on behalf of and under the direction of a limited lines travel insurance producer.

~~(24) "Uniform business entity application" means the current version of the national association of insurance commissioners uniform business entity application for resident and nonresident business entities.~~

~~(25) "Uniform application" means the current version of the national association of insurance commissioners uniform application for resident and nonresident producer licensing.~~

SECTION 35. IC 27-1-15.6-7, AS AMENDED BY P.L.115-2011, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 7. (a) Unless denied licensure under section 12 of this chapter, a person who has met the requirements of sections 5 and 6 of this chapter shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one (1) or more of the following lines of authority:

(1) Life — insurance coverage on human lives, including benefits of endowment and annuities, that may include benefits in the

event of death or dismemberment by accident and benefits for disability income.

(2) Accident and health or sickness — insurance coverage for sickness, bodily injury, or accidental death that may include benefits for disability income.

(3) Property — insurance coverage for the direct or consequential loss of or damage to property of every kind.

(4) Casualty — insurance coverage against legal liability, including liability for death, injury, or disability, or for damage to real or personal property.

(5) Variable life and variable annuity products — insurance coverage provided under variable life insurance contracts and variable annuities.

(6) Personal lines — property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

(7) Credit — limited line credit insurance.

(8) Title — insurance coverage against loss or damage on account of encumbrances on or defects in the title to real estate.

(9) Any other line of insurance permitted under Indiana laws or administrative rules.

(b) A person who requests qualification under subsection (a)(5) for variable life and annuity products must:

(1) be licensed as an insurance producer with a life qualification under subsection (a)(1);

(2) be registered with FINRA; and

(3) meet the broker-dealer registration requirements of:

(A) FINRA for a Series 6 limited representative license; or

(B) FINRA for a Series 7 general securities registered representative license.

(c) A resident insurance producer may not request separate qualifications for property insurance and casualty insurance under subsection (a).

(d) An insurance producer license remains in effect unless revoked or suspended, as long as the renewal fee set forth in section 32 of this chapter is paid and the educational requirements for resident individual producers are met by the due date.

(e) An individual insurance producer who:

(1) allows the individual insurance producer's license to lapse; and

(2) completed all required continuing education before the license expired;

may, not more than twelve (12) months after the expiration date of the license, reinstate the same license without the necessity of passing a written examination. A penalty in the amount of three (3) times the unpaid renewal fee shall be required for any renewal fee received after the expiration date of the license. However, the department of insurance may waive the penalty if the renewal fee is received not more than thirty (30) days after the expiration date of the license.

(f) A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance may request a waiver of the license renewal procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with the license renewal procedures.

(g) An insurance producer license shall contain the licensee's name, address, personal identification number, date of issuance, lines of authority, expiration date, and any other information the commissioner considers necessary.

(h) A licensee shall inform the commissioner of a change of address not more than thirty (30) days after the change by any means acceptable to the commissioner. The failure of a licensee to timely inform the commissioner of a change in legal name or address shall result in a penalty under section 12 of this chapter.

(i) To assist in the performance of the commissioner's duties, the commissioner may contract with nongovernmental entities, including the ~~National Association of Insurance Commissioners (NAIC),~~ **NAIC,** or any affiliates or subsidiaries that the NAIC oversees, to perform ministerial functions, including the collection of fees related to producer licensing, that the commissioner and the nongovernmental entity consider appropriate.

(j) The commissioner may participate, in whole or in part, with the NAIC or any affiliate or subsidiary of the NAIC in a centralized insurance producer license registry through which insurance producer licenses are centrally or simultaneously effected for states that require an insurance producer license and participate in the centralized insurance producer license registry. If the commissioner determines that participation in the centralized insurance producer license registry is in the public interest, the commissioner may adopt rules under IC 4-22-2 specifying uniform standards and procedures that are necessary for participation in the **centralized insurance producer license** registry, including standards and procedures for centralized license fee collection.

SECTION 36. IC 27-1-15.6-8, AS AMENDED BY P.L.72-2016,

SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 8. (a) Unless denied licensure under section 12 of this chapter, a nonresident person shall receive a nonresident producer license if:

(1) the person is currently licensed as a resident and in good standing in the person's home state;

(2) the person has submitted the proper request for licensure and has paid the fees required under section 32 of this chapter;

(3) the person has submitted or transmitted to the commissioner:

(A) the application for licensure that the person submitted to the person's home state; or

(B) a completed uniform application; and

(4) the person's home state awards non-resident producer licenses to residents of Indiana on the same basis as non-resident producer licenses are awarded to residents of other states under this chapter.

(b) The commissioner may verify a producer's licensing status through the ~~Producer Database maintained by the National Association of Insurance Commissioners and its affiliates or subsidiaries.~~ **centralized insurance producer license registry described in section 7 of this chapter.**

(c) A:

(1) person who holds an Indiana nonresident producer's license and moves from one state to another state; or

(2) resident producer who moves from Indiana to another state;

shall file a change of address with the Indiana department of insurance and provide certification from the new resident state not more than thirty (30) days after the change of legal residence. No fee or license application is required under this subsection.

(d) Notwithstanding any other provision of this chapter, a person licensed as a surplus lines producer in the person's home state shall receive a nonresident surplus lines producer license under subsection (a). Except as provided in subsection (a), nothing in this section otherwise amends or supercedes IC 27-1-15.8. ~~as added by this act.~~

(e) Notwithstanding any other provision of this chapter, a person who is not a resident of Indiana and who is licensed as a limited lines credit insurance producer or another type of limited lines producer in the person's home state shall, upon application, receive a nonresident limited lines producer license under subsection (a) granting the same scope of authority as is granted under the license issued by the person's home state.

(f) Notwithstanding any other provision of this chapter, a

nonresident producer who receives a nonresident producer license under this section shall maintain licensure in good standing in the nonresident producer's home state.

(g) If a nonresident producer fails to maintain licensure in good standing in the nonresident producer's home state, the commissioner may:

(1) in the commissioner's sole discretion;

(2) without a hearing; and

(3) in addition to any other sanction allowed by law;

suspend any Indiana insurance producer license held by the nonresident producer until the commissioner receives notice from the nonresident producer's home state that the home state license is in effect.

SECTION 37. IC 27-1-15.6-8.2, AS ADDED BY P.L.146-2015, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 8.2. (a) Unless denied licensure under section 12 of this chapter, a person that is not a resident of Indiana shall receive a designated home state license if:

(1) the person has requested licensure in Indiana for a line of authority for which licensure is not required in the person's home state;

(2) the person has submitted the proper request for licensure and has paid the fees required under section 32 of this chapter;

(3) the person has submitted or transmitted to the commissioner a completed uniform application; and

(4) the person has complied with the prelicensing and continuing education requirements that apply to an insurance producer that:

(A) is a resident of Indiana; and

(B) applies for the line of authority described in subdivision (1).

(b) The commissioner may verify an insurance producer's licensing status through the ~~Producer Database maintained by the National Association of Insurance Commissioners and its affiliates or subsidiaries.~~ **centralized insurance producer license registry described in section 7 of this chapter.**

(c) A person that holds a designated home state license and moves from one state to another state shall file a change of address with the department and provide certification from the new resident state not more than thirty (30) days after the change of legal residence. No fee or license application is required under this subsection.

(d) A person that:

(1) holds a designated home state license; and

(2) becomes a resident of a state that requires licensure for the

line of authority for which the person holds the designated home state license;

shall become licensed for the line of authority in the new state of residence and notify the commissioner of the new licensure.

(e) Upon receiving notice of new licensure under subsection (d), the commissioner shall transfer the person's designated home state license to a nonresident producer license under section 8 of this chapter.

SECTION 38. IC 27-1-15.6-9, AS AMENDED BY P.L.11-2011, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 9. (a) An individual who applies for an insurance producer license in Indiana and who was previously licensed for the same lines of authority in another state is not required to complete any prelicensing education or examination. However, the exemption provided by this subsection is available only if:

(1) the individual is currently licensed in the other state; or

(2) the application is received within ninety (90) days after the cancellation of the applicant's previous license and:

(A) the other state issues a certification that, at the time of cancellation, the applicant was in good standing in that state; or

(B) the state's ~~Producer Database records that are maintained by the National Association of Insurance Commissioners, its affiliates, or its subsidiaries,~~ **records contained in the centralized insurance producer license registry described in section 7 of this chapter** indicate that the producer is or was licensed in good standing for the line of authority requested.

(b) If a person is licensed as an insurance producer in another state and moves to Indiana, the person, to be authorized to act as an insurance producer in Indiana, must make application to become a resident licensee under section 6 of this chapter within ninety (90) days after establishing legal residence in Indiana. However, the person is not required to take prelicensing education or examination to obtain a license for any line of authority for which the person held a license in the other state unless the commissioner determines otherwise by rule.

(c) An individual who:

(1) has attained the designation of chartered life underwriter, certified financial planner, chartered financial consultant, or another nationally recognized designation approved by the commissioner; ~~or the National Association of Insurance Commissioners;~~ and

(2) applies for an insurance producer license in Indiana requesting

qualification under sections:

(A) 7(a)(1);

(B) 7(a)(2); or

(C) 7(a)(5);

of this chapter;

is not required to complete prelicensing education and is required to take only the portion of the examination required under section 5(b) of this chapter that pertains to Indiana laws and rules.

(d) An individual who:

(1) has attained the designation of chartered property and casualty underwriter, certified insurance counselor, accredited advisor in insurance, or another nationally recognized designation approved by the commissioner; ~~or the National Association of Insurance Commissioners;~~ and

(2) applies for an insurance producer license in Indiana requesting qualification under sections:

(A) 7(a)(3);

(B) 7(a)(4); or

(C) 7(a)(6);

of this chapter;

is not required to complete prelicensing education and is required to take only the portion of the examination required under section 5(b) of this chapter that pertains to Indiana laws and rules.

(e) An individual who:

(1) has attained a bachelor's degree in insurance; and

(2) applies for an insurance producer license in Indiana requesting qualification under section 7(a)(1) through 7(a)(6) of this chapter;

is not required to complete prelicensing education and is required to take only the part of the examination required under section 5 of this chapter that pertains to Indiana laws and rules.

SECTION 39. IC 27-1-20-33 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 33. (a) As used in this section, "insurer" refers to each:

(1) domestic company;

(2) foreign company; and

(3) alien company;

that is authorized to transact business in Indiana.

~~(b) As used in this section, "NAIC" means the National Association of Insurance Commissioners.~~

~~(c)~~ **(b)** On or before March 1 of each year, an insurer shall file with the ~~National Association of Insurance Commissioners~~ **NAIC** and with the department a copy of the insurer's ~~annual statement convention~~

~~blank~~ **Annual Statement Blank** and additional filings prescribed by the commissioner for the preceding year. An insurer shall also file quarterly statements with the NAIC and with the department on or before May 15, August 15, and November 15 of each year in a form prescribed by the commissioner. The information filed with the NAIC under this subsection:

(1) must be:

(A) in the same format; and

(B) of the same scope;

as is required by the commissioner under section 21 of this chapter;

(2) to the extent required by the NAIC, must include the signed jurat page and the actuarial certification; and

(3) must be filed electronically in accordance with NAIC electronic filing specifications.

The commissioner may grant an exemption from the requirement of subdivision (3) to domestic companies that operate only in Indiana. If an insurer files any amendment or addendum to an insurer's ~~annual statement convention blank~~ **Annual Statement Blank** or quarterly statement with the commissioner, the insurer shall also file a copy of the amendment or addendum with the NAIC. Annual and quarterly financial statements are deemed filed with the NAIC when delivered to the address designated by the NAIC for the filings regardless of whether the filing is accompanied by any applicable fee.

~~(d)~~ **(c)** The commissioner may, for good cause, grant an insurer an extension of time for the filing required by subsection ~~(c).~~ **(b).**

~~(e)~~ **(d)** A foreign company that:

(1) is domiciled in a state that has a law substantially similar to subsection ~~(c);~~ **(b);** and

(2) complies with that law;

shall be considered to be in compliance with this section.

~~(f)~~ **(e)** In the absence of actual malice:

(1) members of the NAIC;

(2) duly authorized committees, subcommittees, and task forces of members of the NAIC;

(3) delegates of members of the NAIC;

(4) employees of the NAIC; and

(5) other persons responsible for collecting, reviewing, analyzing, and disseminating information developed from the filing of ~~annual statement convention blanks~~ **Annual Statement Blanks** under this section;

shall be considered to be acting as agents of the commissioner under

the authority of this section and are not subject to civil liability for libel, slander, or any other cause of action by virtue of the collection, review, analysis, or dissemination of the data and information collected from the filings required by this section.

~~(g)~~ **(f)** The commissioner may suspend, revoke, or refuse to renew the certificate of authority of an insurer that fails to file the insurer's ~~annual statement convention blank~~ **Annual Statement Blank** or quarterly statements with the NAIC or with the department within the time allowed by subsection **(b) or** (c). ~~or (d).~~

SECTION 40. IC 27-1-23-2.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2.5. (a) The following definitions apply throughout this section:

(1) "Acquisition" means any agreement, arrangement, or activity the consummation of which results in a person acquiring directly or indirectly the control of another person. The term includes the acquisition of voting securities, and the acquisition of assets, assumption reinsurance, and mergers.

(2) "Involved insurer" includes an insurer that:

(A) acquires;

(B) is acquired;

(C) is affiliated with an acquirer;

(D) is affiliated with an acquired; or

(E) is the result of a merger.

(b) Except as provided in subsection (c), this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in Indiana.

(c) This section does not apply to the following:

(1) An acquisition subject to approval or disapproval by the commissioner under section 2 of this chapter.

(2) A purchase of securities solely for investment purposes, so long as those securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under section 1(e) of this chapter, it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and this disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of Indiana.

(3) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily

engaged in the business of insurance, if a pre-acquisition notification is filed with the commissioner in accordance with subsection (d) at least thirty (30) days before the proposed effective date of the acquisition. However, a pre-acquisition notification is not required for an exclusion from this section if the acquisition would otherwise be excluded from this section by any other subdivision of this subsection.

(4) The acquisition of persons already affiliated with the acquirer.

(5) An acquisition if, as an immediate result of the acquisition:

(A) in no market would the combined market share of the involved insurers exceed five percent (5%) of the total market;

(B) there would be no increase in any market share; or

(C) in no market would the combined market share of the involved insurers:

(i) exceed twelve percent (12%) of the total market; or

(ii) increase by more than two percent (2%) of the total market.

(6) An acquisition for which a pre-acquisition notification would be required under this section due solely to the resulting effect on the ocean marine insurance line of business.

(7) An acquisition of an insurer, if:

(A) the domiciliary commissioner of the insurer affirmatively finds that:

(i) the insurer is in failing condition;

(ii) there is a lack of feasible alternatives to improving that condition; and

(iii) the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and

(B) those findings are communicated by the domiciliary commissioner to the commissioner of Indiana.

For the purposes of this subsection, a "market" means the total direct written insurance premium of all insurers providing insurance in Indiana for a particular line of business, as reported in the annual statements required to be filed by insurers licensed to do business in Indiana.

(d) An order pursuant to subsection (j) may be entered with respect to an acquisition to which this section applies unless the acquiring person files a pre-acquisition notification with respect to the acquisition and the waiting period referred to in subsection (f) has expired. An acquired person may also file a pre-acquisition notification with respect to an acquisition. Information in pre-acquisition notifications filed

under this section is confidential and protected from disclosure under section 6 of this chapter.

(e) A pre-acquisition notification filed under this section must be in the form and must contain the information prescribed by the ~~National Association of Insurance Commissioners~~ **NAIC, as adopted by the commissioner in rules under IC 4-22-2,** with respect to markets that meet the description set forth in subsection (c)(5), causing an acquisition not to be exempted from the provisions of this section. The commissioner may require additional material and information that the commissioner considers necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard set forth in subsection (g). The required information may include an opinion of an economist as to the competitive impact of the acquisition in Indiana, accompanied by a summary of the education and experience of the economist, indicating the economist's ability to render an informed opinion.

(f) The waiting period required with respect to a proposed acquisition begins on the day when the commissioner receives a pre-acquisition notification and ends:

(1) on the thirtieth day after the day the commissioner receives the notification; or

(2) upon the commissioner's termination of the waiting period, if earlier.

Before the end of the waiting period, the commissioner, on a one-time basis, may require the submission of additional needed information relevant to the proposed acquisition. If the commissioner requests additional information under this subsection, the waiting period ends on the earlier of the thirtieth day after receipt of the additional information by the commissioner or the termination of the waiting period by the commissioner.

(g) The commissioner may enter an order under subsection (j) with respect to an acquisition if:

(1) there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in Indiana or to tend to create a monopoly in any line of insurance in Indiana; or

(2) the insurer fails to file adequate information in compliance with subsections (d) and (e).

(h) In determining whether a proposed acquisition to which this section applies would violate the competitive standard set forth in subsection (g), the commissioner shall consider the following:

(1) An acquisition to which this section applies that involves two

(2) or more insurers competing in the same market is prima facie evidence of a violation of the competitive standard:

(A) If the market is highly concentrated and the involved insurers possess the following shares of the market:

(i) Insurer A a share of four percent (4%) and insurer B a share of ~~4%~~ **four percent (4%)** or more.

(ii) Insurer A a share of ten percent (10%) and insurer B a share of two percent (2%) or more.

(iii) Insurer A a share of fifteen percent (15%) and insurer B a share of one percent (1%) or more.

(B) If the market is not highly concentrated and the involved insurers possess the following shares of the market:

(i) Insurer A a share of five percent (5%) and insurer B a share of five percent (5%) or more.

(ii) Insurer A a share of ten percent (10%) and insurer B a share of four percent (4%) or more.

(iii) Insurer A a share of fifteen percent (15%) and insurer B a share of three percent (3%) or more.

(iv) Insurer A a share of nineteen percent (19%) and insurer B a share of one percent (1%) or more.

For the purposes of this subdivision, a highly concentrated market is a market in which the share of the four (4) largest insurers is seventy-five percent (75%) or more of the market. Percentages not referred to in this subdivision must be interpolated proportionately to the percentages that are referred to in this subdivision. If more than two (2) insurers are involved in a proposed acquisition, exceeding the total of the two (2) figures set forth for insurer A and insurer B in an item set forth in this subdivision is prima facie evidence of violation of the competitive standard set forth in subsection (g). For the purpose of this subdivision, the insurer with the largest share of the market shall be considered to be insurer A.

(2) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two (2) largest to the eight (8) largest, has increased by seven percent (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years before the acquisition up to the time of the acquisition. Any acquisition or merger to which this section applies involving two (2) or more insurers competing in the same market is prima facie evidence of violation of the competitive standard set forth in subsection (g) if:

(A) there is a significant trend toward increased concentration in the market;

(B) one (1) of the insurers involved is one (1) of the insurers in a grouping of those large insurers showing the requisite increase in the market share; and

(C) the market share of another involved insurer is two percent (2%) or more.

(3) For the purposes of this subsection:

(A) The term "insurer" includes any company or group of companies under common management, ownership, or control.

(B) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets with respect to an acquisition, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the ~~National Association of Insurance Commissioners,~~ **NAIC,** and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business that is used in the annual statement required to be filed by insurers doing business in Indiana, and the relevant geographical market is assumed to be Indiana.

(C) The burden of showing prima facie evidence of a violation of the competitive standard rests upon the commissioner.

(4) Even though an acquisition is not prima facie violative of the competitive standard under subdivisions (1) and (2), the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under subdivisions (1) and (2), a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subdivision include, but are not limited to, the following:

(A) Market shares.

(B) Volatility of ranking of market leaders.

(C) Number of competitors.

(D) Concentration and trend of concentration in the industry.

(E) Ease of entry into and exit from the market.

(i) An order may not be entered under subsection (j) if:

(1) the acquisition will yield substantial economies of scale or

economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits that would arise from those economies exceed the public benefits that would arise from not lessening competition; or

(2) the acquisition will substantially increase the availability of insurance, and the public benefits of that increase exceed the public benefits that would arise from not lessening competition.

(j) If an acquisition violates the standards set forth in this section, the commissioner may enter an order:

(1) requiring an involved insurer to cease and desist from doing business in Indiana with respect to the line or lines of insurance involved in the violation; or

(2) denying the application of an acquired or acquiring insurer for a license to do business in Indiana.

(k) An order may not be entered under subsection (j) unless:

(1) there is a hearing;

(2) notice of the hearing is issued before the end of the waiting period and not less than fifteen (15) days before the hearing; and

(3) the hearing is concluded and the order is issued not more than sixty (60) days after the end of the waiting period.

Every order shall be accompanied by a written decision of the commissioner setting forth the commissioner's findings of fact and conclusions of law.

(l) An order entered under subsection (j) shall not become final less than thirty (30) days after it is issued, during which time the involved insurer may submit a plan to remedy the anticompetitive impact of the acquisition within a reasonable time. Based upon that plan or other information, the commissioner shall specify the conditions, if any, under which the aspects of the acquisition causing a violation of the standards of this section would be remedied and the order vacated or modified, and the time period within which those aspects would have to remedied.

(m) An order entered under subsection (j) does not apply if the acquisition to which the order applies is not consummated.

(n) A person who violates a cease and desist order issued by the commissioner under subsection (j) while that order is in effect may, after notice and hearing under IC 4-21.5 and upon order of the commissioner, be subject at the discretion of the commissioner to any one (1) or more of the following:

(1) A civil penalty of not more than ten thousand dollars ($10,000) for each day of violation.

(2) The suspension or revocation of the person's license.

(3) Both a monetary penalty under subdivision (1) and the suspension or revocation or the person's license under subdivision (2).

(o) An insurer or other person who fails to make any filing required by this section and also fails to demonstrate a good faith effort to comply with that filing requirement is subject to a civil penalty of not more than fifty thousand dollars ($50,000).

(p) Sections 8(b), 8(c), and 10 of this chapter do not apply to an acquisition to which this section applies.

SECTION 41. IC 27-1-23-3, AS AMENDED BY P.L.72-2016, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 3. (a) Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in:

(1) this section;

(2) section 4(a) and 4(c) of this chapter; and

(3) section 4(b) of this chapter or a provision such as the following:

> Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each such change or addition.

Any insurer which is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter by July 1 of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within such extended time. The commissioner may require any authorized insurer which is a member of an insurance holding company system but not subject to registration under this section to furnish a copy of the registration statement or other information filed by such insurer with the insurance regulatory authority of its domiciliary jurisdiction.

(b) Every insurer subject to registration shall file a registration statement on a form prescribed by the commissioner, which shall contain current information about all of the following:

(1) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer.

(2) The identity of every member of the insurance holding company system.

(3) The following agreements in force, relationships subsisting, and transactions that are currently outstanding or that have occurred during the last calendar year between such insurer and its affiliates:

(A) loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(B) purchases, sales, or exchanges of assets;

(C) transactions not in the ordinary course of business;

(D) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(E) all management and service contracts and all cost-sharing arrangements;

(F) reinsurance agreements;

(G) dividends and other distributions to shareholders; and

(H) consolidated tax allocation agreements.

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

(5) If requested by the commissioner, financial statements of the insurance holding company system, the parent corporation of the insurer, or all affiliates, including annual audited financial statements filed with the federal Securities and Exchange Commission under the Securities Act of 1933 **(15 U.S.C. 77a et seq.)** or the federal Securities Exchange Act of 1934 ~~both as amended.~~ **(15 U.S.C. 78a et seq.).**

(6) Statements reflecting that the insurer's:

(A) board of directors oversees corporate governance and internal controls; and

(B) officers or senior management have approved and implemented and maintain and monitor corporate governance and internal control procedures.

(7) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms prescribed by the commissioner.

(8) Other information that the commissioner requires under rules adopted under IC 4-22-2.

(c) Every registration statement must contain a summary outlining

all items in the current registration statement representing changes from the prior registration statement.

(d) No information need be disclosed on the registration statement filed pursuant to subsection (b) if such information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments, involving one-half of one per cent (0.5%) or less of an insurer's admitted assets as of the 31st day of December next preceding shall not be deemed material for purposes of this section.

(e) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms prescribed by the commissioner within fifteen (15) days after the end of the month in which it learns of each such change or addition.

(f) A person within an insurance holding company system subject to registration under this chapter shall provide complete and accurate information to an insurer when that information is reasonably necessary to enable the insurer to comply with this chapter.

(g) The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is subject to the provisions of this section.

(h) The commissioner may require or allow two (2) or more affiliated insurers subject to registration under this section to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

(i) The commissioner may allow an insurer which is authorized to do business in this state and which is a member of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (a) and to file all information and material required to be filed under this section.

(j) The provisions of this section shall not apply to any insurer, information, or transaction if and to the extent that the commissioner by rule or order shall exempt the same from the provisions of this section.

(k) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under

this section which may arise out of the insurer's relationship with such person unless and until the commissioner disallows such disclaimer. A disclaimer of affiliation is considered to have been granted unless the commissioner, less than thirty (30) days after receiving a disclaimer, notifies the person filing the disclaimer that the disclaimer is disallowed. The commissioner shall disallow such disclaimer only after furnishing all parties in interest with notice and opportunity to be heard.

(l) The person that ultimately controls an insurer that is subject to registration shall file with the lead state commissioner of the insurance holding company system (as determined by the procedures in the Financial Analysis Handbook) ~~adopted by the NAIC)~~ an annual enterprise risk report that identifies, to the best of the person's knowledge, the material risks within the insurance holding company system that could pose enterprise risk to the insurer.

(m) The commissioner may impose on a person a civil penalty of one hundred dollars ($100) per day that the person fails to file, within the period specified, a:

(1) registration statement; or

(2) summary of a registration statement or enterprise risk filing;

required by this section. The commissioner shall deposit a civil penalty collected under this subsection in the department of insurance fund established by IC 27-1-3-28.

SECTION 42. IC 27-1-23-6, AS AMENDED BY P.L.81-2012, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 6. (a) Documents, materials, and other information in the possession or control of the department that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to section 5 of this chapter and all information reported pursuant to sections 2(c)(17), 2(c)(18), 3, and 4 of this chapter are confidential and privileged and shall not be subject to subpoena, discoverable, or admissible in evidence in a private civil action. However, the commissioner may use the documents, materials, and other information in the performance of the commissioner's duties as described in subsections (c) and (d). The commissioner shall not make the materials, documents, or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interests of policyholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part

thereof in such manner as the commissioner considers appropriate.

(b) The commissioner and any other person:

(1) who receives documents, materials, or other information while acting under the authority of the commissioner; or

(2) with whom the documents, materials, or other information are shared;

under this chapter is not permitted or required to testify in a private civil action concerning any documents, materials, or other information that is confidential under subsection (a).

(c) The commissioner may do the following:

(1) Except as provided in subdivision (2), share documents, materials, and other information described in this section with the following if the recipient agrees in writing, and provides written verification that the recipient has the legal authority, to maintain the confidential and privileged status of the documents, materials, and other information:

(A) Other state, federal, and international regulatory agencies.

(B) The NAIC and affiliates and subsidiaries of the NAIC.

(C) State, federal, and international law enforcement authorities.

(D) Members of a supervisory college described in section 5.1 of this chapter.

(2) With respect to confidential and privileged documents, materials, and other information reported under section 3(l) of this chapter, share the documents, materials, and other information with commissioners who:

(A) regulate insurance in states with a law that is substantially similar to subsection (a); and

(B) have agreed in writing not to disclose the documents, materials, or other information.

(3) Receive documents, materials, or other information from:

(A) the NAIC and affiliates and subsidiaries of the NAIC; **and**

(B) regulatory and law enforcement officials of domestic or foreign jurisdictions;

if the commissioner maintains the confidential or privileged status of the documents, materials, and other information that are received with notice or the understanding that the documents, materials, and other information are confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, and other information.

(d) The commissioner shall enter into written agreements with the NAIC governing sharing and use of information provided under this

chapter, including the following:

(1) Procedures and protocols concerning the confidentiality and security of information shared:

(A) with the NAIC and affiliates and subsidiaries of the NAIC under this chapter; and

(B) by the NAIC with other state, federal, and international regulators.

(2) A statement that, with respect to information shared with and used by the NAIC and affiliates and subsidiaries of the NAIC under this chapter:

(A) the commissioner maintains ownership of the information; and

(B) the use of the information is subject to the direction of the commissioner.

(3) A requirement that, if confidential information of an insurer that is in the possession of the NAIC under this chapter is subject to a request or subpoena to the NAIC for production or disclosure, the NAIC will provide prompt notice to the insurer.

(4) A requirement that the NAIC and affiliates and subsidiaries of the NAIC will allow intervention by an insurer in a judicial or administrative action under which the NAIC or affiliates or subsidiaries of the NAIC may be required to disclose confidential information concerning the insurer that has been shared with the NAIC or affiliates or subsidiaries of the NAIC under this chapter.

(e) The sharing of information by the commissioner under this chapter is not considered to be a delegation of regulatory authority. The commissioner is solely responsible for the administration, implementation, and enforcement of this chapter.

(f) Disclosure to or sharing by the commissioner of documents, materials, or other information under this chapter is not a waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other information.

(g) Documents, materials, and other information in the possession or control of the NAIC under this section are:

(1) confidential;

(2) privileged;

(3) not subject to subpoena; and

(4) not discoverable or admissible in evidence in a private civil action.

SECTION 43. IC 27-1-23.5-6 IS REPEALED [EFFECTIVE JULY 1, 2018]. ~~Sec. 6. (a) As used in this chapter, "ORSA guidance manual" refers to the current version of the Own Risk and Solvency Assessment~~

~~Guidance Manual of the NAIC.~~

~~(b) As used in subsection (a), "current version" means the version containing:~~

~~(1) all changes that were made before; and~~

~~(2) no changes that were made on or after;~~

~~January 1 of the current calendar year.~~

SECTION 44. IC 27-1-23.5-10, AS ADDED BY P.L.129-2014, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 10. (a) Upon the request of the commissioner, and not more than one (1) time per year, an insurer shall submit to the commissioner:

(1) an ORSA summary report; or

(2) a combination of reports that together contain the information described in the ORSA ~~guidance manual;~~ **Manual;**

applicable to the insurer or insurance group of which the insurer is a member.

(b) Regardless of a request from the commissioner, if the commissioner is the lead state commissioner of an insurance group of which an insurer is a member (as determined by the procedures in the ~~NAIC~~ Financial Analysis Handbook), the insurer shall submit a report described in subsection (a) at least one (1) time per year.

(c) A report required by this section must include a signature of the insurer's or insurance group's chief risk officer, or another executive who has responsibility for the oversight of the insurer's enterprise risk management process, attesting that:

(1) to the best of the officer's or executive's belief and knowledge the insurer applies the enterprise risk management process described in the ORSA summary report; and

(2) a copy of the report has been provided to the insurer's board of directors or the appropriate committee of the insurer's board of directors.

(d) If an insurer or another member of an insurance group of which the insurer is a member submits to the commissioner the most recent report that:

(1) was provided to the:

(A) commissioner of another state; or

(B) regulatory authority of an alien jurisdiction;

(2) is substantially similar to an ORSA summary report; and

(3) contains information that is comparable to the information described in the ORSA ~~guidance manual;~~ **Manual;**

the insurer is considered to have satisfied the requirements of this section.

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(e) If a report described in subsection (d) is completed in a language other than English, a translation of the report into the English language must be submitted with the report.

SECTION 45. IC 27-1-23.5-11, AS ADDED BY P.L.129-2014, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 11. (a) Except as otherwise provided in this section, an insurer is exempt from the requirements of this chapter if:

(1) the insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than five hundred million dollars ($500,000,000); and

(2) the insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than one billion dollars ($1,000,000,000).

(b) If:

(1) an insurer qualifies under subsection (a)(1) for exemption from the requirements of this chapter; and

(2) the insurance group of which the insurer is a member does not qualify for exemption under subsection (a)(2);

an ORSA summary report required by section 10 of this chapter must include every insurer that is a member of the insurance group.

(c) If:

(1) an insurance group described in subsection (b) submits more than one (1) ORSA summary report for a combination of insurers; and

(2) the combination of ORSA summary reports submitted as described in subdivision (1) includes every insurer that is a member of the insurance group;

the insurance group is considered to be in compliance with subsection (b).

(d) If:

(1) an insurer does not qualify under subsection (a)(1) for exemption from the requirements of this chapter; and

(2) the insurance group of which the insurer is a member qualifies for exemption under subsection (a)(2);

the only ORSA summary report that is required under section 10 of this chapter is the report that applies to the insurer.

(e) An insurer that does not qualify under subsection (a) for

exemption from the requirements of this chapter may apply to the commissioner for a waiver from the requirements of this chapter based on unique circumstances. In deciding whether to grant an insurer's request for a waiver, the commissioner:

(1) may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member; and

(2) shall, if the insurer is part of an insurance group with insurers domiciled in more than one (1) state, coordinate with the:

(A) lead state commissioner of the insurance group (as determined by the procedures in the ~~NAIC~~ Financial Analysis Handbook); and

(B) other domiciliary commissioners;

in considering whether to grant the insurer's request for a waiver.

(f) The commissioner may, regardless of an insurer's qualification under this section for exemption from the requirements of this chapter, require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA summary report if one (1) of the following applies:

(1) If unique circumstances exist, as determined by the commissioner, including the following:

(A) The type and volume of business written by the insurer.

(B) The insurer's ownership and organizational structure.

(C) The request of a federal agency.

(D) The request of an international supervisor.

(2) If the insurer:

(A) has authorized control level RBC for a company action level event under IC 27-1-36;

(B) meets at least one (1) of the standards of an insurer considered to be in hazardous financial condition according to rules adopted by the department under IC 27-1-3-7; or

(C) exhibits other qualities of a troubled insurer, as determined by the commissioner.

(g) If an insurer ceases to qualify for an exemption under this section due to changes in premium, as reflected in:

(1) the insurer's most recent annual statement; or

(2) the most recent annual statements of the insurers that are members of the insurance group of which the insurer is a member;

the insurer must meet the requirements of this chapter not later than one (1) year after the date on which the premium change occurs.

SECTION 46. IC 27-1-25-1, AS AMENDED BY P.L.11-2011,

SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. As used in this chapter:

(a) "Administrator" means a person who directly or indirectly and on behalf of an insurer underwrites, collects charges or premiums from, or adjusts or settles claims on residents of Indiana in connection with life, annuity, or health coverage offered or provided by an insurer. The term "administrator" does not include the following persons:

(1) An employer or a wholly owned direct or indirect subsidiary of an employer acting on behalf of the employees of:

(A) the employer;

(B) the subsidiary; or

(C) an affiliated corporation of the employer.

(2) A union acting for its members.

(3) An insurer.

(4) An insurance producer:

(A) that is licensed under IC 27-1-15.6;

(B) that has:

(i) a life; or

(ii) an accident and health or sickness;

qualification under IC 27-1-15.6-7; and

(C) whose activities are limited exclusively to the sale of insurance.

(5) A creditor acting for its debtors regarding insurance covering a debt between them.

(6) A trust established under 29 U.S.C. 186 and the trustees, agents, and employees acting pursuant to that trust.

(7) A trust that is exempt from taxation under Section 501(a) of the Internal Revenue Code and:

(A) the trustees and employees acting pursuant to that trust; or

(B) a custodian and the agents and employees of the custodian acting pursuant to a custodian account that meets the requirements of Section 401(f) of the Internal Revenue Code.

(8) A financial institution that is subject to supervision or examination by federal or state banking authorities to the extent that the financial institution collects and remits premiums to an insurance producer or an authorized insurer in connection with a loan payment.

(9) A credit card issuing company that:

(A) advances for; and

(B) collects from, when a credit card holder authorizes the collection;

credit card holders of the credit card issuing company, insurance

premiums or charges.

(10) A person that adjusts or settles claims in the normal course of the person's practice or employment as an attorney at law and that does not collect charges or premiums in connection with life, annuity, or health coverage.

(11) A health maintenance organization that has a certificate of authority issued under IC 27-13.

(12) A limited service health maintenance organization that has a certificate of authority issued under IC 27-13.

(13) A mortgage lender to the extent that the mortgage lender collects and remits premiums to an insurance producer or an authorized insurer in connection with a loan payment.

(14) A person that:

(A) is licensed as a managing general agent as required under IC 27-1-33; and

(B) acts exclusively within the scope of activities provided for under the license referred to in clause (A).

(15) A person that:

(A) directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of Indiana in connection with life, annuity, or health coverage provided by an insurer;

(B) is affiliated with the insurer; and

(C) performs the duties specified in clause (A) only according to a contract between the person and the insurer for the direct and assumed life, annuity, or health coverage provided by the insurer.

(b) "Affiliate" means an entity or a person that:

(1) directly or indirectly through an intermediary controls or is controlled by; or

(2) is under common control with;

a specified entity or person.

(c) "Church plan" has the meaning set forth in IC 27-8-10-1.

(d) "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(e) "Control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether:

(1) through ownership of voting securities;

(2) by contract other than a commercial contract for goods or nonmanagement services; or

(3) otherwise;

unless the power is the result of an official position with the person or a corporate office held by the person. Control is presumed to exist if a person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing not less than ten percent (10%) of the voting securities of another person.

(f) "Covered individual" means an individual who is covered under a benefit program provided by an insurer.

(g) "Financial institution" means a bank, savings association, credit union, or any other institution regulated under IC 28 or federal law.

(h) "GAAP" refers to consistently applied United States generally accepted accounting principles.

(i) "Governmental plan" has the meaning set forth in IC 27-8-10-1.

(j) "Home state" means the District of Columbia or any state or territory of the United States in which an administrator is incorporated or maintains the administrator's principal place of business. If the place in which the administrator is incorporated or maintains the administrator's principal place of business is not governed by a law that is substantially similar to this chapter, the administrator's home state is another state:

(1) in which the administrator conducts the business of the administrator; and

(2) that the administrator declares is the administrator's home state.

(k) "Insurance producer" has the meaning set forth in IC 27-1-15.6-2.

(l) "Insurer" means:

(1) a person who obtains a certificate of authority under:

(A) IC 27-1-3-20;

(B) IC 27-13-3; or

(C) IC 27-13-34; or

(2) an employer that provides life, health, or annuity coverage in Indiana under a governmental plan or a church plan.

~~(m) "NAIC" refers to the National Association of Insurance Commissioners.~~

~~(n)~~ **(m)** "Negotiate" has the meaning set forth in IC 27-1-15.6-2.

~~(o)~~ **(n)** "Nonresident administrator" means a person that applies for or holds a license under section 12.2 of this chapter.

~~(p)~~ **(o)** "Person" has the meaning set forth in IC 27-1-15.6-2.

~~(q)~~ **(p)** "Sell" has the meaning set forth in IC 27-1-15.6-2.

~~(r)~~ **(q)** "Solicit" has the meaning set forth in IC 27-1-15.6-2.

~~(s)~~ **(r)** "Underwrite" refers to the:

(1) acceptance of a group application or an individual application

for coverage of an individual in accordance with the written rules of the insurer; or

(2) planning and coordination of a benefit program provided by an insurer.

~~(t) "Uniform application" means the current version of the NAIC uniform application for third party administrators.~~

SECTION 47. IC 27-1-25-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 4. (a) An administrator:

(1) shall maintain at its principal administrative office books and records of all transactions between the administrator and insurers for at least five (5) years after the creation of the books and records; or

(2) may transfer the books and records of transactions between the administrator and an insurer with which the administrator has entered into a written agreement under section 2 of this chapter to a new administrator if:

(A) the agreement between the administrator and the insurer is canceled; and

(B) a written agreement for a transfer of the books and records is made between the administrator and the insurer.

If the books and records are transferred to a new administrator under subdivision (2), the new administrator shall acknowledge in writing that the new administrator is responsible for retaining the books and records of the prior administrator as required under subdivision (1). The books and records must be maintained in accordance with generally accepted standards of insurance record keeping.

(b) The commissioner is entitled to inspect all books and records of the administrator for the purpose of examinations and audits. Trade secrets contained within those books and records, including the identity and addresses of policyholders and certificate holders, financial information concerning the administrator, and the business plan of the administrator, are to remain confidential. However, the commissioner may use that confidential information in proceedings instituted against the administrator.

(c) An insurer is the owner of records that:

(1) are generated by an administrator with which the insurer has entered into a written agreement under section 2 of this chapter; and

(2) pertain to the insurer.

However, the administrator retains the right to continuing access to books and records necessary to fulfill the administrator's contractual obligations to covered individuals, claimants, and the insurer.

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(d) An administrator that is licensed under section 11.1 of this chapter shall make available for inspection by the commissioner copies of written agreements with insurers.

(e) An administrator that is licensed under section 11.1 of this chapter shall:

(1) produce the administrator's accounts, records, and files for examination; and

(2) make the administrator's officers available to provide information concerning the affairs of the administrator;

whenever reasonably required by the commissioner.

(f) An administrator that is licensed under section 11.1 of this chapter shall immediately notify the commissioner of a material change in:

(1) the ownership or control of the administrator; or

(2) another fact or circumstance that affects the administrator's qualification for a license.

The commissioner, upon receiving notice under this subsection, shall report the change to ~~an electronic data base maintained by the NAIC or an affiliate or a subsidiary of the NAIC.~~ **the centralized insurance producer license registry described in IC 27-1-15.6-7.**

(g) An administrator that is licensed under section 11.1 of this chapter and that administers a governmental plan or a church plan shall maintain a bond:

(1) for the use and benefit of:

(A) the commissioner; and

(B) the insurance regulator of any state in which the administrator is authorized to conduct business; and

(2) that covers an individual and a person that has remitted premiums, insurance, charges, or other money to the administrator in the course of the administrator's business;

in an amount equal to the greater of one hundred thousand dollars ($100,000) or ten percent (10%) of the total of funds administered in connection with governmental plans or church plans in Indiana and all other states in which the administrator is authorized to conduct business.

SECTION 48. IC 27-1-25-11.1, AS AMENDED BY P.L.11-2011, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 11.1. (a) If the home state of a person is Indiana, the person shall:

(1) apply to act as an administrator in Indiana upon the uniform application **for third party administrator license;**

(2) pay an application fee in an amount determined by the

commissioner; and

(3) receive a license from the commissioner;

before performing the function of an administrator in Indiana. The commissioner shall deposit a fee paid under subdivision (2) into the department of insurance fund established by IC 27-1-3-28.

(b) The uniform application **for third party administrator license** must include or be accompanied by the following:

(1) Basic organizational documents of the applicant, including:

(A) articles of incorporation;

(B) articles of association;

(C) partnership agreement;

(D) trade name certificate;

(E) trust agreement;

(F) shareholder agreement;

(G) other applicable documents; and

(H) amendments to the documents specified in clauses (A) through (G).

(2) Bylaws, rules, regulations, or other documents that regulate the internal affairs of the applicant.

(3) The NAIC biographical affidavits for individuals who are responsible for the conduct of affairs of the applicant, including:

(A) members of the applicant's:

(i) board of directors;

(ii) board of trustees;

(iii) executive committee; or

(iv) other governing board or committee;

(B) principal officers, if the applicant is a corporation;

(C) partners or members, if the applicant is:

(i) a partnership;

(ii) an association; or

(iii) a limited liability company;

(D) shareholders or members that hold, directly or indirectly, at least ten percent (10%) of the:

(i) voting stock;

(ii) voting securities; or

(iii) voting interest;

of the applicant; and

(E) any other person who exercises control or influence over the affairs of the applicant.

(4) Financial information reflecting a positive net worth, including:

(A) audited annual financial statements prepared by an

independent certified public accountant for the two (2) most recent fiscal years; or

(B) if the applicant has been in business for less than two (2) fiscal years, financial statements or reports that are:

(i) prepared in accordance with GAAP; and

(ii) certified by an officer of the applicant;

for any completed fiscal years and for any month during the current fiscal year for which financial statements or reports have been completed.

If an audited financial statement or report required under clause (A) or (B) is prepared on a consolidated basis, the statement or report must include a columnar consolidating or combining worksheet that includes the amounts shown on the consolidated audited financial statement or report, separately reported on the worksheet for each entity included on the statement or report, and an explanation of consolidating and eliminating entries.

(5) Information determined by the commissioner to be necessary for a review of the current financial condition of the applicant.

(6) A description of the business plan of the applicant, including:

(A) information on staffing levels and activities proposed in Indiana and nationwide; and

(B) details concerning the applicant's ability to provide a sufficient number of experienced and qualified personnel for:

(i) claims processing;

(ii) record keeping; and

(iii) underwriting.

(7) Any other information required by the commissioner.

(c) An administrator that applies for licensure under this section shall make copies of written agreements with insurers available for inspection by the commissioner.

(d) An administrator that applies for licensure under this section shall:

(1) produce the administrator's accounts, records, and files for examination; and

(2) make the administrator's officers available to provide information concerning the affairs of the administrator;

whenever reasonably required by the commissioner.

(e) The commissioner may refuse to issue a license under this section if the commissioner determines that:

(1) the administrator or an individual who is responsible for the conduct of the affairs of the administrator:

(A) is not:

(i) competent;
(ii) trustworthy;
(iii) financially responsible; or
(iv) of good personal and business reputation; or

(B) has had an:
(i) insurance certificate of authority or insurance license; or
(ii) administrator certificate of authority or administrator license;

denied or revoked for cause by any jurisdiction;

(2) the financial information provided under subsection (b)(4) does not reflect that the applicant has a positive net worth; or

(3) any of the grounds set forth in section 12.4 of this chapter exists with respect to the administrator.

(f) An administrator that applies for a license under this section shall immediately notify the commissioner of a material change in:

(1) the ownership or control of the administrator; or

(2) another fact or circumstance that affects the administrator's qualification for a license.

The commissioner, upon receiving notice under this subsection, shall report the change to ~~an electronic data base maintained by the NAIC or an affiliate or a subsidiary of the NAIC.~~ **the centralized insurance producer license registry described in IC 27-1-15.6-7.**

(g) An administrator that applies for a license under this section and will administer a governmental plan or a church plan shall obtain a bond as required under section 4(g) of this chapter.

(h) A license that is issued under this section is valid:

(1) for one (1) year after the date of issuance, unless subdivision (2) applies; or

(2) until:

(A) the license is:
(i) surrendered; or
(ii) suspended or revoked by the commissioner; or

(B) the administrator:
(i) ceases to do business in Indiana; or
(ii) is not in compliance with this chapter.

SECTION 49. IC 27-1-25-12.2, AS AMENDED BY P.L.11-2011, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 12.2. (a) An administrator that:

(1) performs the duties of an administrator in Indiana; and

(2) does not hold a license issued under section 11.1 of this chapter;

shall obtain a nonresident administrator license under this section by

filing a uniform application **for third party administrator license,** accompanied by an application fee in an amount determined by the commissioner, with the commissioner. The commissioner shall deposit a fee paid under this subsection into the department of insurance fund established by IC 27-1-3-28.

(b) Unless the commissioner verifies the nonresident administrator's home state license status through ~~an electronic data base maintained by the NAIC or by an affiliate or a subsidiary of the NAIC,~~ **the centralized insurance producer license registry described in IC 27-1-15.6-7,** a uniform application **for third party administrator license** filed under subsection (a) must be accompanied by a letter of certification from the nonresident administrator's home state, verifying that the nonresident administrator holds a resident administrator license in the home state.

(c) A nonresident administrator is not eligible for a nonresident administrator license under this section unless the nonresident administrator is licensed as a resident administrator in a home state that has a law or regulation that is substantially similar to this chapter.

(d) Except as provided in subsections (b) and (h), the commissioner shall issue a nonresident administrator license to a nonresident administrator that makes a filing under subsections (a) and (b) upon receipt of the filing.

(e) Unless a nonresident administrator is notified by the commissioner that the commissioner is able to verify the nonresident administrator's home state licensure through an electronic data base described in subsection (b), the nonresident administrator shall:

(1) on September 15 of each year, file a renewal application and a statement with the commissioner affirming that the nonresident administrator maintains a current license in the nonresident administrator's home state; and

(2) pay to the commissioner a filing fee in an amount determined by the commissioner.

The commissioner shall deposit a filing fee paid under subdivision (2) into the department of insurance fund established by IC 27-1-3-28.

(f) A nonresident administrator that applies for licensure under this section shall:

(1) produce the accounts of the nonresident administrator;

(2) produce the records and files of the nonresident administrator for examination; and

(3) make the officers of the nonresident administrator available to provide information with respect to the affairs of the nonresident administrator;

when reasonably required by the commissioner.

(g) A nonresident administrator is not required to hold a nonresident administrator license in Indiana if the nonresident administrator's function in Indiana is limited to the administration of life, health, or annuity coverage for a total of not more than one hundred (100) Indiana residents.

(h) The commissioner may refuse to issue or may delay the issuance of a nonresident administrator license if the commissioner determines that:

(1) due to events occurring; or

(2) based on information obtained;

after the nonresident administrator's home state's licensure of the nonresident administrator, the nonresident administrator is unable to comply with this chapter or grounds exist for the home state's revocation or suspension of the nonresident administrator's home state license.

(i) If the commissioner makes a determination described in subsection (h), the commissioner:

(1) shall provide written notice of the determination to the insurance regulator of the nonresident administrator's home state; and

(2) may delay the issuance of a nonresident administrator license to the nonresident administrator until the commissioner determines that the nonresident administrator is able to comply with this chapter and that grounds do not exist for the home state's revocation or suspension of the nonresident administrator's home state license.

SECTION 50. IC 27-1-25-12.3, AS AMENDED BY P.L.11-2011, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 12.3. (a) An administrator that is licensed under section 11.1 of this chapter shall, not later than July 1 of each year unless the commissioner grants an extension of time for good cause, file a report for the previous calendar year that complies with the following:

(1) The report must contain financial information reflecting a positive net worth prepared in accordance with section 11.1(b)(4) of this chapter.

(2) The report must be in the form and contain matters prescribed by the commissioner.

(3) The report must be verified by at least two (2) officers of the administrator.

(4) The report must include the complete names and addresses of

insurers with which the administrator had a written agreement during the preceding fiscal year.

(5) The report must be accompanied by a filing fee in an amount determined by the commissioner.

The commissioner shall collect a filing fee paid under subdivision (5) and deposit the fee into the department of insurance fund established by IC 27-1-3-28.

(b) The commissioner shall review a report filed under subsection (a) not later than September 1 of the year in which the report is filed. Upon completion of the review, the commissioner shall:

(1) issue a certification to the administrator:

(A) indicating that:

(i) the financial statement reflects a positive net worth; and

(ii) the administrator is currently licensed and in good standing; or

(B) noting deficiencies found in the report; or

(2) update ~~an electronic data base that is maintained by the NAIC or by an affiliate or a subsidiary of the NAIC:~~ **the centralized insurance producer license registry described in IC 27-1-15.6-7:**

(A) indicating that the administrator is solvent and in compliance with this chapter; or

(B) noting deficiencies found in the report.

SECTION 51. IC 27-1-28-8 IS REPEALED [EFFECTIVE JULY 1, 2018]. ~~Sec. 8. As used in this chapter, "uniform individual application" means the NAIC uniform individual application for resident and nonresident individuals.~~

SECTION 52. IC 27-1-28-9 IS REPEALED [EFFECTIVE JULY 1, 2018]. ~~Sec. 9. As used in this chapter, "uniform business entity application" means the NAIC uniform business entity application for resident and nonresident business entities.~~

SECTION 53. IC 27-1-28-12, AS ADDED BY P.L.11-2011, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 12. (a) An individual may apply for a resident independent adjuster license by submitting:

(1) a ~~uniform individual application~~ **Uniform Application for Individual Adjusters** to the commissioner with a declaration, under penalty of suspension, revocation, or refusal of licensure, that the statements made in the application are true and complete to the best of the individual's knowledge; and

(2) an application fee of forty dollars ($40).

(b) The commissioner shall approve an application submitted under

subsection (a) upon finding all of the following:

(1) The individual is at least eighteen (18) years of age.

(2) The individual is eligible to designate Indiana as the individual's home state.

(3) The individual is determined by the commissioner to be trustworthy, reliable, and of good reputation.

(4) The individual has not committed an act that is grounds for probation, suspension, revocation, or refusal of licensure under section 18 of this chapter.

(5) The individual has completed a prelicensing course of study for the line of authority in which the individual has applied for licensing under this section.

(6) The individual has successfully passed the written examination administered under section 15 of this chapter for the line of authority in which the individual has applied for licensing under this section.

(c) The commissioner may require any documents reasonably necessary to verify the information contained in the application.

SECTION 54. IC 27-1-28-13, AS AMENDED BY P.L.148-2017, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 13. (a) A business entity may apply for a resident independent adjuster license by submitting:

(1) a ~~uniform business entity application~~ **Uniform Application for Business Entity Adjusters** to the commissioner with a declaration, under penalty of suspension, revocation, or refusal of licensure, that the statements made in the application are true and complete to the best knowledge of the individual submitting the application on behalf of the business entity;

(2) an application fee of forty dollars ($40); and

(3) the name, address, and criminal and administrative history of each of the following:

(A) An owner that has at least ten percent (10%) interest or voting interest in the business entity.

(B) A partner of the business entity.

(C) An executive officer of the business entity.

(D) A director of the business entity.

(b) The commissioner shall approve an application submitted by a business entity under subsection (a) upon finding all of the following:

(1) The business entity is eligible to designate Indiana as the business entity's home state.

(2) The business entity has designated an individual independent adjuster licensed under this chapter to be responsible for the

business entity's compliance with Indiana insurance law.

(3) The business entity has not committed any act that is grounds for probation, suspension, revocation, or refusal of an independent adjuster license under section 18 of this chapter.

(c) The commissioner may require a business entity applying under this section to produce any documents reasonably necessary to verify the information contained in the application.

SECTION 55. IC 27-1-35-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. As used in this chapter, "accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established ~~periodically~~ by the ~~National Association of Insurance Commissioners (NAIC).~~ **NAIC.**

SECTION 56. IC 27-1-36-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 4. As used in this chapter, the "authorized control level RBC" means, with respect to an insurer, the number determined under the risk-based capital formula in accordance with the RBC ~~instructions.~~ **Instructions.**

SECTION 57. IC 27-1-36-9.3, AS ADDED BY P.L.276-2013, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 9.3. As used in this chapter, "health insurer" means the following:

(1) A health maintenance organization.

(2) A limited service health maintenance organization.

(3) An insurer that makes one (1) or more of the types of insurance described in Class 1(b) or Class 2(a) of IC 27-1-5-1.

(4) An insurer that files a health ~~blank~~ **Annual Statement Blank** in accordance with the ~~NAIC~~ **applicable** Annual Statement Instructions.

SECTION 58. IC 27-1-36-17 IS REPEALED [EFFECTIVE JULY 1, 2018]. ~~Sec. 17. As used in this chapter, "RBC instructions" means the RBC report including risk based capital instructions adopted by the NAIC, as amended by the NAIC.~~

SECTION 59. IC 27-1-36-24 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 24. As used in this chapter, "total adjusted capital" means the sum of:

(1) an insurer's statutory capital and surplus determined in accordance with the statutory accounting **principles and practices that are** applicable to the annual financial statements required to be filed under IC 27-1-3.5; and

(2) other items, if any, that the RBC ~~instructions~~ **Instructions**

may provide.

SECTION 60. IC 27-1-36-25 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 25. (a) A domestic insurer shall prepare a report of the RBC levels of the insurer as of the last day of the calendar year most recently ended. The report must:

(1) be in the form; and

(2) contain the information;

required by the RBC ~~instructions.~~ **Instructions.**

(b) On or before March 1 of each year, a domestic insurer shall file the RBC report described in subsection (a) with:

(1) the commissioner;

(2) the NAIC, in accordance with the RBC ~~instructions;~~ **Instructions;** and

(3) the insurance commissioner in any state other than Indiana in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer in writing of the commissioner's request for the insurer's RBC report.

An insurer is not required to pay a fee when filing an RBC report under this subsection.

(c) If an insurer is required under subsection (b)(3) to file its RBC report with the insurance commissioner of a state other than Indiana, the insurer shall file the RBC report with the insurance commissioner of that state not later than:

(1) fifteen (15) days after the insurer receives the notice; or

(2) March 1 of the calendar year in which the insurer receives the notice;

whichever occurs later.

SECTION 61. IC 27-2-6-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. Any life insurance, fire insurance, livestock insurance, casualty or accident insurance, or bonding or surety company, or trust company or savings bank now or hereafter organized under the laws of the state of Indiana, in addition to the investments now authorized by law, be and it hereby is authorized and empowered to invest its funds in obligations issued by or for federal land banks, federal intermediate credit banks and banks for cooperatives under the Farm Credit Act of 1971 (12 U.S.C. 2001 et seq.) ~~As amended~~ and such obligations are hereby declared eligible for any deposit required of any such company under the laws of this state.

SECTION 62. IC 27-2-8-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. The insurance commissioner shall annually forward to all departments and divisions of the state requiring the posting of security because of motor vehicle

accidents and resultant damage and loss a list of those insurers which are, or which are agreeable to be, examined by the insurance department in the same manner as set out in IC 27-1-3-7 and IC 27-1-3.1, and set up and maintain liabilities and reserves in the same manner as set out in IC 27-1-13-8, and submit a written statement of their financial condition and their operations on the forms as prescribed by the ~~National Association of Insurance Commissioners~~ **NAIC and adopted in rules adopted under IC 4-22-2 by the insurance commissioner,** and in the same manner as set out in IC 27-1-3-7 and IC 27-1-20-21. No certificates or policies shall be accepted by such departments or divisions as such security unless the insurer so filing the certificate or policy shall have met or is agreeable to meeting the requirements as set out above.

SECTION 63. IC 27-2-10-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 7. The provisions of sections 1, 2, and 3 of this chapter shall not apply to transactions in equity securities of a domestic stock insurance company if:

(a) such securities shall be registered, or shall be required to be registered, pursuant to section 12 of the Securities Exchange Act of 1934 ~~(15 U.S.C. 781), as amended;~~ **(15 U.S.C. 78l);** or

(b) such domestic stock insurance company shall not have any class of its equity securities held of record by one hundred (100) or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of sections 1, 2, and 3 of this chapter except for the provisions of this subdivision.

SECTION 64. IC 27-4-1-4, AS AMENDED BY P.L.227-2015, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 4. (a) The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement:

(A) misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(B) making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer

operates;

(D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(E) making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender the policyholder's insurance.

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Entering into any agreement to commit, or individually or by a concerted action committing any act of boycott, coercion, or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive. Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

(6) Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Making or permitting any of the following:

(A) Unfair discrimination between individuals of the same class and equal expectation of life in the rates or assessments charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract. However, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(B) Unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, assessments, or rates charged or made for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. However, in determining the class, consideration may be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(C) Excessive or inadequate charges for premiums, policy fees, assessments, or rates, or making or permitting any unfair discrimination between persons of the same class involving essentially the same hazards, in the amount of premiums, policy fees, assessments, or rates charged or made for:

(i) policies or contracts of reinsurance or joint reinsurance, or abstract and title insurance;

(ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance; or

(iii) policies or contracts of any other kind or kinds of insurance whatsoever.

However, nothing contained in clause (C) shall be construed to

apply to any of the kinds of insurance referred to in clauses (A) and (B) nor to reinsurance in relation to such kinds of insurance. Nothing in clause (A), (B), or (C) shall be construed as making or permitting any excessive, inadequate, or unfairly discriminatory charge or rate or any charge or rate determined by the department or commissioner to meet the requirements of any other insurance rate regulatory law of this state.

(8) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends, savings, or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract or policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, limited liability company, or partnership, or any dividends, savings, or profits accrued thereon, or anything of value whatsoever not specified in the contract. Nothing in this subdivision and subdivision (7) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(A) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, so long as any such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the company and its policyholders.

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first year or of any subsequent year of insurance thereunder, which may be made retroactive only for such

policy year.

(D) Paying by an insurer or insurance producer thereof duly licensed as such under the laws of this state of money, commission, or brokerage, or giving or allowing by an insurer or such licensed insurance producer thereof anything of value, for or on account of the solicitation or negotiation of policies or other contracts of any kind or kinds, to a broker, an insurance producer, or a solicitor duly licensed under the laws of this state, but such broker, insurance producer, or solicitor receiving such consideration shall not pay, give, or allow credit for such consideration as received in whole or in part, directly or indirectly, to the insured by way of rebate.

(9) Requiring, as a condition precedent to loaning money upon the security of a mortgage upon real property, that the owner of the property to whom the money is to be loaned negotiate any policy of insurance covering such real property through a particular insurance producer or broker or brokers. However, this subdivision shall not prevent the exercise by any lender of the lender's right to approve or disapprove of the insurance company selected by the borrower to underwrite the insurance.

(10) Entering into any contract, combination in the form of a trust or otherwise, or conspiracy in restraint of commerce in the business of insurance.

(11) Monopolizing or attempting to monopolize or combining or conspiring with any other person or persons to monopolize any part of commerce in the business of insurance. However, participation as a member, director, or officer in the activities of any nonprofit organization of insurance producers or other workers in the insurance business shall not be interpreted, in itself, to constitute a combination in restraint of trade or as combining to create a monopoly as provided in this subdivision and subdivision (10). The enumeration in this chapter of specific unfair methods of competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or department or of any court of review under section 8 of this chapter.

(12) Requiring as a condition precedent to the sale of real or personal property under any contract of sale, conditional sales contract, or other similar instrument or upon the security of a chattel mortgage, that the buyer of such property negotiate any policy of insurance covering such property through a particular

insurance company, insurance producer, or broker or brokers. However, this subdivision shall not prevent the exercise by any seller of such property or the one making a loan thereon of the right to approve or disapprove of the insurance company selected by the buyer to underwrite the insurance.

(13) Issuing, offering, or participating in a plan to issue or offer, any policy or certificate of insurance of any kind or character as an inducement to the purchase of any property, real, personal, or mixed, or services of any kind, where a charge to the insured is not made for and on account of such policy or certificate of insurance. However, this subdivision shall not apply to any of the following:

(A) Insurance issued to credit unions or members of credit unions in connection with the purchase of shares in such credit unions.

(B) Insurance employed as a means of guaranteeing the performance of goods and designed to benefit the purchasers or users of such goods.

(C) Title insurance.

(D) Insurance written in connection with an indebtedness and intended as a means of repaying such indebtedness in the event of the death or disability of the insured.

(E) Insurance provided by or through motorists service clubs or associations.

(F) Insurance that is provided to the purchaser or holder of an air transportation ticket and that:

(i) insures against death or nonfatal injury that occurs during the flight to which the ticket relates;

(ii) insures against personal injury or property damage that occurs during travel to or from the airport in a common carrier immediately before or after the flight;

(iii) insures against baggage loss during the flight to which the ticket relates; or

(iv) insures against a flight cancellation to which the ticket relates.

(14) Refusing, because of the for-profit status of a hospital or medical facility, to make payments otherwise required to be made under a contract or policy of insurance for charges incurred by an insured in such a for-profit hospital or other for-profit medical facility licensed by the state department of health.

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of

coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(16) Committing or performing, with such frequency as to indicate a general practice, unfair claim settlement practices (as defined in section 4.5 of this chapter).

(17) Between policy renewal dates, unilaterally canceling an individual's coverage under an individual or group health insurance policy solely because of the individual's medical or physical condition.

(18) Using a policy form or rider that would permit a cancellation of coverage as described in subdivision (17).

(19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1 concerning motor vehicle insurance rates.

(20) Violating IC 27-8-21-2 concerning advertisements referring to interest rate guarantees.

(21) Violating IC 27-8-24.3 concerning insurance and health plan coverage for victims of abuse.

(22) Violating IC 27-8-26 concerning genetic screening or testing.

(23) Violating IC 27-1-15.6-3(b) concerning licensure of insurance producers.

(24) Violating IC 27-1-38 concerning depository institutions.

(25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning the resolution of an appealed grievance decision.

(26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).

(27) Violating IC 27-2-21 concerning use of credit information.

(28) Violating IC 27-4-9-3 concerning recommendations to consumers.

(29) Engaging in dishonest or predatory insurance practices in marketing or sales of insurance to members of the United States Armed Forces as:

(A) described in the federal Military Personnel Financial Services Protection Act, P.L.109-290; or

(B) defined in rules adopted under subsection (b).

(30) Violating IC 27-8-19.8-20.1 concerning stranger originated life insurance.

(31) Violating IC 27-2-22 concerning retained asset accounts.

(32) Violating IC 27-8-5-29 concerning health plans offered through a health benefit exchange (as defined in IC 27-19-2-8).

(33) Violating a requirement of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), that is enforceable by the state.

(34) After June 30, 2015, violating IC 27-2-23 concerning unclaimed life insurance, annuity, or retained asset account benefits.

(35) Willfully violating IC 27-1-12-46 concerning a life insurance policy or certificate described in IC 27-1-12-46(a).

(b) Except with respect to federal insurance programs under Subchapter III of Chapter 19 of Title 38 of the United States Code, the commissioner may, consistent with the federal Military Personnel Financial Services Protection Act ~~(P.L.109-290),~~ **(10 U.S.C. 992 note),** adopt rules under IC 4-22-2 to:

(1) define; and

(2) while the members are on a United States military installation or elsewhere in Indiana, protect members of the United States Armed Forces from;

dishonest or predatory insurance practices.

SECTION 65. IC 27-4-5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. The purpose of this chapter is to subject certain insurers to the jurisdiction of the insurance commissioner and the courts of this state in suits by or on behalf of the state. The general assembly declares that it is concerned with the protection of residents of this state against acts by insurers not authorized to do an insurance business in this state, by the maintenance of fair and honest insurance markets, by protecting authorized insurers which are subject to regulation from unfair competition by unauthorized insurers, and by protecting against the evasion of the insurance regulatory laws of this state. In furtherance of such state interest, the general assembly provides methods in this chapter for substituted service of process upon such insurers in any proceeding, suit, or action in any court and substituted service of any notice, order, pleading, or process upon such insurers in any proceeding by the commissioner of insurance to enforce or effect full compliance with this title. In so doing, the state exercises its powers to protect residents of this state and to define what constitutes transacting an insurance business in this state, and also exercises powers and privileges available to this state by virtue of 15 U.S.C. 1011 through 1015, ~~as amended,~~ which declares that the business of insurance and every

person engaged therein shall be subject to the laws of the several states.

SECTION 66. IC 27-6-8-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 12. To aid in the detection and prevention of insurer insolvencies:

(1) Every member insurer shall file with the ~~National Association of Insurance Commissioners~~ **NAIC** for use in their Early Warning System on or before March 1 of each year a financial statement of the same type and content as required by IC 27-1-20-21.

(2) It shall be the duty of the commissioner:

(A) To notify the commissioners of all of the other states, territories of the United States, and the District of Columbia in which a member insurer is licensed to do business when he takes any of the following actions against a member insurer:

(i) revocation of license;

(ii) suspension of license;

(iii) makes any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or an increase in capital, surplus, or any other account for the security of policyholders or creditors. Such notice shall be mailed to all commissioners within thirty (30) days following the action taken or the date on which such action occurs.

(B) To report to the board of directors when he has taken any of the actions set forth in (A) of this paragraph or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(C) To report to the board of directors when he has reasonable cause to believe from any examination, whether completed or in process, of any member company, that such company may be insolvent or in a financial condition hazardous to the policyholders or the public.

(3) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member companies and companies seeking admission to transact insurance business in this state.

(4) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or

conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Such reports and recommendations shall not be considered public documents.

(5) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within thirty (30) days of the receipt of such request, the commissioner shall begin such examination. The examination may be conducted as a ~~National Association of Insurance Commissioners~~ **NAIC** examination or may be conducted by such persons as the commissioner designates provided such persons are qualified insurance accountants or actuaries. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection (1). The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

(6) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

SECTION 67. IC 27-6-9-11 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 11. As used in this chapter, "qualified United States financial institution" means an institution that:

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

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

(3) has been determined by:

(A) the commissioner; or

(B) the Securities Valuation Office of the ~~National Association of Insurance Commissioners;~~ **NAIC;**

to meet such standards of financial condition and standing as are

considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

SECTION 68. IC 27-6-10-5, AS AMENDED BY P.L.81-2012, SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 5. As used in section 14(c)(3) of this chapter, "qualified United States financial institution" means an institution that:

(1) is organized, or in the case of a United States office of a foreign banking organization licensed, under the laws of the United States or any state thereof;

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

(3) has been determined by the commissioner or the Securities Valuation Office of the ~~National Association of Insurance Commissioners~~ **NAIC** to meet the standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

SECTION 69. IC 27-6-10-11, AS AMENDED BY P.L.81-2012, SECTION 28, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 11. (a) As provided in section 7 of this chapter and subject to section 13.3 of this chapter, credit for reinsurance shall be allowed a domestic ceding insurer when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution (as defined in section 6 of this chapter) for the payment of the valid claims of its United States ceding insurers, their assigns, and successors in interest, and the assuming insurer complies with section 12 of this chapter. In order for the commissioner to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the commissioner substantially the same information as that required to be reported by licensed insurers on the ~~National Association of Insurance Commissioners' annual statement form.~~ **Annual Statement Blank.** The assuming insurer shall submit to the examination of the assuming insurer's books and records by the commissioner and shall bear the expense of the examination. A trust maintained under this section shall comply with the provisions of this section.

(b) The form of a trust described in subsection (a) and any amendments to the trust must:

(1) have been approved by:

(A) the commissioner of the state where the trust is domiciled;

or

(B) the commissioner of another state who, under the terms of the trust instrument, has accepted principal regulatory oversight of the trust; and

(2) be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled.

(c) The following requirements apply to the following categories of assuming insurer:

(1) In the case of a trust of a single assuming insurer, the following apply:

(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.

(B) Except as provided in clause (C), the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars ($20,000,000).

(C) After the assuming insurer has, for at least three (3) full years, permanently discontinued underwriting new business secured by the trust and the commissioner that has principal regulatory oversight of the trust has performed a risk assessment:

(i) that may involve an actuarial review, including an independent analysis of reserves and cash flows; and

(ii) that considers all material risk factors, including the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements specified in clause (B) on the assuming insurer's liquidity or solvency;

and determined that a surplus level that is less than the amount required by clause (B) is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development, the commissioner may authorize a reduction in the trusteed surplus amount required by clause (B). However, the amount required by clause (B) may not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities that are attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(2) In the case of a group including incorporated and individual unincorporated underwriters that is an assuming insurer, the following apply:

(A) For reinsurance ceded under reinsurance agreements with

an inception, amendment, or renewal date after December 31, 1992, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States ceding insurers to any underwriter of the group.

(B) Notwithstanding any other provision of this chapter, for reinsurance ceded under reinsurance agreements with an inception date before January 1, 1993, and not amended or renewed after December 31, 1992, 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 the trusts described in clauses (A) and (B), the group shall maintain in trust a trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of United States ceding insurers of any member of the group for all years of account.

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

Not more than ninety (90) days after the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member. However, if a certification is unavailable, the group shall provide to the commissioner financial statements of each underwriter member of the group, prepared by independent public accountants.

(3) In the case of a group of incorporated underwriters under common administration that is an assuming insurer, the group:

(A) must have continuously transacted an insurance business outside the United States for at least three (3) years immediately before making application for accreditation;

(B) shall maintain an aggregate policyholders' surplus of at least ten billion dollars ($10,000,000,000);

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

(D) shall maintain a joint trusteed surplus of which one

hundred million dollars ($100,000,000) shall be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities; and (E) shall, not more than ninety (90) days after 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) financial statements of each underwriter member of the group prepared by the member's independent public accountant.

(d) The trust instrument of a trust shall provide that contested claims are valid and enforceable upon the final order of any court with jurisdiction in the United States.

(e) A trust shall vest legal title to the trust's assets in the trustees of the trust for the benefit of the assuming insurer's United States ceding insurers, their assigns, and successors in interest.

(f) A trust and the assuming insurer shall be subject to examination as determined by the commissioner.

(g) A trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(h) Not later than February 28 of each year the trustee of a trust permitted under this section shall report in writing to the commissioner the following information:

(1) The balance of the trust.

(2) A listing of the trust's investments at the preceding year end.

(3) A certification of the date of termination of the trust, if applicable, or a certification that the trust shall not expire before the following December 31.

(i) Credit may only be permitted under this section if an assuming insurer also complies with section 12 of this chapter.

SECTION 70. IC 27-6-10-11.5, AS ADDED BY P.L.81-2012, SECTION 29, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 11.5. (a) As provided in section 7 of this chapter and subject to section 13.3 of this chapter, credit for reinsurance shall be allowed a domestic ceding insurer when the reinsurance is ceded to an assuming insurer that:

(1) has been certified as a certified reinsurer by the commissioner in Indiana; and

(2) secures the assuming insurer's obligations as required by this section.

(b) An assuming insurer must do all of the following to be eligible for certification under this section:

(1) Be domiciled and licensed to engage in insurance or reinsurance business in a jurisdiction that has been determined under subsection (d) or (e) by the commissioner to be a qualified jurisdiction.

(2) Maintain minimum capital and surplus, or the equivalent, in an amount determined by the commissioner in rules adopted under IC 4-22-2.

(3) Maintain financial strength ratings from at least two (2) rating agencies that the commissioner determines acceptable under rules adopted under IC 4-22-2.

(4) Agree to submit to the jurisdiction of Indiana.

(5) Appoint the commissioner as the assuming insurer's agent for service of process in Indiana.

(6) Agree to provide security for one hundred percent (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.

(7) Agree to meet information filing requirements determined by the commissioner, at the time of application for certification and on an ongoing basis.

(8) Satisfy any other requirements specified by the commissioner.

(c) An association that includes incorporated and individual unincorporated underwriters may be certified under this section if all of the following requirements are met:

(1) The association must meet all of the requirements described in subsection (b).

(2) The association must satisfy 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, including a joint central fund:

(A) that may be applied to any unsatisfied obligation of the association or any of the association's members; and

(B) in an amount determined by the commissioner to provide adequate protection.

(3) The incorporated members of the association:

(A) may not engage in any business other than underwriting as a member of the association; and

(B) are subject to the same level of regulation and solvency control by the association's domiciliary regulator as the level that applies to the unincorporated members of the association.

(4) Not more than ninety (90) days after the association's financial statements are due to be filed with the association's domiciliary regulator, the association must provide to the commissioner:

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

(B) if a certification is unavailable, financial statements prepared by the independent public accountant;

of each underwriter member of the association.

(d) The commissioner shall create and publish a list of non-United States jurisdictions that the commissioner determines are qualified jurisdictions. The following requirements apply to the commissioner's creation, publication, maintenance, and use of the list created and published under this subsection:

(1) In determining whether a jurisdiction is a qualified jurisdiction, the commissioner shall:

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

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

(C) consider the list of qualified jurisdictions that is published by the ~~National Association of Insurance Commissioners~~ **NAIC** committee process; and

(D) consider any other factors that the commissioner considers necessary, including any of the following:

(i) The framework under which the assuming insurer is regulated.

(ii) The structure and authority of the domiciliary regulator with respect to solvency requirements and financial surveillance.

(iii) The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.

(iv) The form and substance of financial reports required to be filed or made public by reinsurers in the domiciliary jurisdiction, and the accounting principals used.

(v) The domiciliary regulator's willingness to cooperate with United States regulators and the commissioner.

(vi) The history of performance by assuming insurers in the domiciliary jurisdiction.

(vii) Documented evidence of substantial problems in the domiciliary jurisdiction with the enforcement of final United

States judgments.

(viii) Relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors. ~~or a successor organization.~~

(2) A jurisdiction considered for qualification under this subsection must:

(A) agree to share information and cooperate with the commissioner with respect to all certified reinsurers that are domiciled in the jurisdiction; and

(B) not have been determined by the commissioner not to have adequately and promptly enforced final United States judgments and arbitration awards;

to be determined to be a qualified jurisdiction.

(3) If the commissioner determines that a jurisdiction is qualified, but the qualified jurisdiction does not appear on the ~~National Association of Insurance Commissioners~~ **NAIC** list described in subdivision (1)(C), the commissioner must thoroughly document the commissioner's justification for the determination in accordance with criteria established by the commissioner in rules adopted under IC 4-22-2.

(e) The commissioner:

(1) shall consider a United States jurisdiction that meets the requirements for accreditation under the ~~National Association of Insurance Commissioners financial standards and accreditation program~~ **Financial Regulation Standards and Accreditation Program** to be a qualified jurisdiction; and

(2) may, instead of revocation, indefinitely suspend a certified reinsurer's certification under this section if the certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction.

(f) The commissioner shall:

(1) after considering the financial strength ratings assigned to the certified reinsurer by rating agencies considered acceptable to the commissioner according to rules adopted under IC 4-22-2, assign a rating to each certified reinsurer; and

(2) publish a list of all certified reinsurers and the rating assigned to each certified reinsurer under subdivision (1).

(g) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this section at a level consistent with the rating assigned by the commissioner under subsection (f), as follows:

(1) 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:

(A) in a form acceptable to the commissioner and consistent with section 14 of this chapter; or

(B) in a multibeneficiary trust under section 11 of this chapter.

(2) If a certified reinsurer:

(A) maintains a trust to fully secure the certified reinsurer's obligations under section 11 of this chapter; and

(B) chooses to secure the certified reinsurer's obligations incurred as a certified reinsurer under this section in the form of a multibeneficiary trust;

the certified reinsurer shall maintain separate trust accounts for the certified reinsurer's obligations under section 11 of this chapter and for the certified reinsurer's obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security under this section or comparable laws of other United States jurisdictions.

(3) If a certified reinsurer described in subdivision (2) has not agreed:

(A) in the language of the trust; and

(B) under an agreement with the commissioner that has principal regulatory oversight of each trust account described in subdivision (2);

to fund, upon termination of any of the trust accounts and from the surplus of the terminated trust account, any deficiency of any of the other trust accounts, the commissioner shall revoke the certified reinsurer's certification under this section.

(4) The minimum trusteed surplus requirements of section 11 of this chapter do not apply with respect to a multibeneficiary trust that is maintained by a certified reinsurer for the purpose of securing obligations incurred by the certified reinsurer under this section. However, the multibeneficiary trust must maintain a minimum trusteed surplus of at least ten million dollars ($10,000,000).

(5) If the security for obligations incurred by a certified reinsurer under this section is insufficient, the commissioner:

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

(B) may impose further reductions in the allowable credit if the commissioner determines that a material risk exists that the certified reinsurer's obligations will not be paid in full when

the obligations are due.

(6) If the certification of an assuming insurer under this section is revoked, suspended, inactivated, or voluntarily surrendered, the commissioner shall, for purposes of reinsurance in force:

(A) except as provided in clause (B), regulate the assuming insurer as if the assuming insurer were a certified reinsurer; and

(B) require that the assuming insurer provide security for one hundred percent (100%) of the assuming insurer's obligations attributable to the reinsurance in force.

However, clause (B) does not apply to an assuming insurer after certification is suspended or inactivated if, after suspension or inactivation, the commissioner assigns a new rating to the assuming insurer that is higher than the rating assigned under subsection (f)(1) before certification was suspended or inactivated.

(h) If an assuming insurer that applies for certification under this section is a certified reinsurer in a jurisdiction that is accredited by the ~~National Association of Insurance Commissioners,~~ **NAIC,** the commissioner may:

(1) defer to the:

(A) accredited jurisdiction's certification of the assuming insurer; and

(B) rating assigned to the assuming insurer by the accredited jurisdiction; and

(2) consider the assuming insurer a certified reinsurer in Indiana without the assuming insurer meeting the requirements of subsection (b)(2) and (b)(3).

(i) A certified reinsurer that ceases to assume new business in Indiana may request that the commissioner allow the certified reinsurer to maintain certification in inactive status to continue to qualify for the reduction in security for the certified reinsurer's in-force business in Indiana. If inactive status is granted by the commissioner, the certified reinsurer shall continue to comply with this section and the commissioner shall, after considering the reasons that the certified reinsurer has ceased assuming new business in Indiana, assign a new rating to the certified reinsurer.

(j) If a certified reinsurer continues throughout the year to pay claims in a timely manner, the certified reinsurer is not, for one (1) year after the date of the first liability reserve entry by a ceding company resulting from a loss from a catastrophic occurrence recognized by the commissioner, required to post security for the catastrophe

recoverables in the following lines of business (as reported on the ~~National Association of Insurance Commissioners annual financial statement~~ **Annual Statement Blank** and specifically related to the catastrophic occurrence):

(1) Fire.

(2) Allied lines.

(3) Farmowners multiple peril.

(4) Homeowners multiple peril.

(5) Commercial multiple peril.

(6) Inland marine.

(7) Earthquake.

(8) Motor vehicle physical damage.

SECTION 71. IC 27-6-10-14, AS AMENDED BY P.L.81-2012, SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 14. (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 section 8, 9, 10, 11, 11.5, 12, 13, 13.3, 13.6, or 13.8 of this chapter shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer.

(b) The reduction permitted under subsection (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, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder. The security must be held:

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

(2) in the case of a trust, in a qualified United States financial institution (as defined in section 6 of this chapter).

(c) The security described under subsection (b) may be in the following forms:

(1) Cash.

(2) Securities listed by the Securities Valuation Office, ~~of the National Association of Insurance Commissioners,~~ including securities that are considered exempt from filing (as defined by the Purposes and Procedures Manual of the ~~Securities Valuation Office~~) **NAIC Investment Analysis Office)** and qualifying as admitted assets.

(3) Clean, irrevocable, unconditional letters of credit:

(A) issued or confirmed by a qualified United States financial institution (as defined in section 5 of this chapter);

(B) effective not later than December 31 in the year for which the filing is being made; and

(C) in the possession of or in trust for the ceding insurer on or before the filing date of the ceding insurer's annual statement.

Letters of credit that meet 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 the earlier of their expiration, extension, renewal, modification, or amendment.

(4) Any other form of security acceptable to the commissioner.

SECTION 72. IC 27-7-3-15.5, AS AMENDED BY P.L.72-2016, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 15.5. (a) This section applies to the following transactions:

(1) A mortgage transaction (as defined in IC 24-9-3-7(a)) that:

(A) is:

(i) a first lien purchase money mortgage transaction; or

(ii) a refinancing transaction; and

(B) is closed by a closing agent after December 31, 2009.

(2) A real estate transaction (as defined in IC 24-9-3-7(b)) that:

(A) does not involve a mortgage transaction described in subdivision (1); and

(B) is closed by a closing agent (as defined in IC 6-1.1-12-43(a)(2)) after December 31, 2011.

(b) For purposes of this subsection, a person described in this subsection is involved in a transaction to which this section applies if the person participates in or assists with, or will participate in or assist with, a transaction to which this section applies. The department shall establish and maintain an electronic system for the collection and storage of the following information, to the extent applicable, concerning a transaction to which this section applies:

(1) In the case of a transaction described in subsection (a)(1), the name and license number (under IC 23-2-5) of each loan brokerage business involved in the transaction.

(2) In the case of a transaction described in subsection (a)(1), the name and license or registration number of any mortgage loan originator who is:

(A) either licensed or registered under state or federal law as a mortgage loan originator consistent with the Secure and Fair Enforcement for Mortgage Licensing Act of 2008 ~~(H.R. 3221 Title V);~~ **(12 U.S.C. 5101 et seq.);** and

(B) involved in the transaction.

(3) The name and license number (under IC 25-34.1) of each:

(A) broker company; and

(B) broker if any;

involved in the transaction.

(4) The following information:

(A) The:

(i) name of; and

(ii) code assigned by the ~~National Association of Insurance Commissioners (NAIC)~~ **NAIC** to;

each title insurance underwriter involved in the transaction.

(B) The type of title insurance policy issued in connection with the transaction.

(5) The name and license number (under IC 27-1-15.6) of each title insurance agency and agent involved in the transaction as a closing agent (as defined in IC 6-1.1-12-43(a)(2)).

(6) The following information:

(A) The name and:

(i) license or certificate number (under IC 25-34.1-3-8) of each licensed or certified real estate appraiser; or

(ii) license number (under IC 25-34.1) of each broker;

who appraises the property that is the subject of the transaction.

(B) The name and registration number (under IC 25-34.1-11-10) of any appraisal management company that performs appraisal management services (as defined in IC 25-34.1-11-3) in connection with the transaction.

(7) In the case of a transaction described in subsection (a)(1), the name of the creditor and, if the creditor is required to be licensed under IC 24-4.4, the license number of the creditor.

(8) In the case of a transaction described in subsection (a)(1)(A)(i) or (a)(2), the name of the seller of the property that is the subject of the transaction.

(9) In the case of a transaction described in subsection (a)(1)(A)(i), the following information:

(A) The name of the buyer of the property that is the subject of the transaction.

(B) The purchase price of the property that is the subject of the transaction.

(C) The loan amount of the mortgage transaction.

(10) In the case of a transaction described in subsection (a)(2), the following information:

(A) The name of the buyer of the property that is the subject of

the transaction.

(B) The purchase price of the property that is the subject of the transaction.

(11) In the case of a transaction described in subsection (a)(1)(A)(ii), the following information:

(A) The name of the borrower in the mortgage transaction.

(B) The loan amount of the refinancing.

(12) The:

(A) name; and

(B) license number, certificate number, registration number, or other code, as appropriate;

of any other person that is involved in a transaction to which this section applies, as the department may prescribe.

(c) The system established by the department under this section must include a form that:

(1) is uniformly accessible in an electronic format to the closing agent (as defined in IC 6-1.1-12-43(a)(2)) in the transaction; and

(2) allows the closing agent to do the following:

(A) Input information identifying the property that is the subject of the transaction by lot or parcel number, street address, or some other means of identification that the department determines:

(i) is sufficient to identify the property; and

(ii) is determinable by the closing agent.

(B) Subject to subsection (d) and to the extent determinable, input the applicable information described in subsection (b).

(C) Respond to the following questions, if applicable:

(i) "On what date did you receive the closing instructions from the creditor in the transaction?".

(ii) "On what date did the transaction close?".

(D) Submit the form electronically to a data base maintained by the department.

(d) Not later than the time of the closing or the date of disbursement, whichever is later, each person described in subsection (b), other than a person described in subsection (b)(8), (b)(9), (b)(10), or (b)(11), shall provide to the closing agent in the transaction the person's:

(1) legal name; and

(2) license number, certificate number, registration number, or NAIC code, as appropriate;

to allow the closing agent to comply with subsection (c)(2)(B). In the case of a transaction described in subsection (a)(1), the person described in subsection (b)(7) shall, with the cooperation of any person

involved in the transaction and described in subsection (b)(6)(A) or (b)(6)(B), provide the information described in subsection (b)(6). In the case of a transaction described in subsection (a)(1)(A)(ii), the person described in subsection (b)(7) shall also provide the information described in subsection (b)(11). A person described in subsection (b)(3)(B) who is involved in the transaction may provide the information required by this subsection for a person described in subsection (b)(3)(A) that serves as the broker company for the person described in subsection (b)(3)(B). The closing agent shall determine the information described in subsection (b)(8), (b)(9), and (b)(10) from the HUD-1 settlement statement, or in the case of a transaction described in subsection (a)(2), from the contract or any other document executed by the parties in connection with the transaction.

(e) The closing agent in a transaction to which this section applies shall submit the information described in subsection (d) to the data base described in subsection (c)(2)(D) not later than twenty (20) business days after the date of closing or the date of disbursement, whichever is later.

(f) Except for a person described in subsection (b)(8), (b)(9), (b)(10), or (b)(11), a person described in subsection (b) who fails to comply with subsection (d) or (e) is subject to a civil penalty of one hundred dollars ($100) for each closing with respect to which the person fails to comply with subsection (d) or (e). The penalty:

(1) may be enforced by the state agency that has administrative jurisdiction over the person in the same manner that the agency enforces the payment of fees or other penalties payable to the agency; and

(2) shall be paid into the home ownership education account established by IC 5-20-1-27.

(g) Subject to subsection (h), the department shall make the information stored in the data base described in subsection (c)(2)(D) accessible to:

(1) each entity described in IC 4-6-12-4; and

(2) the homeowner protection unit established under IC 4-6-12-2.

(h) The department, a closing agent who submits a form under subsection (c), each entity described in IC 4-6-12-4, and the homeowner protection unit established under IC 4-6-12-2 shall exercise all necessary caution to avoid disclosure of any information:

(1) concerning a person described in subsection (b), including the person's license, registration, or certificate number; and

(2) contained in the data base described in subsection (c)(2)(D);

except to the extent required or authorized by state or federal law.

(i) The department may adopt rules under IC 4-22-2, including emergency rules under IC 4-22-2-37.1, to implement this section. Rules adopted by the department under this subsection may establish procedures for the department to:

(1) establish;

(2) collect; and

(3) change as necessary;

an administrative fee to cover the department's expenses in establishing and maintaining the electronic system required by this section.

(j) If the department adopts a rule under IC 4-22-2 to establish an administrative fee to cover the department's expenses in establishing and maintaining the electronic system required by this section, as allowed under subsection (i), the department may:

(1) require the fee to be paid:

(A) to the closing agent responsible for inputting the information and submitting the form described in subsection (c)(2); and

(B) by the borrower, the seller, or the buyer in the transaction;

(2) allow the closing agent described in subdivision (1)(A) to retain a part of the fee collected to cover the closing agent's costs in inputting the information and submitting the form described in subsection (c)(2); and

(3) require the closing agent to pay the remainder of the fee collected to the department for deposit in the title insurance enforcement fund established by IC 27-7-3.6-1, for the department's use in establishing and maintaining the electronic system required by this section.

SECTION 73. IC 27-7-10-14 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 14. (a) A risk retention group that is chartered and licensed in a state other than Indiana and that seeks to do business in Indiana shall comply with this section and with sections 15 through 22 of this chapter.

(b) Before offering insurance in Indiana, a risk retention group shall submit to the commissioner the following:

(1) A statement that sets forth the following:

(A) The state or states in which the risk retention group is chartered and licensed as a liability insurance company.

(B) The date on which the charter of the group was issued.

(C) The group's principal place of business.

(D) Any other information (including information on the membership of the group) that the commissioner may require to verify that the group meets the definition of risk retention

group in section 11 of this chapter.

(2) A copy of the plan of operations or feasibility study, and of any revisions of that plan or study, submitted by the risk retention group to the state in which the group is chartered and licensed.

(3) A copy of the group's charter or license from its chartering state.

(4) A statement of registration (for which a filing fee shall be determined by the commissioner) that designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

(c) A risk retention group that is chartered and licensed in a state other than Indiana and that is doing or seeks to do business in Indiana shall submit a copy of any revision of its plan of operation or feasibility study to the commissioner of this state at the same time that the revision is submitted to the commissioner of the group's chartering state.

(d) A risk retention group that is chartered and licensed in a state other than Indiana and that is doing business in Indiana shall submit to the commissioner of this state the following:

(1) A copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed, which must be certified by an independent public accountant and must contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist (under criteria established by the ~~National Association of Insurance Commissioners).~~ **NAIC).**

(2) A copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination.

(3) Upon request by the commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group.

(4) Such information as may be required to verify that the group continues to meet the definition of risk retention group in section 11 of this chapter.

SECTION 74. IC 27-7-10-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 17. A risk retention group that is licensed and chartered in a state other than Indiana shall submit to an examination by the commissioner of this state to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an

examination or does not initiate an examination within sixty (60) days after a request by the commissioner of this state. Any examination conducted by the commissioner of this state under this section shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the ~~NAIC's~~ ~~Examiner~~ **Financial Condition Examiner's** Handbook **and the Market Regulation Handbook.**

SECTION 75. IC 27-7-10-26 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 26. (a) A purchasing group, before doing business in Indiana, shall furnish notice to the commissioner. The notice must:

(1) identify the state in which the group is domiciled;

(2) identify all other states in which the group intends to do business;

(3) specify the lines and classifications of liability insurance that the purchasing group intends to purchase;

(4) identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of the company or companies;

(5) specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in Indiana;

(6) identify the principal place of business of the group; and

(7) provide such other information as may be required by the commissioner to verify that the purchasing group meets the definition of a purchasing group under section 10 of this chapter.

(b) A purchasing group shall, within ten (10) days, notify the commissioner of any changes in any of the facts set forth in the notice provided to the commissioner under this section.

(c) A purchasing group, before doing business in Indiana, shall register with and designate the commissioner as its agent solely for the purpose of receiving service of legal documents or process in Indiana (for which a filing fee shall be determined by the commissioner). However, this requirement does not apply in the case of a purchasing group that only purchases insurance that was authorized under the federal Product Liability Risk Retention Act of 1981 ~~P.L.97-45,~~ **(15 U.S.C. 3901 et seq.)** and:

(1) that in any state of the United States:

(A) was domiciled before April 1, 1986; and

(B) is domiciled on and after October 27, 1986;

(2) that:

(A) before October 27, 1986, purchased insurance from an

insurance carrier licensed in any state; and

(B) since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state; or

(3) that was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 **(15 U.S.C. 3901 et seq.)** before October 27, 1986.

(d) Each purchasing group that is required to give notice under subsection (a) shall also furnish information required by the commissioner to:

(1) verify that the entity qualifies as a purchasing group;

(2) determine where the purchasing group is located; and

(3) determine appropriate tax treatment.

(e) Any purchasing group that was doing business in Indiana before April 1, 1988, shall, before May 1, 1988, furnish notice to the commissioner under subsection (a) and furnish information required under subsections (c) through (d).

SECTION 76. IC 27-8-5-1.5, AS AMENDED BY P.L.278-2013, SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1.5. (a) This section applies to a policy of accident and sickness insurance issued on an individual, a group, a franchise, or a blanket basis, including a policy issued by an assessment company or a fraternal benefit society.

(b) As used in this section, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(c) As used in this section, "grossly inadequate filing" means a policy form filing:

(1) that fails to provide key information, including state specific information, regarding a product, policy, or rate; or

(2) that demonstrates an insufficient understanding of applicable legal requirements.

(d) As used in this section, "policy form" means a policy, a contract, a certificate, a rider, an endorsement, an evidence of coverage, or any amendment that is required by law to be filed with the commissioner for approval before use in Indiana.

(e) As used in this section, "type of insurance" refers to a type of coverage listed on the National Association of Insurance Commissioners Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix ~~or a successor document,~~ under the heading "Continuing Care Retirement Communities", "Health", "Long Term Care", or "Medicare Supplement".

(f) Each person having a role in the filing process described in subsection (i) shall act in good faith and with due diligence in the

performance of the person's duties.

(g) A policy form, including a policy form of a policy, contract, certificate, rider, endorsement, evidence of coverage, or amendment that is issued through a health benefit exchange (as defined in IC 27-19-2-8), may not be issued or delivered in Indiana unless the policy form has been filed with and approved by the commissioner.

(h) The commissioner shall do the following:

(1) Create a document containing a list of all product filing requirements for each type of insurance, with appropriate citations to the law, administrative rule, or bulletin that specifies the requirement, including the citation for the type of insurance to which the requirement applies.

(2) Make the document described in subdivision (1) available on the department of insurance Internet site.

(3) Update the document described in subdivision (1) at least annually and not more than thirty (30) days following any change in a filing requirement.

(i) The filing process is as follows:

(1) A filer shall submit a policy form filing that:

(A) includes a copy of the document described in subsection (h);

(B) indicates the location within the policy form or supplement that relates to each requirement contained in the document described in subsection (h); and

(C) certifies that the policy form meets all requirements of state law.

(2) The commissioner shall review a policy form filing and, not more than thirty (30) days after the commissioner receives the filing under subdivision (1):

(A) approve the filing; or

(B) provide written notice of a determination:

(i) that deficiencies exist in the filing; or

(ii) that the commissioner disapproves the filing.

A written notice provided by the commissioner under clause (B) must be based only on the requirements set forth in the document described in subsection (h) and must cite the specific requirements not met by the filing. A written notice provided by the commissioner under clause (B)(i) must state the reasons for the commissioner's determination in sufficient detail to enable the filer to bring the policy form into compliance with the requirements not met by the filing.

(3) A filer may resubmit a policy form that:

(A) was determined deficient under subdivision (2) and has been amended to correct the deficiencies; or

(B) was disapproved under subdivision (2) and has been revised.

A policy form resubmitted under this subdivision must meet the requirements set forth as described in subdivision (1) and must be resubmitted not more than thirty (30) days after the filer receives the commissioner's written notice of deficiency or disapproval. If a policy form is not resubmitted within thirty (30) days after receipt of the written notice, the commissioner's determination regarding the policy form is final.

(4) The commissioner shall review a policy form filing resubmitted under subdivision (3) and, not more than thirty (30) days after the commissioner receives the resubmission:

(A) approve the resubmitted policy form; or

(B) provide written notice that the commissioner disapproves the resubmitted policy form.

A written notice of disapproval provided by the commissioner under clause (B) must be based only on the requirements set forth in the document described in subsection (h), must cite the specific requirements not met by the filing, and must state the reasons for the commissioner's determination in detail. The commissioner's approval or disapproval of a resubmitted policy form under this subdivision is final, except that the commissioner may allow the filer to resubmit a further revised policy form if the filer, in the filer's resubmission under subdivision (3), introduced new provisions or materially modified a substantive provision of the policy form. If the commissioner allows a filer to resubmit a further revised policy form under this subdivision, the filer must resubmit the further revised policy form not more than thirty (30) days after the filer receives notice under clause (B), and the commissioner shall issue a final determination on the further revised policy form not more than thirty (30) days after the commissioner receives the further revised policy form.

(5) If the commissioner disapproves a policy form filing under this subsection, the commissioner shall notify the filer, in writing, of the filer's right to a hearing as described in subsection (m). A disapproved policy form filing may not be used for a policy of accident and sickness insurance unless the disapproval is overturned in a hearing conducted under this subsection.

(6) If the commissioner does not take any action on a policy form that is filed or resubmitted under this subsection in accordance

with any applicable period specified in subdivision (2), (3), or (4), the policy form filing is considered to be approved.

(j) Except as provided in this subsection, the commissioner may not disapprove a policy form resubmitted under subsection (i)(3) or (i)(4) for a reason other than a reason specified in the original notice of determination under subsection (i)(2)(B). The commissioner may disapprove a resubmitted policy form for a reason other than a reason specified in the original notice of determination under subsection (i)(2) if:

(1) the filer has introduced a new provision in the resubmission;

(2) the filer has materially modified a substantive provision of the policy form in the resubmission;

(3) there has been a change in requirements applying to the policy form; or

(4) there has been reviewer error and the written disapproval fails to state a specific requirement with which the policy form does not comply.

(k) The commissioner may return a grossly inadequate filing to the filer without triggering a deadline set forth in this section.

(l) The commissioner may disapprove a policy form if:

(1) the benefits provided under the policy form are not reasonable in relation to the premium charged; or

(2) the policy form contains provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.

(m) Upon disapproval of a filing under this section, the commissioner shall provide written notice to the filer or insurer of the right to a hearing within twenty (20) days of a request for a hearing.

(n) Unless a policy form approved under this chapter contains a material error or omission, the commissioner may not:

(1) retroactively disapprove the policy form; or

(2) examine the filer of the policy form during a routine or targeted market conduct examination for compliance with a policy form filing requirement that was not in existence at the time the policy form was filed.

SECTION 77. IC 27-8-10-1, AS AMENDED BY P.L.234-2007, SECTION 165, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Association" means the Indiana comprehensive health insurance association established under section 2.1 of this chapter.

(c) "Association policy" means a policy issued by the association

that provides coverage specified in section 3 of this chapter. The term does not include a Medicare supplement policy that is issued under section 9 of this chapter.

(d) "Carrier" means an insurer providing medical, hospital, or surgical expense incurred health insurance policies.

(e) "Church plan" means a plan defined in the federal Employee Retirement Income Security Act of 1974 under 26 U.S.C. 414(e).

(f) "Commissioner" refers to the insurance commissioner.

(g) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(h) "Eligible expenses" means those charges for health care services and articles provided for in section 3 of this chapter.

(i) "Federal income poverty level" has the meaning set forth in IC 12-15-2-1.

(j) "Federally eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate period of creditable coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:

(A) group health plan;

(B) governmental plan; or

(C) church plan;

or health insurance coverage in connection with any of these plans;

(2) who is not eligible for coverage under:

(A) a group health plan;

(B) Part A or Part B of Title XVIII of the federal Social Security Act **(42 U.S.C. 1395 et seq.);** or

(C) a state plan under Title XIX of the federal Social Security Act ~~(or any successor program);~~ **(42 U.S.C. 1396 et seq.);**

and does not have other health insurance coverage;

(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and

(5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

(k) "Governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

(l) "Group health plan" means an employee welfare benefit plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan provides medical care payments to, or on behalf of, employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(m) "Health care facility" means any institution providing health care services that is licensed in this state, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease, pain, injury, deformity, or physical condition, including a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, home health care agency, bioanalytical laboratory, or central services facility servicing one (1) or more such institutions.

(n) "Health care institutions" means skilled nursing facilities, home health agencies, and hospitals.

(o) "Health care provider" means any physician, hospital, pharmacist, or other person who is licensed in Indiana to furnish health care services.

(p) "Health care services" means any services or products included in the furnishing to any individual of medical care, dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(q) "Health insurance" means hospital, surgical, and medical expense incurred policies, nonprofit service plan contracts, health maintenance organizations, limited service health maintenance organizations, and self-insured plans. However, the term "health insurance" does not include short term travel accident policies, accident only policies, fixed indemnity policies, automobile medical payment, or incidental coverage issued with or as a supplement to liability insurance.

(r) "Insured" means all individuals who are provided qualified comprehensive health insurance coverage under an individual policy,

including all dependents and other insured persons, if any.

(s) "Medicaid" means medical assistance provided by the state under the Medicaid program under IC 12-15.

(t) "Medical care payment" means amounts paid for:

(1) the diagnosis, care, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(2) transportation primarily for and essential to Medicare services referred to in subdivision (1); and

(3) insurance covering medical care referred to in subdivisions (1) and (2).

(u) "Medically necessary" means health care services that the association has determined:

(1) are recommended by a legally qualified physician;

(2) are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness; and

(3) are not primarily for the scholastic education or career and technical training of the provider or patient.

(v) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(w) "Policy" means a contract, policy, or plan of health insurance.

(x) "Policy year" means a twelve (12) month period during which a policy provides coverage or obligates the carrier to provide health care services.

(y) "Health maintenance organization" has the meaning set out in IC 27-13-1-19.

(z) "Resident" means an individual who is:

(1) legally domiciled in Indiana for at least twelve (12) months before applying for an association policy; or

(2) a federally eligible individual and legally domiciled in Indiana.

(aa) "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.

(bb) "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at least three (3) consecutive days in a hospital for the same condition.

(cc) "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.

(dd) "Medicare supplement policy" means an individual policy of accident and sickness insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, and surgical expenses of individuals who are eligible for Medicare benefits.

(ee) "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

SECTION 78. IC 27-8-10-11.2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 11.2. (a) Not more than ninety (90) days after the ~~effective~~ date of **the version specified in IC 27-1-1.5 of** a diagnostic or procedure code described in this subsection:

(1) the association shall begin using the ~~most current~~ version **specified in IC 27-1-1.5** of the:

(A) ~~current procedural terminology~~ **Current Procedural Terminology** (CPT);

(B) ~~international classification of diseases~~ **International Classification of Diseases** (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) ~~current dental terminology~~ **Current Dental Terminology** (CDT);

(E) Healthcare ~~common procedure coding system~~ **Common Procedure Coding System** (HCPCS); and

(F) third party administrator (TPA);

codes under which the association pays claims for services provided under an association policy; and

(2) a health care provider shall begin using the ~~most current~~ version **specified in IC 27-1-1.5** of the:

(A) ~~current procedural terminology~~ **Current Procedural Terminology** (CPT);

(B) ~~international classification of diseases~~ **International Classification of Diseases** (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) ~~current dental terminology~~ **Current Dental Terminology** (CDT);

(E) Healthcare ~~common procedure coding system~~ **Common Procedure Coding System** (HCPCS); and

(F) third party administrator (TPA);

codes under which the health care provider submits claims for payment for services provided under an association policy.

(b) If a health care provider provides services that are covered under an association policy:

(1) after the ~~effective~~ date of the ~~most current~~ version **specified in IC 27-1-1.5** of a diagnostic or procedure code described in subsection (a); and

(2) before the association begins using the ~~most current~~ version of the diagnostic or procedure code;

the association shall reimburse the health care provider under the version of the diagnostic or procedure code that was ~~in effect~~ **specified in IC 27-1-1.5** on the date that the services were provided.

SECTION 79. IC 27-8-13-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 3. (a) As used in this chapter, "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of health maintenance organizations that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare benefits.

(b) The term does not include a group policy issued:

(1) to or for the benefit of employees;

(2) to one (1) or more labor organizations; or

(3) to the trustees of a fund established:

(A) by one (1) or more employees or former employees; or

(B) for members or former members of a labor organization.

(c) The term does not include:

(1) a policy issued under a contract under Section 1876 or 1833 of the federal Social Security Act (42 U.S.C. 1395 et seq.); or

(2) a policy issued under a demonstration project authorized under amendments to the federal Social Security Act **(42 U.S.C. Chapter 7).**

SECTION 80. IC 27-8-14.2-3, AS AMENDED BY P.L.188-2013, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 3. As used in this chapter, "autism spectrum disorder" means a neurological condition, including Asperger's syndrome and autism, as defined in ~~the most recent edition of~~ the Diagnostic and Statistical Manual of Mental Disorders. ~~of the American Psychiatric Association.~~

SECTION 81. IC 27-8-14.7-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 4. (a) Except as

provided in subsection (f), an insurer shall provide coverage for prostate specific antigen testing in any accident and sickness insurance policy that the insurer issues in Indiana.

(b) Except as provided in subsection (f), the coverage required under subsection (a) must include the following:

(1) At least one (1) prostate specific antigen test annually for an insured who is at least fifty (50) years of age.

(2) At least one (1) prostate specific antigen test annually for an insured who is less than fifty (50) years of age and who is at high risk for prostate cancer according to ~~the most recent published guidelines of~~ the American Cancer Society **guidelines.**

(c) An insured may not be required to pay an annual deductible or coinsurance that is greater than an annual deductible or coinsurance established for similar benefits under the accident and sickness insurance policy. If the policy does not cover a similar benefit, the deductible or coinsurance may not be set at a level that materially diminishes the value of the prostate specific antigen testing benefit required by this chapter.

(d) Except as provided in subsection (f), the coverage that an insurer must provide under this chapter may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the accident and sickness insurance policy.

(e) Except as provided in subsection (f), the coverage that an insurer must provide is in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

(f) In the case of insurance policies that are not employer based, the insurer must offer to provide the coverage described in subsections (a) through (e).

SECTION 82. IC 27-8-14.8-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 3. (a) Except as provided in subsection (d), an insurer shall provide coverage for colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic insured, in accordance with the ~~current~~ American Cancer Society guidelines, in any accident and sickness insurance policy that the insurer issues in Indiana or issues for delivery in Indiana.

(b) For an insured who is:

(1) at least fifty (50) years of age; or

(2) less than fifty (50) years of age and at high risk for colorectal cancer according to ~~the most recent published guidelines of~~ the

American Cancer Society **guidelines;**

the coverage required under this section must meet the requirements set forth in subsection (c).

(c) An insured may not be required to pay an additional annual deductible or coinsurance for the colorectal cancer examination and laboratory testing benefit that is greater than an annual deductible or coinsurance established for similar benefits under an accident and sickness insurance policy. If the accident and sickness insurance policy does not cover a similar benefit, a deductible or coinsurance may not be set at a level that materially diminishes the value of the colorectal cancer examination and laboratory testing benefit required under this section.

(d) In the case of an accident and sickness insurance policy that is not employer based, the insurer shall offer to provide the coverage described in this section.

SECTION 83. IC 27-8-18-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. As used in this chapter, "charitable entity" means an entity that is exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code **(26 U.S.C. 501(c)(3)).**

SECTION 84. IC 27-8-22.1-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 5. (a) Not more than ninety (90) days after the ~~effective~~ date of **the version specified in IC 27-1-1.5 of** a diagnostic or procedure code described in this subsection:

(1) an insurer shall begin using the ~~most current~~ version **specified in IC 27-1-1.5** of the:

(A) ~~current procedural terminology~~ **Current Procedural Terminology** (CPT);

(B) ~~international classification of diseases~~ **International Classification of Diseases** (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) ~~current dental terminology~~ **Current Dental Terminology** (CDT);

(E) Healthcare ~~common procedure coding system~~ **Common Procedure Coding System** (HCPCS); and

(F) third party administrator (TPA);

codes under which the insurer pays claims for services provided under an accident and sickness insurance policy or a worker's compensation policy; and

(2) a provider shall begin using the ~~most current~~ version **specified**

in IC 27-1-1.5 of the:

(A) ~~current procedural terminology~~ **Current Procedural Terminology** (CPT);

(B) ~~international classification of diseases~~ **International Classification of Diseases** (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) ~~current dental terminology~~ **Current Dental Terminology** (CDT);

(E) Healthcare ~~common procedure coding system~~ **Common Procedure Coding System** (HCPCS); and

(F) third party administrator (TPA);

codes under which the provider submits claims for payment for services provided under an accident and sickness insurance policy or a worker's compensation policy.

(b) If a provider provides services that are covered under an accident and sickness insurance policy or a worker's compensation policy:

(1) after the ~~effective~~ date of the ~~most current~~ version **specified in IC 27-1-1.5** of a diagnostic or procedure code described in subsection (a); and

(2) before the insurer begins using the ~~most current~~ version **specified in IC 27-1-1.5** of the diagnostic or procedure code;

the insurer shall reimburse the provider under the version of the diagnostic or procedure code that was ~~in effect~~ **specified in IC 27-1-1.5** on the date that the services were provided.

SECTION 85. IC 27-11-6-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 12. (a) For certificates issued before January 1, 1987, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall comply with the provisions of law applicable on December 31, 1985.

(b) For certificates issued after December 31, 1986, for which reserves are computed on the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Mortality Table, **the Commissioner's 2017 Standard Mortality Table,** or any more recent table made applicable to life insurers **and approved by the commissioner in rules adopted under IC 4-22-2,** every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall not be less than the corresponding amount ascertained in

accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon the tables.

SECTION 86. IC 27-11-8-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. (a) Standards of valuation for certificates issued before January 1, 1987, shall be those provided by the laws applicable on December 31, 1985.

(b) The minimum standards of valuation for certificates issued after December 31, 1986, shall be based on the following tables:

(1) For certificates of life insurance–the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Mortality Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Ordinary Mortality Table, **the Commissioner's 2017 Standard Mortality Table,** or any more recent table made applicable to life insurers **and approved by the commissioner in rules adopted under IC 4-22-2.**

(2) For annuity and pure endowment certificates, total and permanent disability benefits, accidental death benefits, and noncancellable accident and health benefits–such tables as are authorized for use by life insurers in this state.

(c) All of the above shall be under valuation methods and standards (including interest assumptions) in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(d) The commissioner may accept other standards for valuation if the commissioner finds that the reserves produced will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in this section. The commissioner may vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this state.

(e) Any society, with the consent of the commissioner of the state of domicile of the society and under the conditions, if any, that the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

SECTION 87. IC 27-11-8-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. (a) Reports shall be filed in accordance with this section.

(b) Every society transacting business in this state shall annually, before March 1, unless for cause shown the time has been extended by the commissioner:

(1) file with the commissioner:

(A) a true statement of its financial condition, transactions, and affairs for the preceding calendar year **on the Annual Statement Blank for fraternal benefit societies;** and

(B) any additional information required by the commissioner; and

(2) pay a fee of twenty-five dollars ($25) for filing the statement. ~~The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner.~~

(c) As part of the annual statement required in this section, each society shall, before March 1, file with the commissioner a valuation of its certificates in force on December 31 last preceding, provided the commissioner may for cause shown, extend the time for filing the valuation for not more than two (2) calendar months. The valuation shall be done in accordance with the standards specified in section 1 of this chapter. The valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(d) A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit one hundred dollars ($100) for each day during which the neglect continues, and, upon notice by the commissioner to that effect, its authority to do business in Indiana shall cease while the default continues.

SECTION 88. IC 27-13-7-14.7, AS AMENDED BY P.L.188-2013, SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 14.7. (a) As used in this section, "autism spectrum disorder" means a neurological condition, including Asperger's syndrome and autism, as defined in the ~~most recent edition of the~~ Diagnostic and Statistical Manual of Mental Disorders. ~~of the American Psychiatric Association.~~

(b) A group contract with a health maintenance organization that provides basic health care services must provide services for the treatment of an autism spectrum disorder of an enrollee. Services provided to an enrollee under this subsection are limited to services that are prescribed by the enrollee's treating physician in accordance with a treatment plan. A health maintenance organization may not deny or refuse to provide services to, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under a group contract to services to an individual solely because the individual is diagnosed with an autism spectrum disorder.

(c) The services required under subsection (b) may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, deductibles, copayments, or coinsurance provisions that apply to physical illness generally under the contract with the health maintenance organization.

(d) A health maintenance organization that enters into an individual contract that provides basic health care services must offer to provide services for the treatment of an autism spectrum disorder of an enrollee. Services provided to an enrollee under this subsection are limited to services that are prescribed by the enrollee's treating physician in accordance with a treatment plan. A health maintenance organization may not deny or refuse to provide services to, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract to services to an individual solely because the individual is diagnosed with an autism spectrum disorder.

(e) The services that must be offered under subsection (d) may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, deductibles, copayments, or coinsurance provisions that apply to physical illness generally under the contract with the health maintenance organization.

SECTION 89. IC 27-13-7-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 16. (a) As used in this section, "prostate specific antigen test" means a standard blood test performed to determine the level of prostate specific antigen in the blood.

(b) Except as provided in subsection (f), a health maintenance organization issued a certificate of authority in Indiana shall provide prostate specific antigen testing as a covered service under every group contract that provides coverage for basic health care services.

(c) Except as provided in subsection (f), the coverage required under subsection (b) must include the following:

(1) At least one (1) prostate specific antigen test annually for a male enrollee who is at least fifty (50) years of age.

(2) At least one (1) prostate specific antigen test annually for a male enrollee who is less than fifty (50) years of age and who is at high risk for prostate cancer according to ~~the most recent published guidelines of~~ the American Cancer Society **guidelines.**

(d) Except as provided in subsection (f), the coverage that a health maintenance organization must provide under this section may not be subject to a contract provision that is less favorable to an enrollee than a contract provision applying to physical illness generally under the

health maintenance organization contract.

(e) Except as provided in subsection (f), the coverage that a health maintenance organization must provide under this section is in addition to services specifically provided for x-rays, laboratory testing, or wellness examinations.

(f) In the case of coverage that is not employer based, the health maintenance organization must offer to provide the coverage described in subsections (b) through (e).

SECTION 90. IC 27-13-7-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 17. (a) As used in this section, "colorectal cancer testing" means examinations and laboratory tests for cancer for any nonsymptomatic enrollee, in accordance with the ~~current~~ American Cancer Society guidelines.

(b) Except as provided in subsection (e), a health maintenance organization issued a certificate of authority in Indiana shall provide colorectal cancer testing as a covered service under every group contract that provides coverage for basic health care services.

(c) For an enrollee who is:

(1) at least fifty (50) years of age; or

(2) less than fifty (50) years of age and at high risk for colorectal cancer according to ~~the most recent published guidelines of~~ the American Cancer Society **guidelines;**

the colorectal cancer testing required under this section must meet the requirements set forth in subsection (d).

(d) An enrollee may not be required to pay a copayment for the colorectal cancer examination and laboratory testing benefit that is greater than a copayment established for similar benefits under a group contract. If the group contract does not cover a similar covered service, the copayment may not be set at a level that materially diminishes the value of the colorectal cancer examination and laboratory testing benefit required under this section.

(e) In the case of coverage that is not employer based, the health maintenance organization is required only to offer to provide the colorectal cancer testing described in subsections (b) through (d) as a covered service under a proposed group contract providing coverage for basic health care services.

SECTION 91. IC 27-13-8-1.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1.5. (a) Each health maintenance organization authorized to conduct business in Indiana and required to file an ~~annual statement~~ **Annual Statement Blank** with the department under this chapter shall prepare the health maintenance organization's statement:

(1) on the ~~National Association of Insurance Commissioners (NAIC)~~ Annual Statement Blank;

(2) in accordance with ~~NAIC~~ Annual Statement Instructions; and

(3) following practices and procedures prescribed by the ~~most recent NAIC~~ Accounting Practices and Procedures Manual.

(b) To the extent that the ~~NAIC~~ Annual Statement Instructions require disclosure under subsection (a) of compensation paid to or on behalf of a health maintenance organization's officers, directors, or employees, the information may be filed with the department as an exhibit separate from the ~~annual statement blank.~~ **Annual Statement Blank.** The compensation information described under this subsection shall be maintained by the department as confidential and may not be disclosed to the public under IC 5-14-3.

SECTION 92. IC 27-13-8-2, AS AMENDED BY P.L.18-2016, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. (a) In addition to the report required by section 1 of this chapter, a health maintenance organization shall each year file with the commissioner the following:

(1) Audited financial statements of the health maintenance organization for the preceding calendar year prepared in conformity with statutory accounting practices prescribed or otherwise permitted by the department.

(2) A list of participating providers who provide health care services to enrollees or subscribers of the health maintenance organization.

(3) A description of the grievance procedure of the health maintenance organization:

(A) established under IC 27-13-10, including:

(i) the total number of grievances handled through the procedure during the preceding calendar year;

(ii) a compilation of the causes underlying those grievances; and

(iii) a summary of the final disposition of those grievances; and

(B) established under IC 27-13-10.1, including:

(i) the total number of external grievances handled through the procedure during the preceding calendar year;

(ii) a compilation of the causes underlying those grievances; and

(iii) a summary of the final disposition of those grievances;

for each independent review organization used by the health maintenance organization during the reporting year.

(4) The percentage of providers credentialed by the health maintenance organization according to the ~~most current standards or guidelines, if any, developed by the~~ National Committee on Quality Assurance ~~or a successor organization.~~ **standards or guidelines.**

(5) The RBC report required under IC 27-1-36-25.

(6) The health maintenance organization's Health Plan Employer Data and Information Set (HEDIS) data.

(b) The information required by subsection (a)(2) through (a)(5) must be filed with the commissioner on or before March 1 of each year. The audited financial statements required by subsection (a)(1) must be filed with the commissioner on or before June 1 of each year. The health maintenance organization's HEDIS data required by subsection (a)(6) must be filed with the commissioner on or before July 1 of each year. The commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a)(3), (a)(4), and (a)(6) that allows for comparative analysis.

(c) Upon a determination by a health maintenance organization's auditor that the health maintenance organization:

(1) does not meet the requirements of IC 27-13-12-3; or

(2) is in the condition described in IC 27-13-24-1(a)(5);

the health maintenance organization shall notify the commissioner within five (5) business days after the auditor's determination.

(d) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

(e) The commissioner shall do the following:

(1) Compile and analyze complaints received by the department concerning a denial of coverage under an individual contract or a group contract for:

(A) an investigational or experimental treatment; or

(B) a treatment not considered to be medically necessary for an enrollee.

(2) If the commissioner determines that a pattern of denials of coverage is evident through the analysis performed under subdivision (1), report the pattern to the legislative council in an electronic format under IC 5-14-6.

(3) Remove from a report made under subdivision (2) any information that could be used to identify an individual.

SECTION 93. IC 27-13-8-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 3. (a) This section applies to a domestic health maintenance organization that is authorized to transact business in Indiana.

~~(b) As used in this section, "NAIC" refers to the National Association of Insurance Commissioners.~~

~~(c)~~ **(b)** On or before March 1 of each year, a health maintenance organization shall file with the ~~National Association of Insurance Commissioners~~ **NAIC** and with the department a copy of the health maintenance organization's ~~annual statement convention blank~~ **Annual Statement Blank** and additional filings prescribed by the commissioner for the preceding year. A health maintenance organization shall also file quarterly statements with the NAIC and with the department, on or before May 15, August 15, and November 15 of each year, in a form prescribed by the commissioner. The information filed with the NAIC under this subsection:

(1) must be:

(A) in the same format; and

(B) of the same scope;

as is required by the commissioner under section 1 of this chapter;

(2) to the extent required by the NAIC, must include the signed jurat page and the actuarial certification; and

(3) must be filed electronically in accordance with NAIC electronic filing specifications.

The commissioner may, for good cause shown, grant an exemption from the requirement of this section to domestic health maintenance organizations that operate only in Indiana. If a health maintenance organization files any amendment or addendum to the health maintenance organization's ~~annual statement convention blank~~ **Annual Statement Blank** or quarterly statement with the commissioner, the health maintenance organization shall also file a copy of the amendment or addendum with the NAIC. Annual **Statement Blanks** and quarterly financial statements are considered filed with the NAIC when delivered to the address designated by the NAIC for the filings, regardless of whether the filing is accompanied by any applicable fee.

~~(d)~~ **(c)** The commissioner may, for good cause shown, grant a health maintenance organization an extension of time for the filing required by subsection ~~(c).~~ **(b).**

~~(e)~~ **(d)** In the absence of actual malice:

(1) members of the NAIC;

(2) duly authorized committees, subcommittees, and task forces of members of the NAIC;

(3) delegates of members of the NAIC;

(4) employees of the NAIC; and

(5) other persons responsible for collecting, reviewing, analyzing, and disseminating information developed from the filing of ~~annual statement convention blanks~~ **Annual Statement Blanks** under this section;

shall be considered to be acting as agents of the commissioner under the authority of this section and are not subject to civil liability for libel, slander, or any other cause of action by virtue of the collection, review, analysis, or dissemination of the data and information collected from the filings required by this section.

~~(f)~~ **(e)** The commissioner may suspend, revoke, or refuse to renew the certificate of authority of a health maintenance organization that fails to file the health maintenance organization's ~~annual statement convention blank~~ **Annual Statement Blank** or quarterly statements with the NAIC or with the department within the time allowed by subsection **(b) or** (c). ~~or (d).~~

SECTION 94. IC 27-13-23-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 6. Instead of conducting an examination of a health maintenance organization that is not domiciled in Indiana, the commissioner may accept the report of an examination made by the insurance commissioner of another state if the other state is accredited by the ~~National Association of Insurance Commissioners.~~ **NAIC.**

SECTION 95. IC 27-13-33-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. If a health maintenance organization adopts a coordination of benefits provision, the provision must be consistent with the coordination of benefits provisions of 760 IAC 1-38.1. ~~as it may be amended or replaced from time to time.~~

SECTION 96. IC 27-13-34-14 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 14. (a) The commissioner may examine a limited service health maintenance organization as often as is reasonably necessary to protect the interests of Indiana citizens. However, an examination of a limited service health maintenance organization domiciled in Indiana must be conducted at least one (1) time every three (3) years.

(b) A limited service health maintenance organization:

(1) shall make its relevant books and records, and the books and records in its custody and control, available for examination under this section; and

(2) in every way cooperate with the commissioner to facilitate the

examination.

(c) The expenses of an examination under this section shall be paid by the organization being examined.

(d) Instead of conducting an examination of a limited service health maintenance organization that is not domiciled in Indiana, the commissioner may accept the report of an examination made by the chief administrative officer who regulates insurance in another state, if the other state is accredited by the ~~National Association of Insurance Commissioners.~~ **NAIC.**

SECTION 97. IC 27-13-34-26 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 26. (a) The department shall maintain records concerning complaints filed against a limited service health maintenance organization that provides dental care services.

(b) The department shall classify complaints described in subsection (a) in categories according to the ~~National Association of Insurance Commissioners~~ **NAIC** standardized complaint report procedures **or standardized complaint report procedures established by the department in rules adopted under IC 4-22-2.**

(c) The department shall classify the disposition of complaints in each category by:

(1) number of complaints for which corrective action is considered necessary by the department; and

(2) number of complaints classified by ~~National Association of Insurance Commissioners~~ **NAIC** disposition codes **or standardized disposition codes established by the department in rules adopted under IC 4-22-2.**

(d) The department shall make information specified in this section available to the public in a form that does not identify any specific individual.

(e) A limited service health maintenance organization that provides dental care services may not take any retaliatory action, including cancellation or refusal to renew a participating provider contract, individual contract, or group contract, solely because a participating provider, enrollee, or individual or group contract holder files a complaint against the limited service health maintenance organization.

SECTION 98. IC 27-13-36-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. (a) Each health maintenance organization shall appoint a medical director who has an unlimited license to practice medicine under IC 25-22.5 or an equivalent license issued by another state.

(b) The medical director is responsible for oversight of treatment

policies, protocols, quality assurance activities, and utilization management decisions of the health maintenance organization.

(c) A health maintenance organization shall contract with or employ at least one (1) individual who holds an unlimited license to practice medicine under IC 25-22.5 to do the following:

(1) Develop, in consultation with a group of appropriate providers, the health maintenance organization's treatment policies, protocols, and quality assurance activities.

(2) Consult with the treating provider before an adverse utilization review decision is made.

(d) Compliance with ~~the most current standards or guidelines developed by~~ the National Committee on Quality Assurance ~~or a successor organization~~ **standards or guidelines** is sufficient to meet the requirements of this section.

SECTION 99. IC 27-13-36-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. Beginning July 1, 1999, each health maintenance organization shall include a sufficient number and type of primary care providers and other appropriate providers throughout the health maintenance organization's service area to:

(1) meet the needs of; and

(2) provide a choice of primary care providers and other appropriate providers to;

enrollees and subscribers of the health maintenance organization. Compliance with ~~the most current standards or guidelines developed by~~ the National Committee on Quality Assurance ~~or a successor organization~~ **standards or guidelines** is sufficient to meet the requirements of this section.

SECTION 100. IC 27-13-36-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 3. (a) The provisions of this section do not apply until July 1, 1999.

(b) Each health maintenance organization shall demonstrate to the department that the health maintenance organization offers an adequate number of:

(1) acute care hospital services;

(2) primary care providers; and

(3) other appropriate providers;

that are located within a reasonable proximity of subscribers of the health maintenance organization. Compliance with ~~the most current standards or guidelines developed by~~ the National Committee on Quality Assurance ~~or a successor organization~~ **standards or guidelines** is sufficient to meet the requirements of this subsection.

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(c) If a health maintenance organization provides coverage for:

(1) specialty medical services, including physical therapy, occupational therapy, and rehabilitation services;

(2) mental and behavioral care services; or

(3) pharmacy services;

the health maintenance organization shall demonstrate to the department that the offered services are located within a reasonable proximity of subscribers of the health maintenance organization. Compliance with ~~the most current standards or guidelines developed by~~ the National Committee on Quality Assurance ~~or a successor organization~~ **standards or guidelines** is sufficient to meet the requirements of this subsection.

SECTION 101. IC 27-13-41-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. Not more than ninety (90) days after the ~~effective~~ date of **the version specified in IC 27-1-1.5 of** a diagnostic or procedure code described in this section:

(1) a health maintenance organization and a limited service health maintenance organization shall begin using the ~~most current~~ version **specified in IC 27-1-1.5** of the:

(A) ~~current procedural terminology~~ **Current Procedural Terminology** (CPT);

(B) ~~international classification of diseases~~ **International Classification of Diseases** (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) ~~current dental terminology~~ **Current Dental Terminology** (CDT);

(E) Healthcare ~~common procedure coding system~~ **Common Procedure Coding System** (HCPCS); and

(F) third party administrator (TPA);

codes under which the health maintenance organization and limited service health maintenance organization pay claims for health care services covered under an individual contract or a group contract; and

(2) a provider shall begin using the ~~most current~~ version **specified in IC 27-1-1.5** of the:

(A) ~~current procedural terminology~~ **Current Procedural Terminology** (CPT);

(B) ~~international classification of diseases~~ **International Classification of Diseases** (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) ~~current dental terminology~~ **Current Dental Terminology** (CDT);

(E) Healthcare ~~common procedure coding system~~ **Common Procedure Coding System** (HCPCS); and

(F) third party administrator (TPA);

codes under which the provider submits claims for payment for health care services covered under an individual contract or a group contract.

SECTION 102. IC 27-13-41-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. If a provider provides health care services that are covered under an individual contract or a group contract:

(1) after the ~~effective~~ date ~~of the most current version~~ **of the version specified in IC 27-1-1.5** of a diagnostic or procedure code described in section 1 of this chapter; and

(2) before the health maintenance organization or limited service health maintenance organization begins using the ~~most current~~ version of the diagnostic or procedure code;

the health maintenance organization or limited service health maintenance organization shall reimburse the provider under the version of the diagnostic or procedure code that was ~~in effect~~ **specified in IC 27-1-1.5** on the date that the health care services were provided.

SECTION 103. IC 27-14-1-18 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 18. "Internal Revenue Code" refers to the Internal Revenue Code of 1986, ~~as amended.~~ **(26 U.S.C. 1 et seq.).**

SECTION 104. IC 27-15-2-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 3. (a) The board of directors of the converting mutual may adopt a simple plan of conversion under this section. The simple plan of conversion must include the following:

(1) The distribution to the eligible members, upon the extinguishing of their membership interests, of all of the initial issue of the voting common stock of the former mutual or any parent company. The initial issue of the voting common stock may include only one (1) class of stock, and may not include more than one (1) series of stock.

(2) Describe the manner in which the proposed conversion will occur and the insurance and any other companies that will result from or be directly affected by the conversion, including the former mutual and any parent company.

(3) Provide that the membership interests in the converting

mutual will be extinguished as of the effective date of the conversion.

(4) Provide for the registration of that distribution of stock under section 5 of the federal Securities Act of 1933 ~~as amended.~~ **(15 U.S.C. 77e).**

(5) Specify each separate class, category, or group of eligible members, and describe and explain any differences in the amount of stock to be distributed to or among the eligible members of each separate class, category, or group of eligible members.

(6) Require and describe the method or formula for the fair and equitable allocation of the stock among the eligible members.

(7) Provide for the determination and preservation of the reasonable dividend expectations of eligible members and other policyholders with policies that provide for the distribution of policy dividends, through the establishment of a closed block or other method acceptable to the commissioner.

(b) The plan may include other provisions:

(1) that the converting mutual determines to be necessary; and

(2) consistent with this title.

SECTION 105. IC 27-16-2-13, AS ADDED BY P.L.245-2005, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 13. (a) "Professional employer organization" or "PEO" means a person engaged in the business of providing professional employer services.

(b) The term does not include the following:

(1) An arrangement through which a person:

(A) whose principal business activity is an activity other than entering into professional employer agreements; and

(B) that does not hold the person out as a professional employer organization;

shares employees with a commonly owned company within the meaning of Section 414(b) and 414(c) of the Internal Revenue Code of 1986 ~~as amended.~~ **(26 U.S.C. 414(b) and 26 U.S.C. 414(c)).**

(2) An independent contractor arrangement through which a person:

(A) assumes responsibility for a product produced or a service performed by the person or the person's agent; and

(B) retains and exercises primary direction and control over the work performed by an individual whose services are supplied under the independent contractor arrangement.

(3) The provision of temporary help services.

SECTION 106. IC 27-18-1-22, AS ADDED BY P.L.111-2011, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 22. "NRRA" refers to the federal Nonadmitted and Reinsurance Reform Act of 2010 ~~(Subtitle B of Title V of P.L.111-203).~~ **(15 U.S.C. 8201 et seq.).**

SECTION 107. IC 27-18-1-26, AS ADDED BY P.L.111-2011, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 26. "Purchasing group" means a group that:

(1) is formed under the federal Liability Risk Retention Act of 1986 **(15 U.S.C. 3901 et seq.);**

(2) has as one (1) of the group's purposes the purchase of liability insurance on a group basis;

(3) purchases liability insurance only:

(A) for the members of the group; and

(B) to cover the members' similar or related liability exposure;

(4) is composed of members with similar or related business or activity liability exposure due to the members' related, similar, or common:

(A) business;

(B) trade;

(C) product;

(D) services;

(E) premises; or

(F) operations; and

(5) is domiciled in any state.

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: _____ Time: _____

SEA 341 — Concur