HOUSE BILL 1413
By McCormick

SENATE BILL 1617

By Norris

AN ACT to amend Tennessee Code Annotated, Title 56, relative to insurance.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Sections 56-11-101(a), 56-11-110, 56-11-111, 56-11-111, 56-11-112, 56-11-114, and 56-11-115, are amended by deleting the phrase "this chapter" and replacing it with "this part" wherever it appears.

SECTION 2. Tennessee Code Annotated, Section 56-11-101(b), is amended by deleting the subsection in its entirety and substituting instead the following language:

(b) As used in this part unless the context otherwise requires:

(1) "Affiliate" of, or person "affiliated" with, a specific person, means a person that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the person specified;

(2) "Commissioner" means the commissioner of commerce and insurance;

(3) "Control" including "controlling," "controlled by" and "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or 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 any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be

rebutted by a showing made in the manner provided by § 56-11-105(k) that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination that control exists in fact, notwithstanding the absence of a presumption to that effect;

(4) "Health maintenance organization" means a health maintenance organization as defined at § 56-32-102;

(5) "Health maintenance organization holding company system" means two (2) or more affiliated persons, one (1) of which is a health maintenance organization. "Health maintenance organization holding company system" also means a corporation regulated pursuant to the provisions of title 56, chapter 29, which owns or controls, either directly or indirectly, a health maintenance organization;

(6) "Insurance holding company system" means two (2) or more affiliated persons, one (1) or more of which is an insurer;

(7) "Insurer" has the same meaning as "insurance company," as set forth in § 56-1-102, except that it does not include:

(A) Agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(B) Fraternal benefit societies;

(C) Nonprofit medical and hospital service associations; or

(D) Nonprofit dental service corporations;

(8) "Enterprise Risk" means any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's Risk-Based

Capital to fall into company action level as set forth in § 56-46-104 or would cause the insurer to be in hazardous financial condition as set forth in Tenn. Comp. R. & Reg. 0780-01-66, as amended;

(9) "Person" means an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert, but does not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property;

(10) "Securityholder" of a specified person is one who owns any security of the person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing;

(11) "Subsidiary" of a specified person is an affiliate controlled by the person directly or indirectly through one (1) or more intermediaries; and

(12) "Voting security" includes any security convertible into or evidencing a right to acquire a voting security.

SECTION 3. Tennessee Code Annotated, Section 56-11-102, is amended by deleting the section in its entirety and substituting the following:

(a) Authorization. Any domestic insurer or licensed health maintenance organization, either by itself or in cooperation with one (1) or more persons, may organize or acquire one (1) or more subsidiaries. The subsidiaries may conduct any kind of business or businesses and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer or a licensed health maintenance organization.

(b) Additional Investment Authority. In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under all other sections of this title, a domestic insurer or licensed health maintenance organization may also:

(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of ten percent (10%) of the insurer's assets or fifty percent (50%) of the insurer's surplus as regards policyholders, or, with respect to health maintenance organizations, net worth; provided, that after such investments, the insurer's surplus as regards policyholders or health maintenance organizations net worth will be reasonable in relation to the insurer's or health maintenance organization's outstanding liabilities and adequate to meet its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included:

(A) Total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities, and

(B) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities; and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation;

(2) Invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries engaged or organized to engage

exclusively in the ownership and management of assets authorized as investments for the insurer provided that each subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in subdivision (b)(1) or in §§ 56-3-301 through 56-3-307 or §§ 56-3-401 through 56-3-409 of this Title applicable to the insurer. For the purpose of this subdivision, "the total investment of the insurer" shall include:

(A) Any direct investment by the insurer or health maintenance organization in an asset, and

(B) The insurer's or health maintenance organization's proportionate share of any investment in an asset by any subsidiary of the insurer or health maintenance organization, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of the subsidiary;

(3) With the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries; provided that after the investment the insurer's surplus as regards policyholders or health maintenance organization's net worth will be reasonable in relation to the insurer's or health maintenance organization's outstanding liabilities and adequate to its financial needs.

(c) Exemption from Investment Restrictions. Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to subsection (b) shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in this title applicable to such investments of insurers except §§ 56-3-303, 56-3-402, 56-3-403 and 56-3-404.

(d) Qualification of Investment; When Determined. Whether any investment made pursuant to subsection (b) meets the applicable requirements of that subsection is to be determined before the investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

(e) Cessation of Control. If an insurer ceases to control a subsidiary, it shall dispose of any investment in that subsidiary made pursuant to this section within three (3) years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after the investment shall have been made, the investment shall have met the requirements for investment under any other section of this part, and the insurer has so notified the commissioner.

SECTION 4. Tennessee Code Annotated, Section 56-11-103, is amended by deleting subsection (a) and replacing it with the following:

(a) FILING REQUIREMENTS. No person other than the issuer shall make a tender offer for, or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, the person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the insurer, and no such person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time any such offer, request, or invitation is made or any such agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the

insurer, a statement containing the information required by this section and the offer, request, invitation, agreement or acquisition has been approved by the commissioner in the manner hereinafter prescribed.

(1) For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least 30 days prior to the cessation of control. The commissioner shall determine those instances in which the party or parties seeking to divest or to acquire a controlling interest in an insurer will be required to file for, and obtain approval of, the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in his or her discretion, determines that confidential treatment will interfere with enforcement of this section. If the statement referred to above is otherwise filed, this paragraph shall not apply.

(2) With respect to a transaction subject to this section, the acquiring person must also file a pre-acquisition notification with the commissioner, which shall contain the information set forth in § 56-11-104(c)(1). A failure to file the notification may be subject to penalties specified in § 56-11-104(e)(3).

(3) As used in this section, “domestic insurer” includes any person controlling a domestic insurer unless the person as determined by the commissioner is either directly or through its affiliates primarily engaged in business other than the business of insurance.

(4) For the purposes of this section, “person” does not include any securities broker holds in the usual and customary broker's function, less than

twenty percent (20%) of the voting securities of an insurance company or of any person that controls an insurance company.

SECTION 5. Tennessee Code Annotated, Section 56-11-103(b)(4), is amended by deleting the phrase “to set its assets” and replacing it with “to sell its assets”.

SECTION 6. Tennessee Code Annotated, Section 56-11-103(b), is amended by deleting the word “and” at the end of subdivision (12) and adding the following new appropriately designated subdivisions:

() An agreement by the person required to file the statement referred to in subsection (a) that it will provide the annual report, specified in § 56-11-105(l), for so long as control exists, and

() An acknowledgement by the person required to file the statement referred to in subsection (a) that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer.

SECTION 7. Tennessee Code Annotated, Section 56-11-103(b)(13), is amended by deleting the phrase “subdivisions (b)(1)-(12)” where it appears in that subdivision and replacing it with “subdivisions (b)(1)-(15)”.

SECTION 8. Tennessee Code Annotated, Section 56-11-103, is amended by deleting that subsection (d) and replacing it with the following:

(d) APPROVAL BY COMMISSIONER: HEARINGS.

(1) The commissioner shall approve any merger or other acquisition of control referred to in subsection (a) unless, after a public hearing, the commissioner finds that:

(A) After the change of control, the domestic insurer referred to in subsection (a) would not be able to satisfy the requirements for the

issuance of a license to write the line or lines of insurance for which it is presently licensed;

(B) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein. In applying the competitive standard in this subdivision (d)(1)(B):

(i) The informational requirements of § 56-11-104(c)(1) and the standards of § 56-11-104(d)(2) shall apply;

(ii) The merger or other acquisition shall not be disapproved if the commissioner finds that any of the situations meeting the criteria provided by § 56-11-104(d)(3) exist; and

(iii) The commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time;

(C) The financial condition of any acquiring party is such that it might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

(D) The plans or proposals that the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(E) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not

be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(F) The acquisition is likely to be hazardous or prejudicial to the insurance buying public.

(2) The public hearing referred to in subdivision (d)(1) shall be held within thirty (30) days after the statement required by subsection (a) is filed, and at least twenty (20) days' notice thereof shall be given by the commissioner to the person filing the statement. Not less than seven (7) days' notice of the public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the commissioner. The commissioner shall make a determination within the sixty-day period preceding the effective date of the proposed transaction. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby, shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the Uniform Administrative Procedures Act, compiled in title 4, chapter 5. All discovery proceedings shall be concluded not later than three (3) days prior to the commencement of the public hearing.

(3) If the proposed acquisition of control will require the approval of more than one commissioner, the public hearing referred to in subdivision (d)(2) may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (a). Such person shall file the statement referred to in subsection (a) with the National Association of Insurance Commissioners (NAIC) within five (5) days of making the request for a public hearing. A commissioner

may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten (10) days of the receipt of the statement referred to in subsection (a). A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A commissioner may attend such hearing, in person or by telecommunication.

(4) In connection with a change of control of a domestic insurer, any determination by the commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty (60) days after the date of notification of the change in control submitted pursuant to § 56-11-103(a)(1) of this part.

(5) The commissioner may retain, at the acquiring person's expense, any attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

SECTION 9. Tennessee Code Annotated, Section 56-11-103(f)(2), is amended by adding the phrase "divestiture of," after the phrase "acquisition of control of," and before the phrase "or merger with".

SECTION 10. Tennessee Code Annotated, Section 56-11-104, is amended by deleting subdivision (b)(2)(A) and by appropriately redesigning the remaining subdivisions.

SECTION 11. Tennessee Code Annotated, Section 56-11-104, is amended by deleting the phrase "subdivision (b)(2)(E)" wherever it appears in that section and replacing it with the phrase "subdivision (b)(2)(D)".

SECTION 12. Tennessee Code Annotated, Section 56-11-104, is amended by deleting subsection (e) and replacing it with the following:

(e) ORDERS AND PENALTIES.

(1) If an acquisition violates the standards of this section, the commissioner may enter an order requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation.

(2) The commissioner may also issue an order denying the application of an acquired or acquiring insurer for a license to do business in this state.

(3) This order shall not be entered unless there is a hearing, notice of the hearing is issued prior to the end of the waiting period and not less than fifteen (15) days prior to the hearing, and the hearing is concluded and the order is issued no later than sixty (60) days after the date of the filing of the pre-acquisition notification with the commissioner. Every order shall be accompanied by a written decision of the commissioner setting forth the commissioner's findings of fact and conclusions of law.

(4) An order pursuant to this subsection (e) shall not apply if the acquisition is not consummated.

(5) Any person who violates a cease and desist order of the commissioner under this section and while the order is in effect may, after notice and hearing, and upon order of the commissioner, be subject to any one (1) or more of the following at the discretion of the commissioner:

(A) A monetary penalty of not more than ten thousand dollars ($10,000) for every day of violation; or

(B) Suspension or revocation of the person's license.

(6) Any insurer or other person who fails to make any filing required by this section and who also fails to demonstrate a good faith effort to comply with any filing requirement shall be subject to a fine of not more than fifty thousand dollars ($50,000).

SECTION 13. Tennessee Code Annotated, Section 56-11-105, is amended by deleting the section in its entirety and substituting the following:

(a) REGISTRATION. Every insurer and every health maintenance organization that is authorized to do business in this state and that is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in:

(1) This section,

(2) § 56-11-106(a)(1), (b), (d); and

(3) Either § 56-11-106(a)(2) 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 change or addition.

(4) Any insurer or health maintenance organization that is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter by April 30 of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any insurer or health maintenance organization

authorized to do business in the state which is a member of an insurance or health maintenance organization holding company system that is not subject to registration under this section to furnish a copy of the registration statement, the summary specified in § 56-11-105(c), or other information filed by the insurance company or health maintenance organization with the insurance or health maintenance organization regulatory authority of its domiciliary jurisdiction.

(b) INFORMATION AND FORM REQUIRED. Every insurer and every health maintenance organization subject to registration shall file the registration statement on a form prescribed by the National Association of Insurance Commissioners, which shall contain the following current information:

(1) The capital structure, general financial condition, ownership and management of the insurer or health maintenance organization and any person controlling the insurer or health maintenance organization;

(2) The identity and relationship of every member of the insurance holding company system or health maintenance organization holding company system;

(3) The following agreements in force, and transactions currently outstanding or that have occurred during the last calendar year between the insurer or health maintenance organization and its affiliates:

(A) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or health maintenance organization, or of the insurer or health maintenance organization by its affiliates;

(B) Purchases, sales, or exchange of assets;

(C) Transactions not in the ordinary course of business;

(D) Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's or the health maintenance organization's assets to liability, other than insurance or provider or enrollee contracts entered into in the ordinary course of the insurer's or health maintenance organization's business;

(E) All management agreements, 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 or the health maintenance organization's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system or health maintenance organization holding company system; and

(5) If requested by the commissioner, the insurer or health maintenance organization shall include financial statements of, or within an insurance or health maintenance organization holding company system, including all affiliates. Financial statements may include, but are not limited to, annual audited financial statements filed with the U.S. Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer or health maintenance organization required to file financial statements pursuant to this paragraph may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC;

(6) Other matters concerning transactions between registered insurers or registered health maintenance organizations and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner;

(7) Statements that the insurer's or health maintenance organization's board of directors is responsible for and oversees corporate governance and internal controls and that the insurer's or health maintenance organization's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

(8) Any other information required by the commissioner by rule or regulation.

(c) SUMMARY OF REGISTRATION STATEMENT. All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(d) MATERIALITY. No information need be disclosed on the registration statement filed pursuant to subsection (b) if the information is not material for the purposes of this section. Unless the commissioner by rule, regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one percent (0.5%) or less of an insurer's or health maintenance organization's admitted assets as of December 31 next preceding, shall not be deemed material for purposes of this section.

(e) REPORTING OF DIVIDENDS TO SHAREHOLDERS. Subject to § 56-11-106(b), each registered insurer and each registered health maintenance organization shall report to the commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof.

(f) INFORMATION OF INSURERS. Any person within an insurance holding company system or health maintenance organization holding company system subject to registration shall be required to provide complete and accurate information to an insurer or health maintenance organization, where the information is reasonably necessary to enable the insurer or health maintenance organization to comply with the provisions of this part.

(g) TERMINATION OF REGISTRATION. The commissioner shall terminate the registration of any insurer or health maintenance organization that demonstrates that it no longer is a member of an insurance holding company system or health maintenance organization holding company system.

(h) CONSOLIDATED FILING. The commissioner may require or allow two (2) or more affiliated insurers or two (2) or more affiliated health maintenance organizations subject to registration hereunder to file a consolidated registration statement.

(i) ALTERNATIVE REGISTRATION. The commissioner may allow an insurer or health maintenance organization that is authorized to do business in this state and that is part of an insurance holding company system or health maintenance organization holding company system to register on behalf of any affiliated insurer or health maintenance organization that is required to register under subsection (a) and to file all information and material required to be filed under this section.

(j) EXEMPTIONS. The provisions of this section do not apply to any insurer, health maintenance organization, information or transaction if, and to the extent that, the commissioner by rule, regulation, or order may exempt the same from the provisions of this section.

(k) DISCLAIMER. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or health maintenance organization or such a

disclaimer may be filed by the insurer or health maintenance organization or any member of any insurance holding company system or health maintenance organization holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer or health maintenance organization as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of any duty to register or report under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved.

(l) ENTERPRISE RISK FILING. The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(m) VIOLATIONS. The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for the filing is a violation of this section.

SECTION 14. Tennessee Code Annotated, Section 56-11-106, is amended by deleting the section in its entirety and substituting the following:

(a) TRANSACTIONS WITHIN A HOLDING COMPANY SYSTEM.

(1) Transactions within an insurance or health maintenance organization holding company system, to which an insurer or health maintenance organization subject to registration is a party, shall be subject to the following standards:

(A) The terms shall be fair and reasonable;

(B) Agreements for cost sharing services and management shall include such provisions as required by rule and regulation issued by the commissioner;

(C) Charges or fees for services performed shall be reasonable;

(D) Expenses incurred and payment received shall be allocated to the insurer or health maintenance organization in conformity with customary insurance accounting practices, or, in the case of health maintenance organizations, customary accounting practices applicable to health maintenance organizations, applied;

(E) The books, accounts and records of each party to all the transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including the accounting information necessary to support the reasonableness of the charges or fees to the respective parties; and

(F) The insurer's surplus as regards policyholders, or the health maintenance organization's net worth, following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's, or health maintenance organization's, outstanding liabilities and adequate to meet its financial needs.

(2) The following transactions involving a domestic insurer or a health maintenance organization and any person in its insurance or health maintenance

organization holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in subdivisions (A) through (G), may not be entered into unless the insurer or health maintenance organization has notified the commissioner in writing of its intention to enter into the transaction at least thirty (30) days prior thereto, or a shorter period that the commissioner may permit, and the commissioner has not disapproved it within the period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty (30) days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any.

(A) Sales, purchases, exchanges, loans, extensions of credit, or investments, provided, that the transactions are equal to or exceed:

(i) With respect to nonlife insurers and health maintenance organizations, the lesser of three percent (3%) of the insurer's or health maintenance organization's admitted assets, or twenty-five percent (25%) of surplus as regards policyholders, or, with respect to health maintenance organizations, net worth as of December 31 next preceding; and

(ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets, each as of December 31 next preceding;

(B) Loans or extensions of credit to any person who is not an affiliate, where the insurer or health maintenance organization makes the

loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer or health maintenance organization making the loans or extensions of credit; provided, that the transactions are equal to or exceed:

(i) With respect to nonlife insurers and health maintenance organizations, the lesser of three percent (3%) of the insurer's or health maintenance organization's admitted assets, or twenty-five percent (25%) of surplus as regards policyholders, or, with respect to health maintenance organizations, net worth as of December 31 next preceding; and

(ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets as of December 31 next preceding;

(C) Reinsurance agreements or modifications thereto, including:

(i) All reinsurance pooling agreements;

(ii) Agreements in which the reinsurance premium or a change in the insurer's or health maintenance organization's liabilities, or the projected reinsurance premium or a change in the insurer’s liabilities in any of the next three years, equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, or, with respect to health maintenance organizations, net worth, as of December 31 next preceding, including those agreements that may require as consideration the transfer of assets from an insurer or health maintenance

organization to a non-affiliate, if an agreement or understanding exists between the insurer or health maintenance organization and non-affiliate that any portion of the assets will be transferred to one (1) or more affiliates of the insurer or health maintenance organization;

(D) All management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements;

(E) Guarantees when made by a domestic insurer or health maintenance organization; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer's or health maintenance organization's admitted assets, or ten percent (10%) of surplus as regards policyholders, or with respect to health maintenance organizations, net worth, as of December 31 next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this paragraph;

(F) Direct or indirect acquisitions or investments in a person that controls the insurer or health maintenance organization or in an affiliate of the insurer or health maintenance organization in an amount which, together with its present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer's surplus to policyholders, or, with respect to health maintenance organizations, net worth. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to § 56-11-102 (or authorized under any other section of this Title), or in non-

subsidiary insurance affiliates that are subject to the provisions of this part, are exempt from this requirement; and

(G) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer's policyholders or the health maintenance organization's enrollees or providers. Nothing in this subdivision (a)(2) shall be deemed to authorize or permit any transactions that, in the case of an insurer or health maintenance organization that is not a member of the same insurance or health maintenance organization holding company system, would be otherwise contrary to law.

(3) A domestic insurer or a health maintenance organization may not enter into transactions that are part of a plan or series of like transactions with persons within the insurance or health maintenance organization holding company system, if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that the separate transactions were entered into over any twelve-month period for this purpose, the commissioner may exercise the authority under § 56-11-111.

(4) The commissioner, in reviewing transactions pursuant to subdivision (a)(2), shall consider whether the transactions comply with the standards set forth in subdivision (a)(1), and whether they may adversely affect the interests of policyholders, or, in the case of health maintenance organizations, enrollees or providers.

(5) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer or health maintenance organization in any

one (1) corporation if the total investment in the corporation by the insurance holding company system or health maintenance organization holding company system exceeds ten percent (10%) of the corporation's voting securities.

(b) DIVIDENDS AND OTHER DISTRIBUTIONS.

(1) No domestic insurer and no health maintenance organization shall pay an extraordinary dividend or make any other extraordinary distribution to its shareholders until:

(A) Thirty (30) days after the commissioner has received notice of the declaration thereof and has not within the period disapproved the payment; or

(B) The commissioner shall have approved the payment within the thirty-day period.

(2) For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of:

(A) Ten percent (10%) of the insurer's surplus as regards policyholders, or, with respect to health maintenance organizations, net worth, as of December 31 next preceding; or

(B) The net gain from operations of the insurer, if the insurer is a life insurer, or of the net income, if the insurer is not a life insurer, or a health maintenance organization, not including realized capital gains, for the twelve-month period ending December 31 next preceding, but shall not include pro rata distributions of any class of the insurer's or health maintenance organization's own securities.

(3) In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

(4) Notwithstanding any other law, an insurer or health maintenance organization may declare an extraordinary dividend or distribution that is conditional upon the commissioner's approval thereof, and such a declaration shall confer no rights upon shareholders until:

(A) The commissioner has approved the payment of such a dividend or distribution; or

(B) The commissioner has not disapproved the payment within the thirty-day period referred to in subdivision (b)(1).

(c) MANAGEMENT OF DOMESTIC INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS SUBJECT TO REGISTRATION.

(1) Notwithstanding the control of a domestic insurer or any licensed health maintenance organization by any person, the officers and directors of the insurer or health maintenance organization shall not thereby be relieved of any obligation or liability to which they would otherwise be subject to by law, and the insurer or health maintenance organization shall be managed so as to assure its separate operating identity consistent with this part.

(2) Nothing in this section shall preclude a domestic insurer or any licensed health maintenance organization from having or sharing a common management or cooperative or joint use of personnel, property or services with

one (1) or more other persons under arrangements meeting the standards of subdivision (a)(1).

(3) Not less than one-third of the directors of a domestic insurer or any licensed health maintenance organization, and not less than one-third (1/3) of the members of each committee of the board of directors of any domestic insurer or health maintenance organization shall be persons who are not officers or employees of the insurer or health maintenance organization or of any entity controlling, controlled by, or under common control with the insurer or health maintenance organization and who are not beneficial owners of a controlling interest in the voting stock of the insurer or health maintenance organization or entity. At least one such person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

(4) The board of directors of a domestic insurer or any licensed health maintenance organization shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or health maintenance organization or of any entity controlling, controlled by, or under common control with the insurer or health maintenance organization and who are not beneficial owners of a controlling interest in the voting stock of the insurer or health maintenance organization or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer or health maintenance organization and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of subdivisions (c)(3) and (c)(4) shall not apply to a domestic insurer or any licensed health maintenance organization if the person controlling the insurer or health maintenance organization, such as an insurer, a health maintenance organization, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of subdivisions (c)(3) and (c)(4) with respect to such controlling entity.

(6) An insurer or health maintenance organization may make application to the commissioner for a waiver from the requirements of this subsection (c), if the insurer's or health maintenance organization's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than $300,000,000. An insurer or health maintenance organization may also make application to the commissioner for a waiver from the requirements of this subsection based upon unique circumstances. The commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.

(d) ADEQUACY OF SURPLUS.

(1) For purposes of this part, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

(A) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(B) The extent to which the insurer's business is diversified among the several lines of insurance;

(C) The number and size of risks insured in each line of business;

(D) The extent of the geographical dispersion of the insurer's insured risks;

(E) The nature and extent of the insurer's reinsurance program;

(F) The quality, diversification and liquidity of the insurer's investment portfolio;

(G) The recent past and projected future trend in the size of the insurer's investment portfolio;

(H) The surplus as regards policyholders maintained by other comparable insurers;

(I) The adequacy of the insurer's reserves; and

(J) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the commissioner's judgment the investment so warrants.

(2) Subdivisions (d)(1)(A)-(J) shall also apply to health maintenance organizations, to the extent appropriate.

SECTION 15. Tennessee Code Annotated, Section 56-11-107, is amended by deleting the section in its entirety and substituting the following:

(a) POWER OF COMMISSIONER. Subject to the limitation contained in this section, and in addition to the powers that the commissioner has under chapters 1 and 32 of this title, relating to the examination of insurers or health maintenance organizations, the commissioner also has the power to examine any insurer or health maintenance organization registered under § 56-11-105 and its affiliates to ascertain the financial condition of the insurer or health maintenance organization, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance or health maintenance organization holding company system, or by the insurance or health maintenance organization holding company system on a consolidated basis.

(b) Access to Books and Records.

(1) The commissioner may order any insurer or health maintenance organization registered under § 56-11-105 to produce any records, books, or other information papers in the possession of the insurer or health maintenance organization or its affiliates that are reasonably necessary to determine compliance with this title.

(2) To determine compliance with this title, the commissioner may order any insurer or health maintenance organization registered under § 56-11-105 to produce information not in the possession of the insurer or health maintenance organization if the insurer or health maintenance organization can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer or health maintenance organization cannot obtain the information requested by the commissioner, the insurer or health maintenance organization shall provide the commissioner a detailed explanation of the reason that the insurer or health maintenance organization

cannot obtain the information and the identity of the holder of information. Whenever it appears to the commissioner that the detailed explanation is without merit, the commissioner may require, after notice and hearing, the insurer or health maintenance organization to pay a penalty of one hundred dollars ($100) for each day's delay, or may suspend or revoke the insurer's license.

(c) USE OF CONSULTANTS. The commissioner may retain, at the registered insurer or health maintenance organization's expense, attorneys, actuaries, accountants and other experts, not otherwise a part of the commissioner's staff, that shall be reasonably necessary to assist in the conduct of the examination under subsection (a). Any persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

(d) EXPENSES. Each registered insurer or health maintenance organization producing for examination records, books and papers pursuant to subsection (a) shall be liable for and shall pay the expense of the examination in accordance with chapters 1 and 32 of this title.

(e) COMPELLING PRODUCTION. In the event the insurer fails to comply with an order, the commissioner shall have the power to examine the affiliates to obtain the information. The commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this section. 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 an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He

or she shall be entitled to the same fees and mileage, if claimed, as a witness in courts of this state, which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined.

SECTION 16. Tennessee Code Annotated, Section 56-11-108, is amended by deleting the section in its entirety and substituting the following:

(a) Documents, materials or other information in the possession or control of the department of insurance that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to § 56-11-107, and all information reported pursuant to §§ 56-11-103(b)(12) and (13), 56-11-105 and 56-11-106, shall be confidential by law and privileged, shall not be subject to §§ 10-7-503 or 56-1-602, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer or health maintenance organization to which it pertains unless the commissioner, after giving the insurer or health maintenance organization and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, enrollees, providers, shareholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part thereof, in the manner the commissioner may deem appropriate.

(b) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner or

with whom such documents, materials or other information are shared pursuant to this part shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a).

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

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (a), with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, including members of any supervisory college described in § 56-11-116, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has verified in writing the legal authority to maintain confidentiality.

(2) Notwithstanding subdivision (c)(1) above, may only share confidential and privileged documents, material, or information reported pursuant to § 56-11-105(l) with commissioners of states having statutes or regulations substantially similar to subsection (a) and who have agreed in writing not to disclose such information.

(3) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with

notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(4) Shall enter into written agreements with the NAIC governing sharing and use of information provided pursuant to this part consistent with this subsection that shall:

(A) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC and its affiliates and subsidiaries pursuant to this part, including procedures and protocols for sharing by the NAIC with other state, federal or international regulators;

(B) Specify that ownership of information shared with the NAIC and its affiliates and subsidiaries pursuant to this part remains with the commissioner and the NAIC's use of the information is subject to the direction of the commissioner;

(C) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC pursuant to this part is subject to a request or subpoena to the NAIC for disclosure or production; and

(D) Require the NAIC and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the NAIC and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the NAIC and its affiliates and subsidiaries pursuant to this part.

(d) The sharing of information by the commissioner pursuant to this part shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is

solely responsible for the administration, execution and enforcement of the provisions of this part.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (c).

(f) Documents, materials or other information in the possession or control of the NAIC pursuant to this Act shall be confidential by law and privileged, shall not be subject to §§ 10-7-503 or 56-1-602, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

SECTION 17. Tennessee Code Annotated, Section 56-11-109, is amended by deleting the section in its entirety and substituting the following:

The commissioner may promulgate rules, regulations and orders necessary to carry out the provisions of this part.

SECTION 18. Tennessee Code Annotated, Section 56-11-110(b), is amended by deleting the phrase "§ 56-11-104" wherever it appears in this subsection and replacing it with the phrase "§ 56-11-103".

SECTION 19. Tennessee Code Annotated, Section 56-11-110(c), is amended by deleting the language "the sites of the ownership of securities" and substituting the language "situs of the ownership of securities".

SECTION 20. Tennessee Code Annotated, Section 56-11-111(b), is amended by deleting the language "to engage in, transactions or make investments that have not been properly reported or submitted pursuant to §§ 56-11-105(a) and 56-11-106(a) and (b), and" and substituting the language "to engage in transactions or make investments that have not been properly reported or submitted pursuant to §§ 56-11-105(a) and 56-11-106(a)(2) and (b), or".

SECTION 21. Tennessee Code Annotated, Section 56-11-111(e), is amended by deleting the phrase “in the performance of the commissioner's duties” and replacing it with the phrase “in the performance of the officer director or employee’s duties”.

SECTION 22. Tennessee Code Annotated, Section 56-11-111, is amended by adding the following as a new, appropriately designated subsection:

() Whenever it appears to the commissioner that any person has committed a violation of § 56-11-103 of this part and which prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with § 56-9-503.

SECTION 23. Tennessee Code Annotated, Section 56-11-113(a)(1), is amended by deleting the language “other than distributions or shares of the same class of stock” and substituting the language “other than distributions of shares of the same class of stock”.

SECTION 24. Tennessee Code Annotated, Section 56-11-113(d), is amended by deleting the phrase “under subsection (c)” and replacing it with the phrase “under this section”.

SECTION 25. Tennessee Code Annotated, Title 56, Chapter 11, Part 1, is amended by adding the following as new appropriately designated sections:

§ 56-11-116.

(a) Power of Commissioner. With respect to any insurer or health maintenance organization registered under § 56-11-105, and in accordance with subsection (c), the commissioner shall also have the power to participate in a supervisory college for any domestic insurer or health maintenance organization that is part of an insurance holding company system with international operations in order to determine compliance by the insurer or health maintenance organization with this title. The powers of the

commissioner with respect to supervisory colleges include, but are not limited to, the following:

(1) Initiating the establishment of a supervisory college;

(2) Clarifying the membership and participation of other supervisors in the supervisory college;

(3) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(4) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

(5) Establishing a crisis management plan.

(b) Expenses. Each registered insurer or health maintenance organization subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in a supervisory college in accordance with subsection (c), including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or health maintenance organization or its affiliates, and the commissioner may establish a regular assessment to the insurer or health maintenance organization for the payment of these expenses.

(c) Supervisory College. In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with § 56-11-107, the commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or health maintenance organization or its

affiliates, including other state, federal and international regulatory agencies. The commissioner may enter into agreements in accordance with § 56-11-109(c) providing the basis for cooperation between the commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction.

§ 56-11-117.

(a) Solely for purposes of this part, a foreign insurer or health maintenance organization that participates in the TennCare program under Title XIX of the Social Security Act or any successor to the TennCare program shall be deemed to be a domestic insurer, and shall comply with any provisions of this part that apply to domestic insurers.

(b) The confidentiality provisions of § 56-11-108 of this part shall apply to all foreign insurers and health maintenance organizations subject to this part pursuant to this section to the same and full extent as they apply to domestic insurers.

(c) The Commissioner shall have the authority to waive any portion of this part for such a foreign insurer or health maintenance organization subject to this part pursuant to this section upon a determination that the foreign insurer or health maintenance organization is subject to holding company requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained herein. The decision whether to exercise any authority under this subsection is in the sole discretion of the Commissioner.

(d) A foreign insurer or health maintenance organization deemed to be a domestic insurer under this section shall be considered a domestic insurer for the

purposes of this part and shall not be considered a domestic insurer for any other purposes under this chapter, unless otherwise expressly stated.

§ 56-11-118.

All laws and parts of laws of this state inconsistent with this part are hereby superseded with respect to matters covered by this part.

§ 56-11-119.

If any provision of this part or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of this part which can be given effect without the invalid provisions or application, and for this purpose the provisions of this part are separable.

SECTION 26. Tennessee Code Annotated, Title 56, Chapter 11, is amended by adding the following as new part 2 to be entitled "Risk Management and Own Risk and Solvency Assessment" and shall consist of the following language:

§ 56-11-201.

(a) The purpose of this part is to provide the requirements for maintaining a risk management framework and completing an Own Risk and Solvency Assessment (ORSA) and provide guidance and instructions for filing an ORSA Summary Report with the insurance commissioner of this state.

(b) The requirements of this part shall apply to all insurers domiciled in this state and all health maintenance organizations licensed in this state unless exempt pursuant to § 56-11-206.

(c) The ORSA Summary Report will contain confidential and sensitive information related to an insurer, health maintenance organization or insurance group's identification of risks material and relevant to the insurer, health maintenance organization or insurance group filing the report. This information will include proprietary

and trade secret information that has the potential for harm and competitive disadvantage to the insurer, health maintenance organization or insurance group if the information is made public. As such, the ORSA Summary Report shall be a confidential document filed with the commissioner and shared only as stated herein and to assist the commissioner in the performance of his or her duties, and that in no event shall the ORSA Summary Report be subject to public disclosure.

§ 56-11-202.

(a) "Insurance group," for the purpose of conducting an Own Risk and Solvency Assessment, means those insurers or health maintenance organizations and affiliates included within an insurance or health maintenance company holding company system as defined in Title 56, Chapter 11, Part 1;

(b) "Insurer" has the same meaning as set forth in § 56-1-102 of this title, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(c) "Health maintenance organization" means a health maintenance organization as defined at § 56-32-102;

(d) "Own Risk and Solvency Assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale and complexity of an insurer, health maintenance organization or insurance group, conducted by that insurer, health maintenance organization or insurance group of the material and relevant risks associated with the insurer, health maintenance organization or insurance group's current business plan, and the sufficiency of capital resources to support those risks;

(e) "ORSA Guidance Manual" means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National

Association of Insurance Commissioners (NAIC) and as amended from time to time. A change in the ORSA Guidance Manual shall be effective on the January 1 following the calendar year in which the changes have been adopted by the NAIC; and

(f) "ORSA Summary Report" means a confidential high-level summary of an insurer, health maintenance organization or insurance group's ORSA.

§ 56-11-203.

An insurer or health maintenance organization shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer or health maintenance organization is a member maintains a risk management framework applicable to the operations of the insurer or health maintenance organization.

§ 56-11-204.

Subject to § 56-11-206, an insurer or health maintenance organization, or the insurance group of which the insurer or health maintenance organization is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or health maintenance organization or the insurance group of which the insurer or health maintenance organization is a member.

§ 56-11-205.

(a) Upon the commissioner's request, and no more than once each year, an insurer or health maintenance organization shall submit to the commissioner an ORSA Summary Report or any combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the insurer, health maintenance organization and/or the insurance group of which it is a member. Notwithstanding any

request from the commissioner, if the insurer or health maintenance organization is a member of an insurance group, the insurer or health maintenance organization shall submit the report(s) required by this subsection if the commissioner is the lead state commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(b) The report(s) shall include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's or health maintenance organization's enterprise risk management process attesting to the best of his or her belief and knowledge that the insurer or health maintenance organization applies the enterprise risk management process described in the ORSA Summary Report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

(c) An insurer or health maintenance organization may comply with subsection (a) by providing the most recent and substantially similar report or reports provided by the insurer or another member of an insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

§ 56-11-206.

(a) An insurer or health maintenance organization shall be exempt from the requirements of this part, if:

(1) The insurer or health maintenance organization 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, less than $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, less than $1,000,000,000.

(b) If an insurer or health maintenance organization qualifies for exemption pursuant to subdivision (a)(1), but the insurance group of which the insurer or health maintenance organization is a member does not qualify for exemption pursuant to subdivision (a)(2), then the ORSA Summary Report that may be required pursuant to § 56-11-205 shall include every insurer or health maintenance organization within the insurance group. This requirement may be satisfied by the submission of more than one ORSA Summary Report for any combination of insurers or health maintenance organization provided any combination of reports includes every insurer or health maintenance organization within the insurance group.

(c) If an insurer or health maintenance organization does not qualify for exemption pursuant to subdivision (a)(1), but the insurance group of which it is a member qualifies for exemption pursuant to subdivision (a)(2), then the only ORSA Summary Report that may be required pursuant § 56-11-205 shall be the report applicable to that insurer or health maintenance organization.

(d) An insurer or health maintenance organization that does not qualify for exemption pursuant to subsection (a) may apply to the commissioner for a waiver from the requirements of this part based upon unique circumstances. In deciding whether to grant the insurer's or health maintenance organization's request for waiver, the commissioner 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 health maintenance organization or insurance group of which the insurer or health maintenance organization is a member. If the insurer or health maintenance organization is part of an insurance group with insurers or health maintenance organization domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's or health maintenance organization request for a waiver.

(e) Notwithstanding the exemptions stated in this section, the commissioner may require that:

(1) An insurer or health maintenance organization maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests; or

(2) An insurer or health maintenance organization maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report if the insurer or health maintenance organization has Risk-Based Capital for company action level event as set forth in § 56-46-104, meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in Tenn. Comp. R. & Reg. 0780-01-66,, or otherwise exhibits qualities of a troubled insurer or health maintenance organization as determined by the commissioner.

(f) If an insurer or health maintenance organization that qualifies for an exemption pursuant to subsection (a) subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's or health

maintenance organization most recent annual statement or in the most recent annual statements of the insurers or health maintenance organizations within the insurance group of which the insurer or health maintenance organization is a member, the insurer or health maintenance organization shall have one (1) year following the year the threshold is exceeded to comply with the requirements of this part.

§ 56-11-207.

(a) The ORSA Summary Report shall be prepared consistent with the ORSA Guidance Manual, subject to the requirements of subsection (b). Documentation and supporting information shall be maintained and made available upon examination or upon request of the commissioner.

(b) The review of the ORSA Summary Report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multi-state or global insurers or health maintenance organizations and insurance groups.

§ 56-11-208.

(a) Documents, materials or other information, including the ORSA Summary Report, in the possession of or control of the department of insurance that are obtained by, created by or disclosed to the commissioner or any other person under this part, is recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to §§ 10-7-503 or 56-1-602, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the

documents, materials or other information public without the prior written consent of the insurer or health maintenance organization.

(b) Neither the commissioner nor any person who receives documents, materials or other ORSA-related information, through examination or otherwise, while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this part shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a).

(c) In order to assist in the performance of the commissioner's regulatory duties, the commissioner:

(1) May, upon request, share documents, materials or other ORSA-related information, including the confidential and privileged documents, materials or information subject to subsection (a), including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in Title 56, Chapter 11, Part 1 with the NAIC and with any third-party consultants designated by the commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(2) May receive documents, materials or other ORSA-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as defined in Title 56, Chapter 11, Part 1,

and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) Shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this part, consistent with this subsection that shall:

(A) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to this part, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(B) Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this part remains with the commissioner and the NAIC's or a third-party consultant's use of the information is subject to the direction of the commissioner;

(C) Prohibit the NAIC or third-party consultant from storing the information shared pursuant to this part in a permanent database after the underlying analysis is completed;

(D) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party

consultant pursuant to this part is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production;

(E) Require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this part; and

(F) In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

(d) The sharing of information and documents by the commissioner pursuant to this part shall not constitute a delegation of regulatory or rulemaking authority or rulemaking. The commissioner is solely responsible for the administration, execution and enforcement of the provisions of this part.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other ORSA-related information shall occur as a result of disclosure of such ORSA-related information or documents to the commissioner under this section or as a result of sharing as authorized in this part.

(f) Documents, materials or other information in the possession or control of the NAIC or a third-party consultants pursuant to this part shall be confidential by law and privileged, shall not be subject to §§ 10-7-503 or 56-1-602, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

§ 56-11-209.

Any insurer or health maintenance organization failing, without just cause, to timely file the ORSA Summary Report as required in this part shall be required, after notice and hearing,

to pay a penalty of one hundred dollars ($100) for each day's delay, to be recovered by the commissioner and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is ten thousand dollars ($10,000). The commissioner may reduce the penalty if the insurer or health maintenance organization demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer or health maintenance organization.

§ 56-11-210.

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

SECTION 27. Sections 1 through 25 of this act shall become effective upon becoming law, the public welfare requiring it. Section 26 of this act shall become effective on January 1, 2015 and the first filing of the Own Risk and Solvency Assessment Summary Reports shall be made in 2015, the public welfare requiring it.