SENATE BILL 412

51ST LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2013

INTRODUCED BY

Carroll H. Leavell

AN ACT

RELATING TO INSURANCE; ENACTING A PRINCIPLES-BASED VERSION OF THE STANDARD VALUATION LAW; REVISING STANDARD NONFORFEITURE PROVISIONS TO COMPLY WITH THE PRINCIPLE-BASED VERSION OF THE STANDARD VALUATION LAW; CLARIFYING THE PROVISIONS OF THE RISK-BASED CAPITAL ACT AS THEY APPLY TO CERTAIN INSURERS; SUBJECTING HEALTH ORGANIZATIONS TO THE RISK-BASED CAPITAL ACT; INCORPORATING TREND TESTS FOR CERTAIN INSURERS IN THE RISK-BASED CAPITAL ACT; REVISING CERTAIN TRIGGERS FOR REGULATORY INTERVENTION IN THE RISK-BASED CAPITAL ACT; CLARIFYING THAT FRATERNAL BENEFIT ORGANIZATIONS ARE SUBJECT TO THE RISK-BASED CAPITAL ACT; PROVIDING ADDITIONAL TERMS FOR THE ALLOWANCE OF CREDIT FOR REINSURANCE; CLARIFYING THE SUPERINTENDENT OF INSURANCE'S ROLE IN RELATIONSHIP WITH VARIOUS REGULATORY, ENFORCEMENT AND RELATED ENTITIES IN STATE, FEDERAL AND INTERNATIONAL JURISDICTIONS; CLARIFYING TERMS OF

CONFIDENTIALITY OF CERTAIN INFORMATION UNDER THE CONTROL OF THE SUPERINTENDENT; INCLUDING ENTERPRISE RISK IN THE INSURANCE HOLDING COMPANY LAW; REMOVING RESTRICTIONS ON THE TYPE OF SUBSIDIARIES A DOMESTIC INSURER MAY ORGANIZE OR ACQUIRE; EXPANDING REGULATORY REQUIREMENTS INVOLVED IN HOLDING COMPANY TRANSACTIONS; PROVIDING STANDARDS FOR DETERMINING WHEN AN ACQUISITION WOULD LESSEN COMPETITION; EXPANDING FACTORS THAT THE SUPERINTENDENT MAY CONSIDER IN DETERMINING A HAZARDOUS FINANCIAL CONDITION; EXPANDING REQUIREMENTS THAT THE SUPERINTENDENT MAY PLACE ON AN INSURER IN A HAZARDOUS FINANCIAL CONDITION; REVISING THE DEFINITION OF "MEMBER INSURER" IN THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT; CLARIFYING THE PROVISIONS OF REQUIRED PREMIUM TAX PAYMENTS; PROVIDING PENALTIES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 59A-2-12 NMSA 1978 (being Laws 1984, Chapter 127, Section 30) is amended to read:

"59A-2-12. RECORDS--INSPECTION--DESTRUCTION.--

A. The superintendent shall preserve in the office of superintendent of insurance [~~department~~] and in permanent form copies of all notices and orders given or made and of all other papers and records relating to the business and transactions of the [~~department~~] office, and shall hand the same over to [~~his~~] the superintendent's successor in office.

B. Except as otherwise provided by the Insurance Code or by order of court, the papers and records shall be open to public inspection. The superintendent may classify as confidential certain records and information obtained from another governmental agency or other source upon the express condition that they remain confidential or are deemed confidential by the superintendent, and such records and information shall not be subject to public inspection while confidentiality exists; except that no filing required to be made with the superintendent under the Insurance Code shall be deemed confidential unless expressly so provided by law or by the superintendent.

C. The superintendent may destroy unneeded or obsolete records and filings in the office of superintendent of insurance [~~department~~] in accordance with the provisions [~~and procedures applicable in general to records and filings of the corporation commission~~] of rules promulgated by the superintendent."

SECTION 2. Section 59A-2-15 NMSA 1978 (being Laws 1984, Chapter 127, Section 34, as amended) is amended to read:

"59A-2-15. INTERSTATE, FEDERAL AND INTERNATIONAL COOPERATION.--

A. On request of the insurance supervisory official of any other state, province or country; [~~or~~] of the national association of insurance commissioners or similar association of insurance regulatory officials; or of a federal agency, the superintendent shall communicate to [~~such~~] the official, [~~or~~] association [~~any~~] or agency information that it is [~~his~~] the superintendent's duty by law to ascertain respecting [~~any~~] an insurer or other person transacting insurance in this state or otherwise subject to the superintendent's supervision.

B. The superintendent may be a member of the national association of insurance commissioners or any successor organization and may participate in and support cooperative activities of public agencies having supervision of the insurance business."

SECTION 3. Section 59A-5A-2 NMSA 1978 (being Laws 1995, Chapter 149, Section 2) is amended to read:

"59A-5A-2. DEFINITIONS.--As used in the Risk-Based Capital Act:

A. "adjusted risk-based capital report" means a risk-based capital report adjusted in accordance with Subsection E of Section 59A-5A-3 NMSA 1978;

B. "authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions bearing the same designation;

C. "company action level risk-based capital" means an amount equal to two hundred percent of an insurer's or health organization's authorized control level risk-based capital;

D. "corrective order" means an order issued by the superintendent specifying required corrective actions;

E. "domestic insurer or health organization" means an insurer or health organization domiciled in New Mexico;

F. "foreign insurer or health organization" means an insurer or health organization that is authorized to do business in New Mexico but is not domiciled in New Mexico;

G. "fraternal benefit society" means an incorporated society, order or supreme lodge, without capital stock, including one exempted pursuant to the provisions of Paragraph (2) of Subsection A of Section 59A-44-40 NMSA 1978, whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government and that provides benefits in accordance with Chapter 59A, Article 44 NMSA 1978;

H. "health organization" means a health maintenance organization; nonprofit health care plan; limited health service organization; dental or vision plan; hospital, medical and dental indemnity or service corporation; or other managed care organization, but does not mean an organization that is licensed as either a life or health insurer or as a property and casualty insurer and that is otherwise subject to either the life or property and casualty risk-based capital requirements;

[~~E.~~] I. "life or health insurer" means any authorized life insurer, health insurer or a property and casualty insurer writing only health insurance [~~or nonprofit health care plan~~];

[~~F.~~] J. "mandatory control level risk-based capital" means an amount equal to seventy percent of an insurer's or health organization's authorized control level risk-based capital;

[~~G.~~] K. "property [~~or~~] and casualty insurer" means any insurer authorized to write property, marine and transportation, casualty, vehicle or surety insurance, but does not include any insurer writing only one of the following:

(1) mortgage guaranty insurance;

(2) financial guaranty insurance;

(3) title insurance; or

(4) health insurance;

[~~H.~~] L. "negative trend" means, with respect to a life or health insurer or a fraternal benefit society, negative trend over a period of time, as determined in accordance with the trend test calculation included in the life or fraternal risk-based capital instructions;

[~~I.~~] M. "regulatory action level risk-based capital" means an amount equal to one hundred fifty percent of an insurer's or health organization's authorized control level risk-based capital;

[~~J.~~] N. "revised risk-based capital plan" means a risk-based capital plan that has been rejected by the superintendent and revised by the insurer or health organization, with or without the superintendent's recommendation;

[~~K.~~] O. "risk-based capital instructions" means the risk-based capital report, including risk-based capital instructions, adopted by the national association of insurance commissioners, as they may be amended by the national association of insurance commissioners from time to time, and not disapproved by the superintendent;

[~~L.~~] P. "risk-based capital level" means an insurer's or health organization's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital or mandatory control level risk-based capital;

[~~M.~~] Q. "risk-based capital plan" means a comprehensive financial plan as specified in Subsection B of Section 59A-5A-4 NMSA 1978;

[~~N.~~] R. "risk-based capital report" means the report specified in Section 59A-5A-3 NMSA 1978; and

[~~O.~~] S. "total adjusted capital" means the sum of:

(1) an insurer's or health organization's capital and surplus as determined in accordance with statutory

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accounting principles applicable to annual financial statements required to be filed under Section 59A-5-29 NMSA 1978; and

(2) such other items, if any, as the risk-based capital instructions may provide."

SECTION 4. Section 59A-5A-3 NMSA 1978 (being Laws 1995, Chapter 149, Section 3) is amended to read:

"59A-5A-3. RISK-BASED CAPITAL REPORTS.--

A. On or before March 1 each year, every domestic insurer and health organization shall prepare and submit to the superintendent a report of its risk-based capital levels as of December 31 of the immediately preceding calendar year, in a form and containing such information as is required by the risk-based capital instructions. In addition, every domestic insurer and health organization shall file its risk-based capital report with:

(1) the national association of insurance commissioners in accordance with the risk-based capital instructions; and

(2) the insurance commissioner of each state in which the insurer or health organization is authorized to do business, if the insurance commissioner for that state has notified the insurer or health organization of [~~his~~] the request in writing. The insurer or health organization shall file a copy of its risk-based capital report with each [~~such~~] commissioner not later than March 1 each year or fifteen days

from receipt of the notice, whichever is later.

B. A life or health insurer's or a fraternal benefit society's risk-based capital shall be determined in accordance with the formula in the risk-based capital instructions. The formula shall take into account and may adjust for the covariance among the following factors:

(1) asset risk;

(2) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(3) the interest rate risk with respect to the insurer's business; and

(4) all other business risks and other relevant risks set forth in the risk-based capital instructions.

C. A health organization's or property or casualty insurer's risk-based capital shall be determined in accordance with the appropriate formula in the risk-based capital instructions. The formula shall take into account and may adjust for the covariance among the following factors:

(1) asset risk;

(2) credit risk;

(3) underwriting risk; and

(4) all other business risks and other relevant risks set forth in the risk-based capital instructions.

D. [~~An excess of~~] Capital [~~over~~] in excess of the amount [~~calculated~~] produced by the risk-based capital requirements contained in the Risk-Based Capital Act and formulas, schedules and instructions referenced in the Risk-Based Capital Act is desirable in the business of insurance. Additional capital is used and useful in the insurance business and helps to secure an insurer or health organization against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in the Risk-Based Capital Act. Accordingly, insurers and health organizations should seek to maintain capital above the risk-based capital levels required by that act.

E. If a domestic insurer or health organization files a risk-based capital report [~~which~~] that in the superintendent's judgment is inaccurate, then the superintendent shall adjust the risk-based capital report to correct the inaccuracy and shall notify the insurer or health organization of the adjustment. The notice shall contain a statement of the reason for the adjustment."

SECTION 5. Section 59A-5A-4 NMSA 1978 (being Laws 1995, Chapter 149, Section 4) is amended to read:

"59A-5A-4. COMPANY ACTION LEVEL EVENT.--

A. As used in the Risk-Based Capital Act, a "company action level event" means any [~~one or more~~] of the

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following events:

(1) the filing of a risk-based capital report by an insurer [~~which~~] or health organization that indicates [~~that~~]:

(a) that the insurer or health organization has total adjusted capital greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital; [~~or~~]

(b) in the case of a life or health insurer or fraternal benefit society, that the insurer has total adjusted capital greater than or equal to its company action level risk-based capital but less than [~~two hundred fifty~~] three hundred percent of its authorized control level risk-based capital and has a negative trend;

(c) in the case of a property and casualty insurer, that the insurer has total adjusted capital greater than or equal to its company action level risk-based capital but less than three hundred percent of its authorized control level risk-based capital and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty risk-based capital instructions; or

(d) in the case of a health organization, that the health organization has total adjusted capital greater than or equal to its company action level risk-

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based capital but less than three hundred percent of its authorized control level risk-based capital and triggers the trend test determined in accordance with the trend test calculation included in the health risk-based capital instructions;

(2) the superintendent's notification to an insurer or health organization that its adjusted risk-based capital report indicates the existence of an event described in Paragraph (1) of this subsection, unless the insurer or health organization challenges the adjusted report pursuant to Section 59A-5A-8 NMSA 1978; or

(3) if an insurer or health organization challenges the adjusted report, notification to the insurer or health organization that the superintendent has, after hearing, rejected the challenge.

B. In the event of a company action level event, the insurer or health organization shall prepare and submit to the superintendent a risk-based capital plan, which shall:

(1) identify the conditions [~~which~~] that contribute to the company action level event;

(2) contain proposals of corrective actions [~~which~~] that the insurer or health organization intends to take to eliminate the company action level event;

(3) provide projections of the insurer's or health organization's expected financial results in the current

year and at least the four succeeding years, both in the absence of and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. Projections for new and renewal business may, if appropriate, include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

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

(5) identify the quality of, and problems associated with, the insurer's or health organization's business, including [~~but not limited to~~] its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

C. The risk-based capital plan shall be submitted on or before the later of the following dates:

(1) forty-five days after the company action level event; or

(2) if the insurer or health organization challenges the adjusted risk-based capital report pursuant to Section 59A-5A-8 NMSA 1978, forty-five days after the date of the notification to the insurer or health organization that the

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superintendent has, after hearing, rejected the insurer's or health organization's challenge.

D. Within sixty days after the submission of an insurer's or health organization's risk-based capital plan, the superintendent shall notify the insurer or health organization whether the plan shall be implemented or is, in the superintendent's judgment, unsatisfactory. If the superintendent determines that the risk-based capital plan is unsatisfactory, the notification to the insurer or health organization shall set forth the reasons for the determination and may set forth proposed revisions that will render the plan satisfactory. Upon notification, the insurer or health organization shall prepare a revised risk-based capital plan, which may incorporate by reference any revisions proposed by the superintendent, and shall submit the revised plan to the superintendent. The revised plan shall be submitted on or before the last of the following dates:

(1) forty-five days after the date of the superintendent's notification; or

(2) if the insurer or health organization challenges the notification pursuant to Section 59A-5A-8 NMSA 1978, forty-five days after the date of the notification to the insurer or health organization that the superintendent has, after hearing, rejected the insurer's or health organization's challenge.

E. A notification that the insurer's or health organization's risk-based capital plan or revised risk-based capital plan is unsatisfactory may include a statement that the notification constitutes a regulatory action level event, subject to the insurer's or health organization's right to a hearing pursuant to Section 59A-5A-8 NMSA 1978.

F. Every domestic insurer [~~which~~] or health organization that files a risk-based capital plan or revised risk-based capital plan with the superintendent shall file a copy of the risk-based capital plan and any revised risk-based capital plan with the insurance commissioner of each state in which the insurer or health organization is authorized to do business if:

(1) the state has confidentiality provisions substantially similar to those in Subsection A of Section 59A-5A-9 NMSA 1978; and

(2) the insurance commissioner for that state has notified the insurer or health organization of [~~his~~] the request in writing. The insurer or health organization shall file a copy of the risk-based capital plan or revised risk-based capital plan with each [~~such~~] commissioner on or before the later of the following dates:

(a) fifteen days after the receipt of notice to file a copy of its risk-based capital plan or revised risk-based capital plan with the state; or

(b) the date that the risk-based capital plan or revised risk-based capital plan is filed under Subsections C and D of this section."

SECTION 6. Section 59A-5A-5 NMSA 1978 (being Laws 1995, Chapter 149, Section 5) is amended to read:

"59A-5A-5. REGULATORY ACTION LEVEL EVENT.--

A. For purposes of the Risk-Based Capital Act, "regulatory action level event" means any of the following events:

(1) the filing of a risk-based capital report by an insurer [~~which~~] or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its authorized control level risk-based capital but less than its regulatory action level risk-based capital;

(2) the superintendent's notification to an insurer or health organization that its adjusted risk-based capital report indicates the existence of an event described in Paragraph (1) of this subsection, unless the insurer or health organization challenges the adjusted report pursuant to Section 59A-5A-8 NMSA 1978;

(3) if an insurer or health organization challenges the adjusted report, notification to the insurer or health organization that the superintendent has, after hearing, rejected the challenge;

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(4) an insurer's or health organization's failure to file a risk-based capital report by the filing date, unless the insurer or health organization has provided an explanation satisfactory to the superintendent and has cured the failure within ten days after the filing date;

(5) an insurer's or health organization's failure to submit a risk-based capital plan to the superintendent by the date specified in Subsection C of Section 59A-5A-4 NMSA 1978;

(6) the superintendent's notification to an insurer or health organization that:

(a) the risk-based capital plan or revised risk-based capital plan submitted by the insurer or health organization is, in the superintendent's judgment, unsatisfactory; and

(b) the notification constitutes a regulatory action level event with respect to the insurer or health organization, unless the insurer or health organization has challenged the determination pursuant to Section 59A-5A-8 NMSA 1978;

(7) if an insurer or health organization challenges the superintendent's determination made pursuant to Paragraph (6) of this subsection, notification to the insurer or health organization that the superintendent has, after hearing, rejected the challenge;

(8) the superintendent's notification to an insurer or health organization that the insurer or health organization has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that the failure has had or will have a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event, unless the insurer or health organization has challenged the determination pursuant to Section 59A-5A-8 NMSA 1978; or

(9) if an insurer or health organization challenges the superintendent's determination made pursuant to Paragraph (8) of this subsection, notification to the insurer or health organization that the superintendent has, after hearing, rejected the challenge.

B. In the event of a regulatory action level event, the superintendent shall:

(1) require the insurer or health organization to prepare and submit a risk-based capital plan or, if applicable, a revised risk-based capital plan;

(2) perform such examination or analysis as the superintendent deems necessary of the assets, liabilities and operations of the insurer or health organization, including a review of its risk-based capital plan or revised risk-based capital plan; and

(3) subsequent to the examination or analysis,

issue an order specifying such corrective actions as the superintendent determines are required.

C. In determining corrective actions, the superintendent may take into account such factors as are deemed relevant based upon the superintendent's examination or analysis of the assets, liabilities and operations of the insurer or health organization, including [~~but not limited to~~] the results of any sensitivity tests undertaken pursuant to the risk-based capital instructions. The risk-based capital plan or revised risk-based capital plan shall be submitted on or before the later of the following dates:

(1) forty-five days after the occurrence of the regulatory action level event; or

(2) if the insurer or health organization challenges an adjusted or revised risk-based capital report or plan pursuant to Section 59A-5A-8 NMSA 1978 and the challenge is not frivolous in the superintendent's judgment, forty-five days after notification to the insurer or health organization that the superintendent has, after hearing, rejected the insurer's or health organization's challenge.

D. The superintendent may retain actuaries and investment experts and other consultants as [~~he may deem~~] the superintendent deems necessary to review the insurer's or health organization's risk-based capital plan or revised risk-based capital plan, examine or analyze the assets, liabilities and operations of the insurer or health organization and formulate the corrective order with respect to the insurer or health organization. The fees, costs and expenses incurred by consultants shall be paid by the affected insurer or health organization or such other party as the superintendent directs."

SECTION 7. Section 59A-5A-6 NMSA 1978 (being Laws 1995, Chapter 149, Section 6) is amended to read:

"59A-5A-6. AUTHORIZED CONTROL LEVEL EVENT.--

A. As used in the Risk-Based Capital Act, "authorized control level event" means any of the following events:

(1) the filing of a risk-based capital report by an insurer [~~which~~] or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its mandatory control level risk-based capital but less than its authorized control level risk-based capital;

(2) the superintendent's notification to an insurer or health organization that its adjusted risk-based capital report indicates the existence of an event described in Paragraph (1) of this subsection, unless the insurer or health organization challenges the adjusted report pursuant to Section 59A-5A-8 NMSA 1978;

(3) if an insurer or health organization

challenges the adjusted capital report, notification to the insurer or health organization that the superintendent has, after hearing, rejected the challenge;

(4) an insurer's or health organization's failure to respond, in a manner satisfactory to the superintendent, to a corrective order unless the insurer or health organization has challenged the order pursuant to Section 59A-5A-8 NMSA 1978; or

(5) if an insurer or health organization has challenged a corrective order and the superintendent has, after hearing, rejected the challenge or modified the corrective order, the failure of the insurer or health organization to respond, in a manner satisfactory to the superintendent, to the corrective order subsequent to rejection or modification.

B. In the event of an authorized control level event with respect to an insurer or health organization, the superintendent shall:

(1) take such actions as are required pursuant to Section 59A-5A-5 NMSA 1978 regarding an insurer or health organization with respect to which a regulatory action level event has occurred; or

(2) if the superintendent deems it to be in the best interests of the insurer's or health organization's policyholders and creditors and of the public, take such actions as are necessary to cause the insurer or health

organization to be placed under regulatory control pursuant to Chapter 59A, Article 41 NMSA 1978. The authorized control level event [~~shall constitute~~] constitutes sufficient grounds for the superintendent to take action pursuant to Chapter 59A, Article 41 NMSA 1978, and the superintendent [~~shall have~~] has the rights, powers and duties with respect to the insurer or health organization set forth in Chapter 59A, Article 41 NMSA 1978."

SECTION 8. Section 59A-5A-7 NMSA 1978 (being Laws 1995, Chapter 149, Section 7) is amended to read:

"59A-5A-7. MANDATORY CONTROL LEVEL EVENT.--

A. As used in the Risk-Based Capital Act, "mandatory control level event" means any of the following events:

(1) the filing of a risk-based capital report [~~which~~] that indicates that an insurer's or health organization's total adjusted capital is less than its mandatory control level risk-based capital;

(2) the superintendent's notification to an insurer or health organization that its adjusted risk-based capital report indicates the existence of an event described in Paragraph (1) of this subsection, unless the insurer or health organization challenges the adjusted report pursuant to Section 59A-5A-8 NMSA 1978; or

(3) if the insurer or health organization

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challenges the adjusted report, notification to the insurer or health organization that the superintendent has, after hearing, rejected the insurer's or health organization's challenge.

B. In the event of a mandatory control level event, the superintendent shall:

(1) with respect to a life or health insurer, fraternal benefit society or health organization, take such actions as are necessary to place the life or health insurer, fraternal benefit society or health organization under regulatory control pursuant to Chapter 59A, Article 41 NMSA 1978. In that event, the mandatory control level event [~~shall constitute~~] constitutes sufficient grounds for the superintendent to take action pursuant to Chapter 59A, Article 41 NMSA 1978, and the superintendent [~~shall have~~] has the rights, powers and duties with respect to the insurer set forth in Chapter 59A, Article 41 NMSA 1978. Notwithstanding the foregoing provisions of this paragraph, the superintendent may [~~forego~~] forgo action for up to ninety days after the mandatory control level event if the superintendent finds that there is a reasonable expectation that the mandatory control level event can be eliminated within the ninety-day period; or

(2) with respect to a property [~~or~~] and casualty insurer, take such actions as are necessary to place the insurer under regulatory control pursuant to Chapter 59A, Article 41 NMSA 1978, or, in the case of an insurer that is

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writing no business and that is running off its existing business, may allow the insurer to continue its run off under the superintendent's supervision. In either event, the mandatory control level event [~~shall constitute~~] constitutes sufficient grounds for the superintendent to take action pursuant to Chapter 59A, Article 41 NMSA 1978, and the superintendent [~~shall have~~] has the rights, powers and duties with respect to the insurer as are set forth in Chapter 59A, Article 41 NMSA 1978. Notwithstanding the foregoing provisions of this paragraph, the superintendent may [~~forego~~] forgo action for up to ninety days after the mandatory control level event if the superintendent finds that there is a reasonable expectation that the mandatory control level event can be eliminated within the ninety-day period."

SECTION 9. Section 59A-5A-8 NMSA 1978 (being Laws 1995, Chapter 149, Section 8) is amended to read:

"59A-5A-8. CHALLENGE HEARINGS.--Any insurer or health organization has the right to a confidential administrative hearing of record in accordance with Chapter 59A, Article 4 NMSA 1978 at which the insurer or health organization may challenge any determination or action by the superintendent pursuant to the Risk-Based Capital Act.

A. The insurer or health organization shall file and serve on the superintendent its request for hearing within five days after any of the following events:

(1) the superintendent's notification to the insurer or health organization of an adjusted risk-based capital report;

(2) the superintendent's notification to the insurer or health organization that:

(a) the insurer's or health organization's risk-based capital plan or revised risk-based capital plan is unsatisfactory; and

(b) such notification constitutes a regulatory action level event with respect to [~~such~~] the insurer or health organization;

(3) the superintendent's notification to the insurer or health organization that the insurer or health organization has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that such failure has had or will have a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event; or

(4) the superintendent's notification to an insurer or health organization of a corrective order with respect to the insurer or health organization.

B. Upon receipt of the insurer's or health organization's request for hearing, the superintendent shall set a hearing date, which shall be not less than ten nor more than thirty days after the date of the insurer's or health

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organization's request."

SECTION 10. Section 59A-5A-9 NMSA 1978 (being Laws 1995, Chapter 149, Section 9) is amended to read:

"59A-5A-9. CONFIDENTIALITY--PROHIBITION ON ANNOUNCEMENTS--PROHIBITION ON USE IN RATEMAKING.--

A. To the extent not set forth in any other form accessible to the public, all information in risk-based capital reports, risk-based capital plans, results or reports of any examination or analysis of an insurer or health organization performed pursuant to the Risk-Based Capital Act and all corrective orders issued by the superintendent pursuant to such examination or analysis [~~is~~] are and shall be kept confidential by the superintendent. This information shall not be made public [~~or~~]; be subject to the Inspection of Public Records Act; be subject to discovery or be admissible as evidence in a private civil action; or be subject to subpoena, other than by the superintendent and then only for the purpose of enforcement actions taken by the superintendent pursuant to the Insurance Code. Neither the superintendent nor a person who receives documents, materials or other information while acting pursuant to the authority of the superintendent shall be permitted or required in a private civil action to testify on the confidential documents, materials or information subject to this subsection. No waiver of an applicable privilege or claim of confidentiality in the documents, materials or information

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results from a disclosure to the superintendent pursuant to this section or as a result of the superintendent sharing such documents, materials or information with other state, federal or international regulatory agencies, with the national association of insurance commissioners, its affiliates or its subsidiaries, and with state, federal and international law enforcement authorities if the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information.

B. The comparison of an insurer's or health organization's total adjusted capital to any of its risk-based capital levels is a regulatory tool that may indicate the need for possible corrective action by the superintendent with respect to the insurer or health organization and is not intended as a means to rank insurers or health organizations generally or to compare insurers or health organizations for marketing purposes. Use of such comparisons for such purposes is inherently misleading and deceptive. Except as otherwise required under the provisions of the Risk-Based Capital Act or applicable law, no insurer, health organization, agent, broker or other person engaged in any manner in the business of insurance shall make, publish, disseminate, circulate or place before the public, or cause, 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 an assertion, representation or statement with regard to the risk-based capital levels of any insurer or health organization, or of any component derived in their calculation; provided, however, that if any materially false statement with respect to the comparison regarding an insurer's or health organization's total adjusted capital to its risk-based capital levels or an inappropriate comparison of any other amount to the insurer's or health organization's risk-based capital levels is published in any written publication and the insurer or health organization is able to demonstrate to the superintendent's satisfaction the falsity or inappropriateness of the statement, then the insurer or health organization may publish an announcement approved in advance by the superintendent in a written publication whose sole purpose is to rebut the materially false statement.

C. The risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans and revised risk-based capital plans are intended solely for use by the superintendent in monitoring the solvency of insurers and health organizations and the need for possible corrective action with respect to insurers and health organizations. They shall not be used by the superintendent for ratemaking, considered or introduced as evidence in any rate proceeding or used to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance [~~which~~] that an insurer, health organization or any affiliate is authorized to write."

SECTION 11. Section 59A-5A-11 NMSA 1978 (being Laws 1995, Chapter 149, Section 11) is amended to read:

"59A-5A-11. FOREIGN INSURERS.--

A. Any foreign insurer or health organization shall, upon the superintendent's written request, submit to the superintendent a risk-based capital report, as of the end of the most recent calendar year, on the same date risk-based capital reports are required to be filed by domestic insurers and health organizations under the Risk-Based Capital Act or fifteen days after the request is received by the foreign insurer or health organization, whichever is later. Any foreign insurer or health organization shall, upon the superintendent's written request, promptly submit to the superintendent a copy of any risk-based capital plan filed with the insurance commissioner of any other state.

B. In the event of a company action level event, regulatory action level event or authorized control level event with respect to any foreign insurer or health organization as determined pursuant to the risk-based capital statute applicable in an insurer's or health organization's state of

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domicile, or, if no risk-based capital requirements are in force in that state, under the provisions of the Risk-Based Capital Act, the superintendent may require the foreign insurer <u>or health organization</u> to file a risk-based capital plan with the superintendent unless the insurance commissioner of the insurer's <u>or health organization's</u> state of domicile has previously so required. The failure of the foreign insurer <u>or health organization</u> to timely file a risk-based capital plan with the superintendent shall be grounds to order the insurer <u>or health organization</u> to cease and desist from writing new insurance business in this state or to suspend or revoke its certificate of authority.

C. In the event of a mandatory control level event with respect to any foreign insurer <u>or health organization</u>, the superintendent may proceed in accordance with Subsection B of Section 59A-5A-7 NMSA 1978."

SECTION 12. Section 59A-5A-13 NMSA 1978 (being Laws 1995, Chapter 149, Section 13) is amended to read:

"59A-5A-13. NOTICES.--The superintendent's notices to an insurer <u>or health organization</u> pursuant to the Risk-Based Capital Act shall be effective upon mailing by certified mail or, in the case of any other mode of transmission, shall be effective upon the insurer's <u>or health organization's</u> receipt."

SECTION 13. A new section of the Risk-Based Capital Act is enacted to read:

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"[NEW MATERIAL] SEVERABILITY.--If any part or application of the Risk-Based Capital Act is held invalid, the remainder or its application to other situations or persons shall not be affected."

SECTION 14. Section 59A-6-2 NMSA 1978 (being Laws 1984, Chapter 127, Section 102, as amended) is amended to read:

"59A-6-2. PREMIUM TAX--HEALTH INSURANCE PREMIUM SURTAX.--

A. The premium tax provided for in this section shall apply as to the following taxpayers:

(1) each insurer authorized to transact insurance in New Mexico;

(2) each insurer formerly authorized to transact insurance in New Mexico and receiving premiums on policies remaining in force in New Mexico, except that this provision shall not apply as to an insurer that withdrew from New Mexico prior to March 26, 1955;

(3) each plan operating under provisions of Chapter 59A, Articles 46 through 49 NMSA 1978;

(4) each property bondsman, as that person is defined in Section 59A-51-2 NMSA 1978, as to any consideration received as security or surety for a bail bond in connection with a judicial proceeding, which consideration shall be considered "gross premiums" for the purposes of this section; and

(5) each unauthorized insurer that has assumed

a contract or policy of insurance directly or indirectly from an authorized or formerly authorized insurer and is receiving premiums on such policies remaining in force in New Mexico, except that this provision shall not apply if a ceding insurer continues to pay the tax provided in this section as to such policy or contract.

B. Each such taxpayer shall pay in accordance with this subsection a premium tax of three and three-thousandths percent of the gross premiums and membership and policy fees received or written by it, as reported in Schedule T and supporting schedules of its annual financial statement on insurance or contracts covering risks within this state during the preceding calendar year, less all return premiums, including dividends paid or credited to policyholders or contract holders and premiums received for reinsurance on New Mexico risks.

C. In addition to the premium tax imposed pursuant to Subsection B of this section, each taxpayer described in Subsection A of this section that transacts health insurance in New Mexico or is a plan described in Chapter 59A, Article 46 or 47 NMSA 1978 shall pay a health insurance premium surtax of one percent of the gross health insurance premiums and membership and policy fees received by it on hospital and medical expense incurred insurance or contracts; nonprofit health care service plan contracts, excluding dental or vision only contracts; and health maintenance organization subscriber contracts covering health risks within this state during the preceding calendar year, less all return health insurance premiums, including dividends paid or credited to policyholders or contract holders and health insurance premiums received for reinsurance on New Mexico risks. Except as provided in this section, all references in the Insurance Code to the premium tax shall include both the premium tax and the health insurance premium surtax.

D. For each calendar quarter, an estimated payment of the premium tax and the health insurance premium surtax shall be made on April 15, July 15, October 15 and the following January 15. The estimated payments shall be equal to at least one-fourth of [~~either~~] the payment made during the previous calendar year or [~~eighty percent~~] <u>one-fifth</u> of the actual payment due for the current calendar year, whichever is greater. The final adjustment for payments due for the prior year shall be made with the return, which shall be filed on April 15 of each year, at which time all taxes for that year are due. Dividends paid or credited to policyholders or contract holders and refunds, savings, savings coupons and similar returns or credits applied or credited to payment of premiums for existing, new or additional insurance shall, in the amount so used, constitute premiums subject to tax under this section for the year in which so applied or credited.

E. Exempted from the taxes imposed by this section are:

(1) premiums attributable to insurance or contracts purchased by the state or a political subdivision for the state's or political subdivision's active or retired employees; and

(2) payments received by a health maintenance organization from the federal secretary of health and human services pursuant to a contract issued under the provisions of 42 U.S.C. Section 1395 mm(g)."

SECTION 15. Section 59A-7-11 NMSA 1978 (being Laws 1984, Chapter 127, Section 117, as amended) is amended to read:

"59A-7-11. REINSURANCE.--

A. An insurer may reinsure all or any part of a particular risk or of a particular class of risks in another insurer, or accept such reinsurance from another insurer. No domestic insurer shall so reinsure with an insurer not authorized to transact insurance in [~~this state~~] New Mexico unless the unauthorized insurer is authorized to transact insurance in another state and conforms to the same standards of solvency as would be required if at the time such reinsurance is effected the reinsurer was so authorized in [~~this state~~] New Mexico or unless, in the case of a group that includes incorporated and individual, unincorporated alien insurers, it has assets held in trust for the benefit of its

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United States policyholders in an amount not less than one hundred million dollars ($100,000,000) and is authorized to transact insurance in at least one state or unless with the superintendent's approval in advance. With the superintendent's approval, a domestic insurer may reinsure all or substantially all of its risks in another insurer, or similarly reinsure the risks of another insurer, as provided in Section 59A-34-40 NMSA 1978.

B. Credit for reinsurance shall be allowed as an asset or as a deduction from liability to any ceding insurer for reinsurance lawfully ceded only when the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contracts reinsured without diminution because of the insolvency of the ceding insurer directly to the ceding insurer or to its domiciliary liquidator or receiver, except where the assuming insurer with the consent of the direct insured or insureds has assumed such policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under such policies and in substitution for the obligations of the ceding insurer to such payees, and the reinsurer meets the requirements of Paragraph (1), (2), (3), [~~or~~] (4), (5) or (6) of this subsection. If meeting the requirements of Paragraph (3) or (4) of this subsection, the requirements of Paragraph [~~(5)~~] (7) of this subsection [~~must~~] shall also be met. Credit shall be allowed

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pursuant to Paragraph (1), (2) or (3) of this subsection only for cessions of those kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance.

(1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer [~~which is~~] authorized to transact insurance or reinsurance in [~~this state~~] New Mexico.

(2) Credit shall be allowed when the reinsurance is ceded to an assuming insurer [~~which is~~] accredited as a reinsurer in [~~this state~~] New Mexico. An accredited reinsurer is one [~~which~~] that:

(a) files with the superintendent evidence of its submission to [~~this state~~] New Mexico's jurisdiction;

(b) submits to [~~this state's~~] New Mexico's authority to examine its books and records;

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

(d) files annually with the superintendent a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement and [~~either 1) maintains a surplus as regards policyholders in an amount which is not less than twenty million dollars ($20,000,000) and whose accreditation has not been denied by the superintendent within ninety days of its submission or 2) maintains a surplus as regards policyholders in an amount less than twenty million dollars ($20,000,000) and whose accreditation has been approved by the superintendent.~~

~~(e) No credit shall be allowed a ceding insurer, if the assuming insurer's accreditation has been revoked by the superintendent after notice and hearing~~] demonstrates to the satisfaction of the superintendent that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement at the time of its application if it maintains a surplus for policyholders in an amount not less than twenty million dollars ($20,000,000) and its accreditation has not been denied by the superintendent within ninety days after the submission of its application.

(3) Credit shall be allowed when the reinsurance is ceded to an assuming insurer domiciled in or, in

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the case of a United States branch of an alien assuming insurer, is entered through, a state that employs standards for credit for reinsurance substantially similar to those provided in this section if the assuming insurer or United States branch of an alien assuming insurer:

(a) maintains a surplus as regards policyholders in an amount not less than twenty million dollars ($20,000,000), unless the reinsurance is ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system; and

(b) submits to New Mexico's authority to examine the insurer's books and records.

[~~(3)~~] (4) Credit shall be allowed when [~~the following requirements are met:~~

~~(a)~~] the reinsurance is ceded to an assuming insurer [~~which~~] that maintains a trust [~~fund~~] in a qualified United States financial institution, as defined in Paragraph (2) of Subsection D of this section, for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the superintendent information substantially the same as that required to be reported on the national association of insurance commissioners annual statement form by licensed insurers to enable the superintendent to determine the sufficiency of the trust [~~fund.~~

~~In the case of~~] <u>and shall submit to and bear the expense of the examination of its books and records by the superintendent. Credit for reinsurance shall not be granted pursuant to this paragraph unless the trust and amendments to the trust have been approved by the insurance supervisory official of the state in which the trust is domiciled or the insurance supervisory official of another state who, pursuant to the terms of the trust, has accepted principal regulatory oversight of the trust. The trust and every trust amendment shall be filed with the superintendent and with the insurance supervisory official of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust shall provide that contested claims be valid and enforceable upon the final order of a court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns and successors in interest and shall remain in effect for as long as the assuming insurer has an outstanding obligation due pursuant to the reinsurance agreements subject to the trust. The superintendent may examine the trust and the assuming insurer. No later than February 28 of each year, the trustee of the trust shall report in writing to the superintendent the balance of the trust and a list of the trust's investments at the preceding year's end and certify the date of termination of the</u>

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trust, if planned, or that the trust will not expire prior to the following December 31.

(a) For a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars ($20,000,000). [~~In the case of~~]

(b) At any time after a single assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three years and after a finding based on an assessment of the risk that the new required surplus level, in light of reasonably foreseeable adverse loss development, is adequate for the protection of United States ceding insurers, policyholders and claimants, the insurance supervisory official with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus shall not be reduced to less than thirty percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(c) For a group that includes incorporated and individual unincorporated underwriters, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, the group shall maintain 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; provided that the group shall make available to the superintendent an annual certification of the solvency of each underwriter by the group's domiciliary regulator and its independent public accounts; and provided further that the incorporated members of the group shall not engage in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members.

[~~(b) in the case of~~] (d) A group of incorporated insurers under common administration [~~which complies with the filing requirements contained in Subparagraph (a) of this paragraph and which has~~] shall: 1) have continuously transacted an insurance business outside the United States for at least three years immediately prior to

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making application for accreditation [~~and submits to this state's authority to examine its books and records and bears the expense of the examination, and which has~~]; 2) maintain aggregate policyholders' surplus of at least ten billion dollars ($10,000,000,000) [~~the trust shall be~~]; 3) maintain a trust fund in an amount [~~equal to~~] not less than the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of such group [~~plus the group shall~~]; and 4) maintain a joint trusteed surplus of which one hundred million dollars ($100,000,000) [~~shall be~~] is held jointly and exclusively for the benefit of the United States ceding insurers of any member of the group as additional security for any such liabilities. [~~and~~] Each member of the group shall make available to the superintendent an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountant.

[~~(c) such trust shall be established in a form approved by the superintendent. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers, their assigns and successors in interest. The trust and the assuming insurer~~

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~~shall be subject to examination as determined by the superintendent. The trust described herein must remain in effect for as long as the assuming insurer shall have outstanding obligations due under the reinsurance agreements subject to the trust; and~~

~~(d) no later than February 28 of each year, the trustees of the trust shall report to the superintendent in writing setting forth the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.~~]

(5) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the superintendent as a reinsurer in New Mexico and that secures its obligations in accordance with the requirements of this paragraph.

(a) To be eligible for certification, an assuming insurer shall: 1) be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, pursuant to Subparagraph (c) of this paragraph; 2) maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the superintendent pursuant to rule; 3) maintain financial strength ratings from two or more rating agencies deemed acceptable by the superintendent pursuant to rule; 4) agree to submit to the jurisdiction of New Mexico, appoint the superintendent as its agent for service of process in New Mexico and agree to provide security for one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment; 5) in an initial application for certification and on an ongoing basis, agree to meet applicable information-filing requirements, as determined by the superintendent; and 6) satisfy other requirements for certification that the superintendent deems relevant.

(b) To be eligible for certification, an association including incorporated and individual unincorporated underwriters shall: 1) satisfy the requirements of Subparagraph (a) of this paragraph; 2) satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, which shall include a joint central fund that may be applied to an unsatisfied obligation of the association or any of its members, in an amount determined by the superintendent to provide adequate protection; 3) not have incorporated members who engage in a business other than underwriting as a member of the association and who are subject to the same level of regulation and solvency control by the association's domiciliary regulator as the unincorporated members; and 4) within ninety days after its financial statements must be filed with the association's domiciliary regulator, provide to the superintendent an annual certification by the association's domiciliary regulator of the solvency of each underwriter member or if a certification is unavailable, provide to the superintendent financial statements, prepared by independent public accountants, of each underwriter member of the association.

(c) The superintendent shall create and publish a list of qualified jurisdictions in which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be considered by the superintendent for certification as a reinsurer. 1) In creating the list of qualified jurisdictions, the superintendent shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, initially and on an ongoing basis, and the rights, benefits and extent of reciprocal recognition afforded by the alien jurisdiction to reinsurers licensed and domiciled in the United States. The superintendent may consider additional factors. A jurisdiction shall not be recognized as a qualified jurisdiction if it does not agree to share information and cooperate with the superintendent with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction shall not be recognized as a qualified jurisdiction if the superintendent has determined that a

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jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. 2) The superintendent shall consider the list of qualified jurisdictions published through the national association of insurance commissioners' committee process in determining qualified jurisdictions. If the superintendent recognizes as qualified a jurisdiction that does not appear on the list of qualified jurisdictions, the superintendent shall provide thoroughly documented justification in accordance with criteria developed by rule. 3) United States jurisdictions that meet the requirement for accreditation pursuant to the national association of insurance commissioners' financial standards and accreditation program shall be recognized as qualified jurisdictions. 4) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the superintendent may suspend the reinsurer's certification indefinitely in lieu of revocation.

(d) The superintendent shall consider the financial strength ratings that have been assigned by rating agencies deemed acceptable to the superintendent pursuant to rule and assign a rating to each certified reinsurer. The superintendent shall publish a list of all certified reinsurers and their ratings.

(e) A certified reinsurer shall secure obligations assumed from United States ceding insurers pursuant to this subsection at a level consistent with its rating, as specified in rules promulgated by the superintendent. 1) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the superintendent and consistent with the provisions of Subsection C of this section, or in a multi-beneficiary trust in accordance with Paragraph (4) of this subsection, except as otherwise provided in this subsection. 2) If a certified reinsurer maintains a trust to fully secure its obligations pursuant to Paragraph (4) of this subsection and secures its obligations incurred as a certified reinsurer in the form of a multi-beneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred pursuant to reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other United States jurisdictions and for its obligations pursuant to Paragraph (4) of this subsection. To be certified pursuant to Paragraph (5) of this subsection, a certified reinsurer shall have bound itself, by the language of the trust and by agreement with the insurance supervisory official with principal regulatory oversight of each such trust account, to fund, upon termination of that trust account, out of the remaining surplus of the trust any deficiency of any other such trust account. 3) The minimum trusteed surplus requirements provided in Paragraph (4) of this subsection do not apply to a multi-beneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred pursuant to this subsection if that multi-beneficiary trust maintains a minimum trusteed surplus of ten million dollars ($10,000,000). 4) If the security for obligations incurred by a certified reinsurer pursuant to this subsection is insufficient, the superintendent shall reduce the allowable credit by an amount proportionate to the deficiency and may, upon a finding of material risk that the certified reinsurer's obligations will not be paid in full when due, impose further reductions in allowable credit. 5) For the purposes of this paragraph, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent of its obligations. If the superintendent continues to assign a higher rating as permitted by other provisions of this section, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended. As used in this subparagraph, "terminated" means revocation, suspension, voluntary surrender or inactive status.

(f) If an applicant for certification has been certified as a reinsurer in a jurisdiction accredited by the national association of insurance commissioners, the superintendent may defer to that jurisdiction's certification and to the rating assigned by that jurisdiction, and the assuming insurer shall be considered a certified reinsurer in New Mexico.

(g) To continue to qualify for a reduction in security for its in-force business, a certified reinsurer that ceases to assume new business in New Mexico may request that it maintain its certification in inactive status. An inactive, certified reinsurer shall comply with all applicable requirements of this subsection, and the superintendent shall assign a rating that reflects, if relevant, the reason that the reinsurer is not assuming new business.

[~~(4)~~] (6) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of Paragraph (1), (2), [~~or~~] (3), (4) or (5) of this subsection but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by applicable law or regulation of that jurisdiction.

[~~(5)~~] (7) If the assuming insurer is not licensed, [~~or~~] accredited or certified to transact insurance or reinsurance in [~~this state~~] New Mexico, the credit permitted by [~~Paragraph~~] Paragraphs (3) and (4) of this subsection shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

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

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

<u>(8) If an assuming insurer does not meet the requirements of Paragraph (1), (2) or (3) of this subsection, the insurer shall not receive the credit permitted by Paragraph (4) or (5) of this subsection unless the assuming insurer agrees in the trust to the following conditions:</u>

<u>(a) notwithstanding any other provision in the trust, if the trust is inadequate because it contains an amount less than the amount required by Paragraph (4) of this</u>

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subsection, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceeding pursuant to the laws of its state or country of domicile, the trustee shall comply with an order of either the superintendent or the insurance supervisory official with regulatory oversight over the trust or of a court of competent jurisdiction directing the trustee to transfer to the superintendent or the insurance supervisory official with regulatory oversight all of the assets of the trust fund;

(b) in accordance with the laws of the state in which the trust is domiciled that apply to the liquidation of domestic insurance companies, claims are filed with the superintendent or the insurance supervisory official with regulatory oversight, who will value the claim and distribute the assets;

(c) if the superintendent or the insurance supervisory official with regulatory oversight determines that the assets of the trust fund or any part of the trust fund are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or a part thereof will be returned by the superintendent or the insurance supervisory official with regulatory oversight to the trustee for distribution in accordance with the trust; and

(d) the grantor will waive any right

otherwise available to it pursuant to federal law that is inconsistent with the provisions of this paragraph.

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

(a) The superintendent shall give the reinsurer notice and the opportunity for a hearing. The suspension or revocation shall not take effect until after the superintendent delivers an order on the hearing, unless: 1) the reinsurer waives its right to a hearing; 2) the superintendent's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer pursuant to Subparagraph (f) of Paragraph (5) of this subsection; or 3) the superintendent finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the superintendent's action.

(b) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension shall qualify for credit except to the extent that the reinsurer's obligations pursuant to the contract are secured in accordance with Subsection C of this section. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance shall be granted after the effective date of the revocation except to the extent that the reinsurer's obligations pursuant to the contract are secured in accordance with either Subparagraph (e) of Paragraph (5) of this subsection or Subsection C of this section.

(10) A ceding insurer shall attempt to manage its reinsurance recoverables in proportion to its book of business. Within thirty days after one of the following events, a domestic ceding insurer shall notify the superintendent of the event and, in the notification, demonstrate that the domestic ceding insurer is safely managing the exposure:

(a) reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers exceed fifty percent of the domestic ceding insurer's last reported surplus to policyholders; or

(b) reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, are likely to exceed fifty percent of the domestic ceding insurer's last reported surplus to policyholders.

(11) A ceding insurer shall attempt to diversify its reinsurance program. Within thirty days after one of the following events, a domestic ceding insurer shall

notify the superintendent of the event and, in the notification, demonstrate that the domestic ceding insurer is safely managing the exposure:

(a) ceding to any single assuming insurer or group of affiliated assuming insurers more than twenty percent of the ceding insurer's gross written premium in the prior calendar year; or

(b) reinsurance ceded to a single assuming insurer or group of affiliated assuming insurers is likely to exceed twenty percent of the ceding insurer's gross written premium in the prior calendar year.

C. An asset or a reduction from liability for the reinsurance ceded by an insurer to an assuming insurer not meeting the requirements of Subsection B of this section shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer and such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder, if such security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution, as defined in Paragraph (2) of Subsection D of this section. This security may be in the form of:

(1) cash;

(2) securities listed by the securities valuation office of the national association of insurance commissioners, including those deemed exempt from filing as defined by the purposes and procedures manual of the securities valuation office, and qualifying as admitted assets;

(3) clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in Paragraph (1) of Subsection D of this section, no later than December 31 in respect of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

(4) any other form of security acceptable to the superintendent.

D. A "qualified United States financial institution" means:

(1) for purposes of Paragraph (3) of Subsection C of this section, an institution that:

(a) 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;

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

(c) has been determined by either the superintendent or the securities valuation office of the national association of insurance commissioners 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 are acceptable to the superintendent; and

(2) for purposes of those provisions of this section specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(a) is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

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

E. No insurer shall accept reinsurance of risk of any kind of insurance that it is not authorized to transact directly in [~~this state~~] New Mexico, if an authorized insurer, or in another state if the insurer does not hold a certificate of authority in [~~this state~~] New Mexico.

F. Upon the superintendent's request, an insurer shall furnish the superintendent with copies of its reinsurance treaties then in effect and promptly inform the superintendent in writing of cancellation or other material change in its reinsurance treaties or arrangements.

G. No person shall have any rights against the reinsurer [~~which~~] that are not expressly stated in the reinsurance contract or in a written agreement between such person and the reinsurer.

H. This section does not apply to wet marine and transportation insurance."

SECTION 16. A new Section 59A-8A-1 NMSA 1978 is enacted to read:

"59A-8A-1. [NEW MATERIAL] SHORT TITLE.--Chapter 59A, Article 8A NMSA 1978 may be cited as the "Standard Valuation Law"."

SECTION 17. A new Section 59A-8A-2 NMSA 1978 is enacted to read:

"59A-8A-2. [NEW MATERIAL] DEFINITIONS.--As used in the Standard Valuation Law:

A. "accident and health insurance" means a policy that reflects morbidity risk and provides protection against economic loss resulting from an accident, a sickness or a medical condition and includes policies identified by the valuation manual as accident and health insurance;

B. "appointed actuary" means a qualified actuary who is appointed pursuant to the valuation manual to prepare the actuarial opinion required by Section 59A-8A-4 NMSA 1978;

C. "company" means an entity that has written, issued or reinsured life insurance contracts, accident and health insurance contracts or deposit-type contracts in New Mexico and has at least one contract for a life insurance, accident and health insurance or deposit-type policy in force or on claim or an entity that has written, issued or reinsured life insurance contracts, accident and health insurance contracts or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance or deposit-type contracts in New Mexico;

D. "deposit-type contract" means a contract that does not reflect mortality or morbidity risks and includes contracts identified by the valuation manual as deposit-type contracts;

E. "life insurance" means a policy that reflects mortality risk and includes annuity policies, pure endowment policies and policies identified by the valuation manual as life insurance;

F. "operative date of the valuation manual" means the January 1 of the first calendar year following the first July 1 after which the following have occurred:

(1) the valuation manual has been adopted by the national association of insurance commissioners by an affirmative vote of at least forty-two members or three-fourths of the members voting, whichever is greater;

(2) the Standard Valuation Law of the national association of insurance commissioners, as amended in 2009, or legislation including substantially similar terms and provisions, has been enacted by states that collectively represent more than seventy-five percent of written direct premiums, as reported in the life, accident and health annual statements, the health annual statements and the fraternal annual statements submitted for 2008; and

(3) the Standard Valuation Law of the national association of insurance commissioners, as amended in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two of the following fifty-five jurisdictions:

(a) the fifty states of the United States;

(b) American Samoa;

(c) the Virgin Islands of the United States;

(d) the District of Columbia;

(e) Guam; and

(f) Puerto Rico;

G. "policyholder behavior" means an action that a policyholder, a contract holder or a person who has the right to elect options, such as a certificate holder, may take pursuant to a policy or contract that is subject to the Standard Valuation Law and, if allowed pursuant to the policy or contract, includes lapses, withdrawals, transfers, deposits, premium payments, loans and annuitization and benefit elections, but excludes events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract;

H. "principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and that is required to comply with Section 59A-8A-9 NMSA 1978;

I. "qualified actuary" means an individual who, according to the applicable qualification standards of the American academy of actuaries, is qualified to sign the applicable statement of actuarial opinion and who meets the applicable requirements indicated by the valuation manual;

J. "tail risk" means a risk that occurs either when the frequency of low-probability events is higher than expected under a normal probability distribution or when events of very significant magnitude are observed; and

K. "valuation manual" means the most recent version of the manual of valuation instructions adopted by the national association of insurance commissioners."

SECTION 18. Section 59A-8-6 NMSA 1978 (being Laws 1984, Chapter 127, Section 123, as amended) is recompiled as Section 59A-8A-3 NMSA 1978 and is amended to read:

"59A-8A-3. [~~ANNUAL~~] RESERVE VALUATION [~~RESERVES~~].--

A. For policies and contracts issued prior to the operative date of the valuation manual:

(1) the superintendent shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer authorized to do business in [~~this state, except that as to an alien insurer the valuation shall be limited to its United States business. The superintendent may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest and methods (net level premium method or other) used in calculation of such reserves.~~

~~B.~~] New Mexico and that are issued on or after the operative date of Section 59A-20-31 NMSA 1978. In calculating such reserves the superintendent may use group methods and

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approximate averages for fractions of a year or otherwise. In lieu of valuation of reserves herein required of a foreign or alien insurer, the superintendent may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard [~~herein~~] provided [~~and if the official of such state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the superintendent when such certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction~~

~~C. The insurer may increase the standards of mortality in particular cases of invalid lives and other extra hazards.~~

~~D. For all health insurance policies the insurer shall maintain an active life reserve which shall place a sound value on its liabilities under such policies and be not less than the reserve according to appropriate standards set forth in regulations issued by the superintendent and in no event less in the aggregate than the pro rata gross unearned premiums for such policies~~] by the Standard Valuation Law;

(2) the provisions of Sections 59A-8A-6 and 59A-8A-7 NMSA 1978 apply, as appropriate, to a policy or

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contract that is subject to the provisions of the Standard Valuation Law and that is issued on or after the operative date of Section 59A-20-31 NMSA 1978 but prior to the operative date of the valuation manual. The provisions of Sections 59A-8A-8 and 59A-8A-9 NMSA 1978 do not apply to a policy or contract that is subject to the provisions of the Standard Valuation Law and that is issued on or after the operative date of Section 59A-20-31 NMSA 1978 but prior to the operative date of the valuation manual; and

(3) the minimum standard for the valuation of a policy or contract that is issued prior to the operative date of Section 59A-20-31 NMSA 1978 is the minimum standard provided in the laws in effect immediately prior to that date.

B. For a policy or contract that is issued on or after the operative date of the valuation manual:

(1) the superintendent shall annually value, or cause to be valued, the reserve liabilities, hereinafter called reserves, of all outstanding life insurance, annuity and pure endowment, accident and health and deposit-type contracts of a life insurer authorized to do business in New Mexico that are issued on or after the operative date of the valuation manual. In the case of a foreign or alien insurer, the superintendent may, in the alternative, accept a valuation made, or caused to be made, by the insurance supervisory official of a state or other jurisdiction if that valuation

complies with the minimum standard provided in the Standard Valuation Law; and

(2) the provisions of Sections 59A-8A-8 and 59A-8A-9 NMSA 1978 apply to all policies and contracts issued on or after the operative date of the valuation manual.

~~E.~~] C. In no event shall the aggregate reserves for all [~~polices~~] policies, contracts and benefits be less than the aggregate reserves determined by the qualified actuary to be necessary to render the opinion required by Section [~~59A-8-7~~] 59A-8A-4 NMSA 1978."

SECTION 19. Section 59A-8-7 NMSA 1978 (being Laws 1993, Chapter 320, Section 22) is recompiled as Section 59A-8A-4 NMSA 1978 and is amended to read:

"59A-8A-4. ACTUARIAL OPINION OF RESERVES ISSUED PRIOR TO OPERATIVE DATE OF VALUATION MANUAL.--

A. This section [~~shall become operative on January 1, 1995 for calendar years 1994 and thereafter~~] applies to actuarial opinions issued prior to the operative date of the valuation manual.

B. Every life insurer doing business in [~~this state~~] New Mexico shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the superintendent by regulation are computed appropriately, are based on assumptions [~~which~~] that satisfy

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contractual provisions, are consistent with prior reported amounts and comply with applicable laws of [~~this state~~] New Mexico. The superintendent by regulation shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

C. Every life insurer, except as exempted by or pursuant to regulation, shall also annually include in the opinion required by Subsection B of this section, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the superintendent by regulation, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts. The superintendent may provide by regulation for a transition period for establishing any higher reserves [~~which~~] that the qualified actuary may deem necessary in order to render the opinion required by this section.

D. Every opinion required by Subsection C of this section shall be governed by the following provisions:

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(1) a memorandum, in form and substance acceptable to the superintendent as specified by regulation, shall be prepared to support each actuarial opinion; and

(2) if the insurer fails to provide a supporting memorandum at the request of the superintendent <u>within a period specified by rule or if the superintendent</u> determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the superintendent, the superintendent may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the superintendent.

E. Every opinion required by this section shall be governed by the following provisions:

(1) the opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1994;

(2) the opinion shall apply to all business in force, including individual and group health insurance plans in form and substance acceptable to the superintendent as specified by regulation;

(3) the opinion shall be based on standards adopted from time to time by the actuarial standards board and on such additional standards as the superintendent may by

regulation prescribe;

(4) in the case of an opinion required to be submitted by a foreign or alien insurer, the superintendent may accept the opinion filed by that insurer with the insurance supervisory official of another state if the superintendent determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in [~~this state~~] New Mexico;

(5) for the purposes of this section, "qualified actuary" means a member in good standing of the American academy of actuaries who meets the requirements set forth in such regulations;

(6) except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurer and the superintendent, for any act, error, omission, decision or conduct with respect to the actuary's opinion;

(7) disciplinary action by the superintendent against the insurer or the qualified actuary shall be defined in regulations by the superintendent; [~~and~~]

(8) except as provided in Paragraph (12) of this subsection, the documents, materials and other information that constitute a memorandum in support of the opinion and that are in the possession or control of the office of superintendent of insurance, and other materials provided by the company to the superintendent in connection with the

memorandum, are confidential and privileged, not subject to the Inspection of Public Records Act, not subject to subpoena and, in a private civil action, not subject to discovery or admissible in evidence; but the superintendent may use the documents, materials or other information in the furtherance of a regulatory or legal action brought in the course of the superintendent's official duties;

(9) neither the superintendent nor any person who receives documents, materials or other information while acting pursuant to the authority of the superintendent shall be permitted or required in a private civil action to testify on the confidential documents, materials or information subject to Paragraph (8) of this subsection;

(10) to assist in the performance of the superintendent's duties, the superintendent may:

(a) if the recipient agrees to maintain the confidentiality and privilege of the document, material or other information, share documents, materials or other information, including the confidential and privileged documents of a state, federal or international regulatory agency, with the national association of insurance commissioners, its affiliates or its subsidiaries and with state, federal and international law enforcement authorities;

(b) receive documents, materials or information, including that which is otherwise confidential and privileged, from the national association of insurance commissioners, its affiliates or its subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions if the superintendent maintains as confidential or privileged a document, material or other information received with notice or the understanding that the content is confidential or privileged pursuant to the laws of the jurisdiction from which the information originates; and

(c) consistent with Paragraphs (8) through (10) of this subsection, enter into agreements governing sharing and the use of information;

(11) a disclosure to or a sharing by the superintendent pursuant to this section does not constitute a waiver of an applicable privilege or claim of confidentiality in the documents, materials or information; and

[~~(8) any~~] (12) a memorandum in support of the opinion and any other material provided by the insurer to the superintendent in connection therewith [~~shall be kept confidential by the superintendent and shall not be made public and shall not~~] may be subject to subpoena [~~other than~~] for the purpose of defending an action seeking damages from [~~any person~~] the actuary by reason of any action required by this section or by regulations promulgated hereunder; provided, however, that the memorandum or other material may otherwise be released by the superintendent, with the written consent of the

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insurer, or to the American academy of actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the superintendent for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited by the insurer in its marketing or is cited before any governmental agency other than a state insurance department or is released by the insurer to the news media, all portions of the confidential memorandum shall be no longer confidential."

SECTION 20. A new Section 59A-8A-5 NMSA 1978 is enacted to read:

"59A-8A-5. [NEW MATERIAL] ACTUARIAL OPINION OF RESERVES ISSUED AFTER OPERATIVE DATE OF VALUATION MANUAL.--

A. This section applies to actuarial opinions issued after the operative date of the valuation manual.

B. A company with outstanding life insurance, accident and health insurance or deposit-type contracts in New Mexico and that is subject to regulation by the superintendent shall annually submit the opinion of the appointed actuary on whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, based on assumptions that satisfy contractual provisions, consistent with prior reported amounts and comply with the laws of New Mexico. The opinion shall comport with related provisions of the valuation manual.

C. Except as excluded by the provisions of the valuation manual, a company with outstanding life insurance, accident and health insurance or deposit-type contracts in New Mexico and that is subject to regulation by the superintendent shall include in the opinion required by Subsection B of this section an assessment of whether, when considering the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the anticipated considerations to be received and retained pursuant to the policies and contracts, the reserves and related actuarial items that are held in support of the policies and contracts that are specified in the valuation manual make adequate provision for the company's obligations pursuant to the policies and contracts, including the benefits pursuant to and expenses associated with the policies and contracts.

D. An opinion required by Subsection B of this section shall be accompanied by a memorandum of support, whose form and substance comply with the provisions of the valuation manual and are acceptable to the superintendent. If, within a period of time specified by the provisions of the valuation manual and upon the request of the superintendent, an insurance company fails to provide a memorandum of support, the superintendent may engage, at the insurance company's expense, a qualified actuary to review the opinion and the basis for it and prepare a memorandum of support. If the superintendent determines that an insurance company's memorandum of support fails to meet the standards provided in the valuation manual or is otherwise unacceptable, the superintendent may engage the services of a qualified actuary to review the opinion and the basis for it and prepare a memorandum of support.

E. An opinion required by this section shall:

(1) conform in form and substance to the provisions of the valuation manual and be acceptable to the superintendent;

(2) accompany an annual statement that indicates the valuation of reserve liabilities for each year ending on or after the operative date of the valuation manual;

(3) apply to all policies and contracts subject to Subsection B of this section and other actuarial liabilities specified by the provisions of the valuation manual; and

(4) meet the standards adopted by the actuarial standards board or its successor and the relevant standards provided in the valuation manual.

F. In the case of a foreign or alien company, the superintendent may accept, instead of an opinion filed pursuant to Subsection B of this section, an opinion filed by the company with the insurance supervisory official of another state if the superintendent determines that the opinion reasonably meets the requirements applicable to a company domiciled in New Mexico.

G. Except in cases of fraud or willful misconduct, an appointed actuary is not liable for damages to a person, except the insurance company that appointed the actuary or the superintendent, resulting from an act, error, omission, decision or conduct related to the appointed actuary's opinion.

H. Disciplinary action by the superintendent against a company or its appointed actuary shall be defined by rules promulgated by the superintendent."

SECTION 21. Section 59A-8-5 NMSA 1978 (being Laws 1984, Chapter 127, Section 122, as amended) is recompiled as Section 59A-8A-6 NMSA 1978 and is amended to read:

"59A-8A-6. [~~STANDARD VALUATION LAW, LIFE INSURANCE AND ANNUITIES~~] RULE-BASED RESERVE VALUATION METHODS.--

A. This subsection shall apply to only those policies and contracts issued prior to the operative date of Section 59A-20-31 NMSA 1978.

The legal minimum standard for valuation of life insurance contracts issued before the first day of January 1926 shall be the method and basis of valuation heretofore applied by the insurer in the valuation of such contracts, and for life insurance contracts issued on or after this date shall be the American experience table of mortality, with interest at the

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rate of three and one-half percent a year; or any other basis not producing a lower net value; provided, however, that the insurer may provide for not more than one-year preliminary term insurance by incorporating in the contracts a clause plainly showing that the first year's insurance under such policies is term insurance.

Except as otherwise provided in Paragraphs (2), (3), (4) and (5) of Subsection B of this section and in Subsections C, D and E of this section for group annuity and pure endowment contracts, the legal minimum standard for the valuation of annuities shall be the American experience table of mortality, with interest at the rate of five percent a year for group annuity and pure endowment contracts and four percent a year for other annuities.

B. Subsections B, C, D and E of this section shall apply to only those policies and contracts issued on and after the operative date of Section 59A-20-31 NMSA 1978, except as otherwise provided in Paragraphs (2), (3), (4) and (5) of this subsection and in Subsections C, D and E of this section for group annuity and pure endowment contracts issued prior to such operative date.

(1) Except as otherwise provided in Paragraphs (2), (3), (4) and (5) of this subsection and Subsections C, D and E of this section, the minimum standard for the valuation of all such policies and contracts shall be the commissioners

reserve valuation methods defined in Paragraphs (1) and (2) of Subsection E of this section, five percent interest for group annuity and pure endowment contracts and three and one-half percent interest for all other such policies and contracts, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after July 1, 1973, four percent interest for such policies issued prior to July 1, 1977, five and one-half percent interest for single premium life insurance policies and four and one-half percent interest for all other such policies issued on or after July 1, 1977, and the following tables:

(a) for [~~all~~] ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the commissioners 1941 standard ordinary mortality table for such policies issued prior to the operative date of Paragraph (1) of Subsection D of Section 59A-20-31 NMSA 1978 and the commissioners 1958 standard ordinary mortality table for such policies issued on or after the operative date of Paragraph (1) of Subsection D of Section 59A-20-31 NMSA 1978 and prior to the operative date of Subsection F of Section 59A-20-31 NMSA 1978, provided that for any category of such policies issued on female risks, all modified net premiums and present values referred to in Subsections B, C, D and E of this section may be calculated according to an age not more than six years younger

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than the actual age of the insured; and for such policies issued on or after the operative date of Subsection F of Section 59A-20-31 NMSA 1978: 1) the commissioners 1980 standard ordinary mortality table; or 2) at the election of the insurer for any one or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with ten-year select mortality factors; or 3) any ordinary mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies;

(b) for [~~all~~] industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the 1941 standard industrial mortality table for such policies issued prior to the operative date of Subsection E of Section 59A-20-31 NMSA 1978, and for such policies issued on or after such operative date, the commissioners 1961 standard industrial mortality table or any industrial mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies;

(c) for individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 standard annuity mortality table or, at the option of the insurer, the annuity mortality table for 1949, ultimate, or any modification of either of these tables approved by the superintendent;

(d) for group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the group annuity mortality table for 1951, any modification of such table approved by the superintendent, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(e) for total and permanent disability benefits in or supplementary to ordinary policies or contracts: 1) for policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the national association of insurance commissioners, that are approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies; 2) for policies or contracts issued on or after January 1, 1961 and prior to January 1, 1966, either such tables or, at the option of the insurer, the class (3) disability table (1926); and 3) for policies issued prior to January 1, 1961, the class (3) disability table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(f) for accidental death benefits in or supplementary to policies: 1) for policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any accidental death benefits table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies; 2) for policies issued on or after January 1, 1961 and prior to January 1, 1966, either such table or, at the option of the insurer, the intercompany double indemnity mortality table; and 3) for policies issued prior to January 1, 1961, the intercompany double indemnity mortality table. 4) Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and

(g) for group life insurance, life insurance issued on the substandard basis and other special benefits, such tables as may be approved by the superintendent.

(2) Except as provided in Paragraphs (3), (4) and (5) of this subsection and in Subsections C, D and E of this section, the minimum standard [~~for the~~] <u>of</u> valuation [~~of all~~] <u>for</u> individual annuity and pure endowment contracts issued

on or after the operative date of this paragraph, as defined herein, and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the commissioners reserve valuation methods defined in Paragraphs (1) and (2) of Subsection E of this section and the following tables and interest rates:

(a) for individual annuity and pure endowment contracts issued prior to July 1, 1977, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table, or any modification of this table approved by the superintendent, and six percent interest for single premium immediate annuity contracts, and four percent interest for all other individual annuity and pure endowment contracts;

(b) for individual single premium immediate annuity contracts issued on or after July 1, 1977, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table, or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the superintendent, and seven and one-half percent interest;

(c) for individual annuity and pure endowment contracts issued on or after July 1, 1977, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table, or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the superintendent, and five and one-half percent interest for single premium deferred annuity and pure endowment contracts and four and one-half percent interest for all other such individual annuity and pure endowment contracts;

(d) for [~~all~~] annuities and pure endowments purchased prior to July 1, 1977, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 group annuity mortality table, or any modification of this table approved by the superintendent, and six percent interest; and

(e) for [~~all~~] annuities and pure endowments purchased on or after July 1, 1977, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts,

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the 1971 group annuity mortality table, or any group annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of this table approved by the superintendent, and seven and one-half percent interest.

(f) After July 1, 1973, any insurer may file with the superintendent a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1979, which shall be the operative date of this paragraph for such insurer, provided that an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the operative date of this paragraph for such insurer shall be January 1, 1979.

(3) The interest rates used in determining the minimum standard for the valuation of:

(a) [~~all~~] life insurance policies issued in a particular calendar year, on or after the operative date of Subsection F of Section 59A-20-31 NMSA 1978;

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

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

(d) the net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts shall be the calendar year statutory valuation interest rates as defined in Paragraph (4) of this subsection.

(4) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearest one-quarter of one percent:

(a) for life insurance,

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

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

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

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

(c) for other annuities with cash settlement options and guaranteed interest contracts with cash

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

(d) for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in Subparagraph (b) of this paragraph shall apply; and

(e) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in Subparagraph (b) of this paragraph shall apply.

(5) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory

valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when Subsection F of Section 59A-20-31 NMSA 1978 becomes operative.

C. The weighting factors referred to in the formulas stated above are given in the following tables:

(1) Weighting Factors for Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

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

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

.80

(3) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in Paragraph (2) of this subsection, shall be as specified in the tables set forth in Subparagraphs (a), (b) and (c) of this paragraph, according to the rules and definitions set forth in Subparagraphs (d), (e) and (f) of this paragraph:

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

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

(b) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in the table set forth in Subparagraph (a) of this paragraph increased by:

Plan Type		
A	B	C
.15	.25	.05

(c) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) [~~which~~] that do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis [~~which~~] that do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in the table set forth in Subparagraph (a) of this paragraph or derived as required in the table set forth in Subparagraph (b) of this paragraph increased by:

Plan Type		
A	B	C
.05	.05	.05

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

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

Plan Type A: At any time policyholder may withdraw funds only: with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or without such adjustment but in installments over five years or more; or as an immediate life annuity; or no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only: with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or without such adjustment but in installments over five years or more; or no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either: without adjustment to reflect changes in interest rates or

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asset values since receipt of the funds by the insurer; or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

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

D. The reference interest rate referred to in Paragraph (4) of Subsection B of this section shall be defined as follows:

(1) for [~~all~~] life insurance, the lesser of

the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year next preceding the year of issue, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(2) for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or year of purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(3) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Paragraph (2) of this subsection, with guarantee duration in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(4) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement

options, valued on a year of issue basis, except as stated in Paragraph (2) of this subsection, with guarantee duration of ten years or less, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(5) for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(6) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in Paragraph (2) of this subsection, the average over a period of twelve months, ending on June 30 of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated; and

(7) in the event that the national association of insurance commissioners determines that the monthly average of the composite yield on seasoned corporate bonds, as

published by Moody's investors service, incorporated, is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate [~~which~~] that is adopted by the national association of insurance commissioners and approved by regulation promulgated by the superintendent may be substituted.

E. The reserve valuation method shall be defined as follows:

(1) Except as otherwise provided in this paragraph and Paragraph (2) of this subsection, reserves according to the national association of insurance commissioners reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of Subparagraph (a) over Subparagraph (b) of this

paragraph, as follows:

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

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

Provided that for any life insurance policy issued on or after January 1, 1985 for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and [~~which~~] that provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in Subparagraph [~~(e)~~] (f) of this paragraph, be the greater of the reserve as of such policy anniversary calculated as described previously in this paragraph and the reserve as of such policy anniversary calculated as previously described in this paragraph, but with: the value defined in Subparagraph (a) of this paragraph being reduced by fifteen percent of the amount of such excess first year premium; all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date; the policy being assumed to mature on such date as an endowment; and the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in Paragraphs (1), (3), (4) and (5) of Subsection B of this section and in Subsections C and D of this section shall be used.

Reserves according to the commissioners reserve valuation method for: 1) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums; 2) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended; 3) disability and accidental death benefits in all policies and contracts; and 4) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this paragraph [~~except that any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums~~];

(c) in no event shall an insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, be less than the aggregate reserves calculated in accordance with the methods set forth in this paragraph and Paragraph (2) of this subsection and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies;

<u>(d) at the option of the insurer, reserves for policies and contracts issued prior to the operative date of Section 59A-20-31 NMSA 1978 may be calculated according to a standard that produces greater aggregate reserves for the policies and contracts than the minimum required by the laws in effect immediately prior to that date;</u>

[~~(d)~~] <u>(e)</u> reserves for any category of policies, contracts or benefits as established by the superintendent that are issued on or after the operative date of Section 59A-20-31 NMSA 1978, may be calculated, at the option of the insurer, according to any standards [~~which~~] that produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be [~~higher~~] greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for [~~therein~~] in the policies or contracts.

Any such insurer [~~which~~] that at any time [~~shall have adopted~~] adopts any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard [~~herein~~] provided by the Standard Valuation Law may, with the approval of the superintendent, adopt any lower standard of valuation, but not lower than the minimum herein provided; but, for the purpose of this section, the holding of additional reserves previously determined by [~~a qualified~~] the appointed actuary to be necessary to render the opinion required by Section [~~59A-8-7~~] 59A-8A-4 NMSA 1978 shall not be deemed to be the adoption of a higher standard of valuation;

[~~(e)~~] (f) if in any contract year the gross premium charged by any insurer on any policy or contract

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is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this paragraph are those standards stated in Paragraphs (1), (3), (4) and (5) of Subsection B of this section.

Provided that for any life insurance policy issued on or after January 1, 1985 for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and [~~which~~] that provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of Subparagraph [~~(e)~~] (f) of this paragraph shall be applied as if the method actually used in calculating the reserve for such policy were the method previously described in this paragraph ignoring the unnumbered paragraph immediately following Subparagraph (b) of this paragraph. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with the method previously described in this paragraph, including the unnumbered paragraph immediately following Subparagraph (b), and the minimum reserve calculated in accordance with Subparagraph [~~(e)~~] (f) of this paragraph; and

[~~(f)~~] (g) in the case of any plan of life insurance [~~which~~] that provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance or annuity [~~which~~] that is of such a nature that the minimum reserves cannot be determined by the methods described in Paragraphs (1) and (2) of this subsection, the reserves [~~which~~] that are held under any such plan must: 1) be appropriate in relation to the benefits and the pattern of premiums for that plan; and 2) be computed by a method [~~which~~] that is consistent with the principles of this standard valuation law, as determined by regulations promulgated by the superintendent.

(2) This paragraph shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan

of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended.

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

SECTION 22. A new Section 59A-8A-7 NMSA 1978 is enacted to read:

"59A-8A-7. [NEW MATERIAL] MINIMUM STANDARDS FOR ACCIDENT AND HEALTH INSURANCE CONTRACTS.--For an accident and health insurance contract issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required by Subsection B of Section 59A-8A-3 NMSA 1978. For an accident and health insurance contract issued on or after the operative date of Section 59A-20-31 NMSA 1978 and prior to the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the superintendent by rule."

SECTION 23. A new Section 59A-8A-8 NMSA 1978 is enacted to read:

"59A-8A-8. [NEW MATERIAL] VALUATION MANUAL FOR POLICIES ISSUED ON OR AFTER OPERATIVE DATE OF VALUATION MANUAL.--

A. For a policy issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required by Subsection B of Section 59A-8A-3 NMSA 1978, except as provided in Subsection D or F of this section.

B. Unless an amendment to the valuation manual provides for a later effective date, an amendment to the valuation manual takes effect on the January 1 after the date that the amendment was adopted by the national association of insurance commissioners by an affirmative vote of:

(1) at least three-fourths of the members of the national association of insurance commissioners voting, but not less than a majority of the total membership; and

(2) members representing jurisdictions that collectively represent more than seventy-five percent of written direct premiums, as reported in the life, accident and health annual statements, the health annual statements and the fraternal annual statements most recently available before the time of the vote referred to in Paragraph (1) of this subsection.

C. The valuation manual shall indicate:

(1) minimum valuation standards for and definitions of the policies or contracts subject to Subsection B of Section 59A-8A-3 NMSA 1978, including:

(a) the superintendent's reserve valuation method for life insurance contracts, other than annuity contracts, subject to that subsection;

(b) the superintendent's annuity reserve valuation method for annuity contracts subject to that subsection; and

(c) minimum reserves for all other policies or contracts subject to that subsection;

(2) which policies and contracts or types of policies and contracts are subject to the requirements of a principle-based valuation in Subsection A of Section 59A-8A-9

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NMSA 1978 and the minimum standards of valuation consistent with those requirements;

(3) for policies and contracts subject to a principle-based valuation pursuant to Section 59A-8A-9 NMSA 1978:

(a) requirements for the format of reports filed with the superintendent pursuant to Paragraph (3) of Subsection B of Section 59A-8A-9 NMSA 1978, which shall include information necessary to determine if the valuation is appropriate and complies with the Standard Valuation Law;

(b) prescribed assumptions for risks over which the company has no significant control or influence; and

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

(4) for policies not subject to a principle-based valuation pursuant to Section 59A-8A-9 NMSA 1978, the minimum standard of valuation shall either:

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

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

(5) other requirements, including those related to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memoranda, transition rules and internal controls; and

(6) the data and form of the data required by Section 59A-8A-10 NMSA 1978, the person with whom the data must be submitted and, if appropriate, data analyses and reporting of analyses.

D. In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual does not, in the opinion of the superintendent, comply with the Standard Valuation Law, then a company shall comply with the minimum valuation standards promulgated by rule by the superintendent.

E. The superintendent may engage, at the company's expense, a qualified actuary to conduct an actuarial examination of a company and issue an opinion on the appropriateness of the company's reserve assumption or method, or to review and issue an opinion on the company's compliance with a requirement of the Standard Valuation Law. The superintendent may rely upon the opinion of a qualified actuary engaged by the insurance supervisory official of another state, district or territory of the United States if that opinion relates to the provisions of the Standard Valuation Law. As used in this subsection, "engage" includes employment and contract employment.

F. The superintendent may require a company to change an assumption or method if the superintendent believes that the change is necessary to comply with the requirements of the valuation manual or the Standard Valuation Law. The company shall adjust its reserves to comply with the superintendent's requirement."

SECTION 24. A new Section 59A-8A-9 NMSA 1978 is enacted to read:

"59A-8A-9. [NEW MATERIAL] REQUIREMENTS OF A PRINCIPLE-BASED VALUATION.--

A. For policies and contracts that the valuation manual indicates are subject to this section, a company shall establish reserves using a principle-based valuation that:

(1) quantifies the benefits and guarantees and the funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events with a reasonable probability of occurring during the lifetime of the contracts and, for a policy or contract with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk;

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(2) incorporates assumptions, risk analysis methods, financial models and management techniques that are consistent with, but not necessarily identical to, those used in the company's overall risk assessment process and that recognize potential differences in financial reporting structures and prescribed assumptions or methods;

(3) incorporates assumptions that:

(a) derive from the valuation manual; or

(b) do not derive from the valuation manual, but: 1) are established using the company's available experience and are relevant and statistically credible; or 2) if company data is not available, relevant or statistically credible, are established utilizing other relevant, statistically credible experience; and

(4) provides margins for uncertainty, including adverse deviation and estimation error, whose sizes vary in proportion to the margin and resulting reserve.

B. A company using a principle-based valuation for policies and contracts that the valuation manual indicates are subject to this section shall:

(1) establish procedures for corporate governance and oversight of the actuarial valuation function that are consistent with those provided for in the valuation manual;

(2) design its internal controls of

principle-based valuation to ensure that all material risks inherent in the liabilities and associated assets subject to the valuation are included in the valuation and that valuations are made in accordance with the valuation manual;

(3) each year, provide to the superintendent and to the company's board of directors a certification of effectiveness of the internal controls of the company's principle-based valuation that are in place at the end of the preceding calendar year; and

(4) develop and, upon the request of the superintendent, file a principle-based valuation report that complies with the standards prescribed in the valuation manual.

C. A principle-based valuation may include a prescribed formulaic reserve component."

SECTION 25. A new Section 59A-8A-10 NMSA 1978 is enacted to read:

"59A-8A-10. [NEW MATERIAL] EXPERIENCE REPORTING FOR POLICIES IN FORCE ON OR AFTER OPERATIVE DATE OF VALUATION MANUAL.--For policies in force on or after the operative date of the valuation manual, a company shall submit mortality, morbidity, policyholder behavior or expense experience and other data as prescribed in the valuation manual."

SECTION 26. A new Section 59A-8A-11 NMSA 1978 is enacted to read:

"59A-8A-11. [NEW MATERIAL] CONFIDENTIALITY.--

A. As used in this section, "confidential information" includes:

(1) memoranda in support of opinions submitted pursuant to Sections 59A-8A-4 and 59A-8A-5 NMSA 1978 and other documents, materials and information, including all working papers and copies of those papers, that are produced or obtained by or disclosed to the superintendent or another person in connection with those memoranda;

(2) documents, materials and other information, including all working papers and copies of those papers, that are produced or obtained by or disclosed to the superintendent or another person in the course of an examination conducted pursuant to Subsection E of Section 59A-8A-8 NMSA 1978; provided, however, that if an examination report or other material prepared in connection with an examination pursuant to Sections 59A-4-5 through 59A-4-13 NMSA 1978 is not held as private and confidential information pursuant to Sections 59A-4-5 through 59A-4-13 NMSA 1978, an examination report made under Subsection E of Section 59A-8A-8 NMSA 1978 shall not be confidential information to the same extent as if the examination report or other material had been prepared pursuant to Sections 59A-4-5 through 59A-4-13 NMSA 1978;

(3) reports, documents, materials and other information developed by a company in support of or in

connection with an annual certification by a company pursuant to Paragraph (3) of Subsection B of Section 59A-8A-9 NMSA 1978, including working papers and copies of those papers that are produced by, obtained by or disclosed to the superintendent or another person in connection with those reports, documents, materials or other information;

(4) principle-based valuation reports developed pursuant to Paragraph (4) of Subsection B of Section 59A-8A-9 NMSA 1978 and other documents, materials and other information, including working papers and copies of those papers that are produced or obtained by or disclosed to the superintendent or another person in connection with those reports; and

(5) documents, materials, data and other information, including working papers and copies those papers, that contain potentially identifying company or personal information and that are produced or obtained by or disclosed to the superintendent or another person in connection with the submissions required by Section 59A-8A-10 NMSA 1978.

B. Except as provided in this section, a company's confidential information is confidential and privileged, not subject to the Inspection of Public Records Act, not subject to subpoena and, in a private civil action, not subject to discovery or admissible in evidence; provided that the superintendent may use the documents, materials or other information in the furtherance of a regulatory or legal action brought as a part of the superintendent's official duties. Neither the superintendent nor another person who received documents, materials or other information while acting pursuant to the authority of the superintendent shall be permitted or required in a private civil action to testify on the confidential documents, materials or information subject to this subsection.

C. In order to assist in the performance of the superintendent's duties, the superintendent may share confidential information:

(1) with another state, federal or international regulatory agency and with the national association of insurance commissioners, its affiliates or its subsidiaries; and

(2) in the case of confidential information specified in Paragraphs (1) and (4) of Subsection A of this section:

(a) with the actuarial board for counseling and discipline or its successor if the actuarial board for counseling and discipline or its successor requests the confidential information and states that it is required for a professional disciplinary proceeding; and

(b) with a state, federal or international law enforcement official if that official has the legal authority to agree and does agree to maintain the confidentiality and privilege of the documents, materials, data and other information in the same manner and to the same extent as the superintendent.

D. The superintendent may receive documents, materials, data and other information, including otherwise-confidential and privileged documents, materials, data and other information, from the national association of insurance commissioners, its affiliates or its subsidiaries, from regulatory or law enforcement officials of foreign or domestic jurisdictions and from the actuarial board for counseling and discipline or its successor. The superintendent shall maintain as confidential or privileged a document, materials, data or other information received with notice or the understanding that the content is confidential or privileged pursuant to the laws of the jurisdiction from which the information originates.

E. The superintendent may enter into agreements governing the sharing and use of information that are consistent with Subsections B through H of this section.

F. No waiver of an applicable privilege or claim of confidentiality in confidential information results from a disclosure to the superintendent pursuant to the provisions of this section or as a result of the sharing authorized by Subsection C of this section.

G. A privilege established by the laws of a state

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or jurisdiction that is substantially similar to the privilege established by Subsections B through H of this section shall be available and enforced in any official proceeding in, and in any court of, New Mexico.

H. For the purposes of this section, "regulatory agency", "law enforcement agency" and "national association of insurance commissioners" include the employees, agents, consultants and contractors of the entity.

I. Notwithstanding Subsections B through H of this section, the confidential information specified in Paragraphs (1) and (4) of Subsection A of this section:

(1) is subject to subpoena for the purpose of defending an action seeking damages from an appointed actuary who submits a related memorandum in support of an opinion pursuant to Sections 59A-8A-4 and 59A-8A-5 NMSA 1978 or who submits a principle-based valuation report developed pursuant to Paragraph (4) of Subsection B of Section 59A-8A-9 NMSA 1978 if the submission is required by the Standard Valuation Law or the rules promulgated in furtherance of that law;

(2) may, with the written consent of the company, be released by the superintendent; and

(3) ceases to be confidential once a portion of a memorandum in support of an opinion submitted pursuant to Sections 59A-8A-4 and 59A-8A-5 NMSA 1978 or a principle-based valuation report developed pursuant to Paragraph (4) of

Subsection B of Section 59A-8A-9 NMSA 1978 is cited by the company in its marketing, publicly volunteered to a governmental agency other than a state insurance department or released by the company to the news media."

SECTION 27. A new Section 59A-8A-12 NMSA 1978 is enacted to read:

"59A-8A-12. [NEW MATERIAL] SINGLE STATE EXEMPTION.--

A. The superintendent may exempt from the requirements of Section 59A-8A-8 NMSA 1978 the specific product forms or product lines of a domestic company that is licensed and doing business only in New Mexico if:

(1) the superintendent has issued a written exemption to the company and has not subsequently revoked the exemption in writing; and

(2) the company computes reserves using the assumptions and methods used prior to the operative date of the valuation manual and using any requirements established by the superintendent and promulgated by rule.

B. For a company granted an exemption pursuant to this section, Sections 59A-8A-4, 59A-8A-6 and 59A-8A-7 NMSA 1978 apply. For a company that applies this exemption, a reference to Section 59A-8A-8 NMSA 1978 that is found in Sections 59A-8A-4, 59A-8A-6 and 59A-8A-7 NMSA 1978 does not apply."

SECTION 28. Section 59A-20-31 NMSA 1978 (being Laws 1984, Chapter 127, Section 396) is amended to read:

"59A-20-31. THE STANDARD NONFORFEITURE LAW OF LIFE INSURANCE.--

A. In the case of policies issued on and after the operative date of this section, as defined in Subsection K of this section, no policy of life insurance, except as stated in Subsection J of this section, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions [~~which~~] that in the opinion of the superintendent are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with Subsection I of this section:

(1) that, in the event of default in any premium payment the insurer will grant, upon proper request not later than sixty 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 such amount as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit [~~which~~] that provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits;

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(2) that, upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified;

(3) that a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty days after the due date of the premium in default;

(4) that, if the policy shall have become paid-up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit [~~which~~] that 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 insurer will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified;

(5) in the case of policies [~~which~~] that cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or [~~which~~] that provide an option for changes in benefits or premiums other than a change to a new

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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 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 credited to the policy and that there is no indebtedness to the insurer on the policy; and

(6) a statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation

has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

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

The insurer shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with 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, whether or not required by Subsection A of this section, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits [~~which~~] that 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, E and F of this section, corresponding to premiums [~~which~~] that would have fallen due on or after such anniversary; and

(2) the amount of any indebtedness to the

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insurer on the policy.

Provided, however, that for any policy issued on or after the operative date of Subsection F of this section, as defined therein, 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 referred to in [~~the first~~] Paragraph (1) of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such 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 such paragraph for a policy [~~which~~] that provides only the benefits otherwise provided by such rider or supplemental policy provision.

Provided, further, that for any family policy issued on or after the operative date of Subsection F of this section as defined therein, 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 of seventy-one, 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 such 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 such paragraph for a policy [~~which~~] that provides only the benefits otherwise provided by such term insurance on the life of the spouse. Any cash surrender value available within thirty 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, whether or not required by Subsection A of this section, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on the policy.

C. Any paid-up nonforfeiture benefit available under the 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 at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value [~~which~~] that would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

D. This subsection shall not apply to policies issued on or after the operative date of Subsection F of this section. Except as provided in Paragraph (2) 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

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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: (a) the then present value of the future guaranteed benefits provided for by the policy; (b) two percent 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; (c) forty percent of the adjusted premium for the first policy year; (d) twenty-five percent 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, however, that in applying the percentages specified in (c) and (d) [~~above~~], no adjusted premium shall be deemed to exceed four percent of the amount of insurance or uniform amount equivalent thereto. 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.

(1) 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 the date of issue as the benefits under the policy; provided, however, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten were the amount provided by such policy at age ten.

(2) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to: (1) 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 (2) the adjusted premiums for such term insurance, the foregoing items (1) and (2) being calculated separately and as specified in the first two paragraphs (the first paragraphs and Paragraph (1)) of this subsection except that, for the purposes of (b), (c) and (d) 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 (2) 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 (1).

(3) Except as otherwise provided in Paragraph (4) of this subsection and Subsection E of this section, 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 national association of insurance 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 three 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 per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Provided, however, that 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 one hundred thirty percent of the rates of mortality according to such applicable table. Provided, further, 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 of mortality as may be specified by the insurer and approved by the superintendent.

(4) This paragraph shall not apply to ordinary policies issued on or after the operative date of Subsection F of this section. In the case of ordinary policies issued on or after the operative date of this paragraph as defined herein, 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 a year, except that a rate of interest not exceeding four percent a year may be used for policies issued on or after July 1, 1973 and prior to July 1, 1977 and a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after July 1, 1977, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent per annum may be used, and 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 years younger than the actual age of the insured. Provided, however, that 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 1958 extended term insurance table. Provided, further, 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 of mortality as may be specified by the insurer and approved by the superintendent.

After June 9, 1961, any insurer may file with the superintendent a written notice of its election to comply with the provisions of Paragraph (4) of this subsection 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 this subsection for such insurer), this subsection shall become operative with respect to the ordinary policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1966.

E. This subsection shall not apply to industrial policies issued on or after the operative date of Subsection F of this section.

In the case of industrial policies issued on or after the operative date of this subsection as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the bases of <u>the</u> 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 a year except that a rate of interest not exceeding four percent a year may be used for policies issued on or after July 1, 1973 and prior to July 1, 1977 and a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after July 1, 1977, except that, for any single premium whole life or endowment insurance policy, a rate of interest not exceeding six and one-half percent per annum may be used. Provided, however, that 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 1961 industrial extended term insurance table. Provided, further, 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 of mortality as may be specified by the insurer and approved by the superintendent.

After June 7, 1963, any insurer may file with the superintendent a written notice of its election to comply with the provisions of this subsection 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 this subsection for such insurer), this subsection shall become operative with respect to the industrial policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1968.

F. This subsection shall apply to all policies issued on or after the operative date of this subsection. Except as provided in Paragraph (6) 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 impairment 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 the then present value of the future guaranteed benefits provided for by the policy; one percent 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 policy years; and one hundred [~~and~~] twenty-five percent of the nonforfeiture net level premium as hereinafter defined. Provided, however, that, in applying the last percentage specified above, no nonforfeiture net level premium shall be deemed to exceed four percent 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 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; and

(1) 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 per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due;

(2) in the case of policies [~~which~~] that cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or [~~which~~] that 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;

(3) except as otherwise provided in Paragraph (6) 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 the sum of the then present value of the then future guaranteed benefits provided for by the policy and the additional expense allowance, if any, over the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy;

(4) the additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of one percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten 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 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 one hundred twenty-five percent of the increase, if positive, in the nonforfeiture net level premium;

(5) the recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (a) by (b) where:

(a) equals the sum of: (1) the nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one 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 [~~occured~~] occurred; and (2) 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 per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due;

(6) notwithstanding any other provisions of this subsection to the contrary, in the case of a policy issued on a substandard basis [~~which~~] that provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis [~~which~~] that 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;

(7) 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 1980 standard ordinary mortality table or, at the election of the insurer for any one 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. Provided, however, that:

(a) at the option of the insurer, 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) an insurer 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 aforementioned tables;

(f) <u>for a policy issued prior to the operative date of the valuation manual</u>, any ordinary mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by regulation promulgated by the superintendent 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; [~~and~~]

(g) for a policy issued on or after the operative date of the valuation manual, the commissioners standard mortality table in the valuation manual shall be used to determine the minimum nonforfeiture standard that may be substituted for the commissioners 1980 standard ordinary mortality table, either with or without ten-year select mortality factors, or for the commissioners 1980 extended term insurance table. If the superintendent adopts through rulemaking a commissioners standard ordinary mortality table that was adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard shall substitute for the minimum nonforfeiture standard provided in the valuation manual;

[~~(g)~~] (h) for a policy issued prior to the operative date of the valuation manual, any industrial mortality tables, adopted after 1980 by the national

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association of insurance commissioners, that are approved by regulation promulgated by the superintendent 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; and

(i) for a policy issued on or after the operative date of the valuation manual, the commissioners standard mortality table in the valuation manual shall be used to determine 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 superintendent adopts through rulemaking a commissioners standard industrial mortality table that was adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard shall substitute for the minimum nonforfeiture standard provided in the valuation manual;

(8) the nonforfeiture interest rate:

(a) for a policy issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five percent of the calendar year statutory valuation interest rate for such policy as defined in the Standard Valuation Law [~~(Section 122 of the Insurance Code~~], rounded to the nearest [~~one-quarter~~] one-fourth of one percent; and

(b) for a policy issued on or after the operative date of the valuation manual, the valuation manual shall be used to determine the nonforfeiture interest rate per annum for any policy issued in a particular calendar year;

(9) notwithstanding any other provision in the laws relating to insurance to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form [~~which~~] that 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; and

(10) after the effective date of this subsection, any insurer may file with the superintendent a written notice of its election to comply with the [~~provision~~] provisions of this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for such insurer. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1989.

G. In the case of any plan of life insurance [~~which~~] that provides for future premium determination, the

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amounts of which are to be determined by the insurer based on the then estimates of future experience, or in the case of any plan of life insurance [~~which~~] that is of such a nature that minimum values cannot be determined by the methods described in Subsection A, B, C, D, E or F of this section, then:

(1) the superintendent 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, E or F of this section;

(2) the superintendent 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 superintendent.

H. 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

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in Subsections B, C, D, E and F of this section 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 of this section, additional benefits payable (a) in the event of death or dismemberment by accident or accidental means; (b) in the event of total and permanent disability; (c) as reversionary annuity or deferred reversionary annuity benefits; (d) 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; (e) 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, is uniform in amount after the child's age is one and has not become paid up by reason of the death of a parent of the child; and (f) 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.

I. This subsection, in addition to all other applicable sections of this law, shall apply 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 in an amount [~~which~~] that does not differ by more than two-tenths of one percent 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 policy years, from the sum of (a) the greater of zero and the basic cash value hereinafter specified; and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the insurer under the policy.

The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits [~~which~~] that would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums [~~which~~] that would have fallen due on and after such anniversary. Provided, however, that 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 therein.

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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 F of this section, 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 the fifth policy anniversary and 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 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 policy years; and

(2) must be such that no percentage after the later of the two policy anniversaries specified in Paragraph (1) of this subsection may apply to fewer than five consecutive policy years.

Provided that no basic cash value may be less than the value [~~which~~] that would be obtained if the adjusted premiums for the policy, as defined in Subsection D or F 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, F and H 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 items (a) through (d) in Subsection H of this section shall conform with the principles of this subsection.

J. 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~~] that provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty years or less expiring before age seventy-one for which uniform premiums are payable during the entire term of the policy, nor to any term policy of decreasing amount, [~~which~~] that provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in Subsections D, E and F of this section, is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, [~~which~~] that 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 years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy, nor to any policy, [~~which~~] that 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, E and F of this section, exceeds two and one-half percent of the amount of insurance at the beginning of the same policy year; nor to any policy [~~which~~] that shall be delivered outside this state through an agent or other representative of the insurer 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 of expiry of the oldest life.

K. After the effective date of this act, any insurer may file with the superintendent a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1952. After the filing of such notice, then upon such specified date (which shall be the operative date for such insurer), this section shall become operative with respect to policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this section for such insurer shall be January 1, 1952.

L. As used in this section:

(1) "operative date of the valuation manual" means the January 1 of the first calendar year following the first July 1 after which the following have occurred:

(a) the valuation manual has been adopted by the national association of insurance commissioners by an affirmative vote of at least forty-two members or three-fourths of the members voting, whichever is greater;

(b) the Standard Valuation Law of the national association of insurance commissioners, as amended in 2009, or legislation including substantially similar terms and provisions, has been enacted by states that collectively represent more than seventy-five percent of written direct premiums, as reported in the life, accident and health, health and fraternal annual statements submitted for 2008; and

(c) the Standard Valuation Law of the national association of insurance commissioners, as amended in

2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two of the following fifty-five jurisdictions: 1) the fifty states of the United States; 2) American Samoa; 3) the Virgin Islands of the United States; 4) the District of Columbia; 5) Guam; and 6) Puerto Rico; and

(2) "valuation manual" means the most recent version of the manual of valuation instructions adopted by the national association of insurance commissioners."

SECTION 29. Section 59A-37-2 NMSA 1978 (being Laws 1984, Chapter 127, Section 617, as amended) is amended to read:

"59A-37-2. DEFINITIONS.--As used in [~~Chapter 59A, Article 37 NMSA 1978~~] The Insurance Holding Company Law:

A. "acquire" means to come into possession or control of, and "acquisition" means any agreement, arrangement or activity the consummation of which results in a person acquiring directly or indirectly the control of another person and includes the acquisition of voting securities or assets, bulk reinsurance and mergers;

B. "affiliate" means a person that directly or indirectly is controlled by, is under common control with or controls another person;

C. "control" means the possession of the power to direct or cause the direction of the management and policies of a person, whether directly or indirectly, through the ownership

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of voting securities, through licensing or franchise agreements, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by an individual. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote or holds <u>proxies representing</u> ten or more percent of the voting securities of any other person. This presumption may be rebutted by a showing, in the manner provided by Section 59A-37-19 NMSA 1978, that control does not in fact exist. The superintendent may determine, after furnishing all persons in interest notice and an opportunity to be heard, that control exists in fact, notwithstanding the absence of a presumption to that effect, provided the determination is based on specific findings of fact in its support;

<u>D. "enterprise risk" means an activity, a circumstance, an event or a 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 whole insurance holding company system and includes a situation that would cause the insurer's risk-based capital to fall to a company action level as defined in Section 59A-5A-4 NMSA 1978 or would cause the insurer to be in a hazardous financial condition as</u>

defined in Section 59A-41-24 NMSA 1978;

E. "health maintenance organization" means a person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis; provided that "prepaid basis" may include the payment of copayments and deductibles by enrollees;

[~~D.~~] F. "insurance holding company" is a person that controls an insurer; "insurance holding company system" means a combination of two or more affiliated persons, at least one of which is an insurer;

[~~E.~~] G. "insurer" means a person that undertakes, under contract, to indemnify a person against loss, damage or liability arising from an unknown or contingent future event. The term does not include agencies, authorities or instrumentalities of the United States, its possessions or territories, the commonwealth of Puerto Rico, the District of Columbia, a state or any of its political subdivisions or a fraternal benefit society;

[~~F.~~] H. "person" means an individual, corporation, association, partnership, joint stock company, trust, unincorporated organization or any similar entity or combination of entities;

[~~G.~~] I. "securityholder" means the owner of any security of a person, including common stock, preferred stock, debt obligations and any other security convertible into or

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evidencing the right to acquire any of the foregoing;

[~~H.~~] J. "subsidiary" means an affiliate of a person controlled by the person either directly or indirectly through one or more intermediaries; and

[~~I.~~] K. "voting security" means a certificate evidencing the ownership or indebtedness of a person, to which is attached a right to vote on the management or policymaking of that person and includes any security convertible into or evidencing a right to acquire such a voting security [~~and~~

~~J. "health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for co-payments or deductibles~~]."

SECTION 30. Section 59A-37-3 NMSA 1978 (being Laws 1993, Chapter 320, Section 72, as amended) is amended to read:

"59A-37-3. SUBSIDIARIES OF INSURERS.--

A. Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries. [~~engaged in the following kinds of business:~~

~~(1) an insurance business authorized by the jurisdiction in which it is incorporated;~~

~~(2) acting as an insurance broker or as an insurance agent for its parent or for any of its parent's~~

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~~insurer subsidiaries;~~

~~(3) investing, reinvesting or trading in securities for its own account, that of its parent, any subsidiary of its parent, or any affiliate or subsidiary;~~

~~(4) management of any investment company subject to or registered pursuant to the federal Investment Company Act of 1940, as amended, including related sales and services;~~

~~(5) acting as a broker-dealer subject to or registered pursuant to the federal Securities Exchange Act of 1934, as amended;~~

~~(6) rendering investment advice to governments, government agencies, corporations or other organizations or groups;~~

~~(7) rendering other services relating to the operations of an insurance business;~~

~~(8) owning and managing assets that the parent corporation could itself own or manage;~~

~~(9) acting as administrative agent for a governmental instrumentality that is performing an insurance function;~~

~~(10) financing of insurance premiums, agents and other forms of consumer financing;~~

~~(11) any other business activity determined by the superintendent to be reasonably ancillary to an insurance~~

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~~business; and~~

~~(12) owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section~~] A subsidiary may conduct any kind of business. Its authority to conduct one or more businesses shall not be limited by its status as a subsidiary of a domestic insurer.

B. In addition to investments in common stock, preferred stock, debt obligations and other securities permitted pursuant to The [~~federal~~] Insurance Holding Company Law, a domestic insurer may also invest:

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

(a) total net money 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 the investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in Paragraph (1) of this subsection or in Chapter 59A, Article 9 NMSA 1978 applicable to the insurer. For the purpose of this paragraph, "the total investment of the insurer" includes:

(a) any direct investment by the insurer in an asset; and

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

(3) with the approval of the superintendent, [~~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 will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

C. Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to Subsection B of this section shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in the Insurance Code applicable to the investments of the insurer.

D. Whether any investment pursuant to Subsection B of this section meets the applicable requirements of that subsection shall 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 and not including dividends.

E. If an insurer ceases to control a subsidiary, it shall dispose of any investment made in it pursuant to this section within three years from the time of the cessation of control or within such further time as the superintendent may prescribe, unless at any time after the investment is made, the investment meets the requirements for investment under any other section of the Insurance Code and the insurer has so notified the superintendent."

SECTION 31. Section 59A-37-4 NMSA 1978 (being Laws 1984, Chapter 127, Section 619, as amended) is amended to read:

"59A-37-4. ACQUISITION OF CONTROL OF <u>OR MERGER WITH</u> DOMESTIC INSURER.--

A. No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into [~~any~~] <u>an</u> agreement to exchange securities for, acquire, seek to acquire, in the open market or otherwise, [~~any~~] <u>a</u> voting security of a domestic insurer if, after the consummation [~~thereof, such~~] <u>of it, the</u> person would, directly or indirectly or by conversion or by exercise of any right to acquire, be in control of [~~such~~] <u>the</u> insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer unless, at the time any such offer, request or invitation is made or [~~any such~~] <u>an</u> agreement is entered into, or prior to the acquisition of [~~such~~] <u>the</u> securities if no offer or agreement is involved,

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[~~such~~] the person has filed with the superintendent and has sent to [~~such~~] the insurer, and [~~such~~] the insurer has sent to its shareholders, a statement containing the information required by Section 59A-37-5 NMSA 1978 and [~~such~~] the offer, request, invitation, agreement or acquisition has been approved by the superintendent in the manner hereinafter prescribed.

B. For the purposes of Sections 59A-37-4 through 59A-37-10 NMSA 1978, the superintendent shall identify the circumstances in which a person seeking to divest or acquire an interest of control of a domestic insurer is required to obtain the superintendent's approval for the transaction. A person who controls a domestic insurer and seeks to divest its interest of control of the domestic insurer shall, at least thirty days prior to the cessation of control, file with the superintendent confidential notice of the proposed divestiture and give a copy of that notice to the insurer. Information contained in the notice shall remain confidential until the conclusion of the transaction if the superintendent has not determined that treating the information as confidential will interfere with the provisions of this section. This subsection does not apply to a statement filed pursuant to Subsection A of this section.

C. For a transaction subject to Sections 59A-37-4 through 59A-37-10 NMSA 1978, the acquiring person shall file with the superintendent a pre-acquisition notice, which shall

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<u>contain the information set forth in Paragraph (1) of Subsection C of Section 43 of this 2013 act. The superintendent may subject a person who fails to file the notice required by this subsection to a fine of not more than fifty thousand dollars ($50,000).</u>

[~~B.~~] <u>D.</u> For the purposes of this section and Sections 59A-37-5 through 59A-37-10 NMSA 1978:

(1) [~~a~~] "domestic insurer" includes any other person controlling a domestic insurer unless [~~such~~] <u>the</u> other person, <u>as determined by the superintendent</u>, is either directly or through its affiliates primarily engaged in business other than the business of insurance; and

(2) "person" shall not include any securities broker holding, while in the performance of [~~his~~] <u>the broker's</u> usual and customary broker's function, less than twenty percent of the voting securities of an insurer, or of any person [~~which~~] <u>that</u> controls an insurer."

SECTION 32. Section 59A-37-5 NMSA 1978 (being Laws 1984, Chapter 127, Section 620, as amended) is amended to read:

"59A-37-5. CONTENTS OF STATEMENT.--

A. The statement to be filed with the superintendent under Section 59A-37-4 NMSA 1978 shall be made under oath or affirmation and shall contain the following information:

(1) the name and address of each person,

hereinafter called "acquiring party", by whom or on whose behalf the merger or other acquisition of control referred to in Section 59A-37-4 NMSA 1978 is to be effected and:

(a) if the acquiring party is an individual, [~~his~~] the individual's principal occupation and all offices and positions held by [~~him~~] the individual during the past five years and any conviction of crime other than minor traffic violations during the past ten years; or

(b) if the acquiring party is not an individual, a report of the nature of its business operations during the past five years or for such lesser period as it and any of its predecessors shall have been in existence; an informative description of the business intended to be done by it and its subsidiaries; and a list of all individuals who are or who have been selected to become its directors or executive officers or who perform or will perform functions appropriate to such positions. The list shall include for each individual the information required by Subparagraph (a) of this paragraph;

(2) the source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction where funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates and the identity of persons furnishing such consideration. However, where a

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source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if the person filing the statement so requests;

(3) fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five fiscal years of each acquiring party, or for such lesser period that the acquiring party and any of its predecessors shall have been in existence if less than five years, and similar unaudited information as of a date not earlier than ninety days prior to the date of the filing of the statement;

(4) any plans or proposals [~~which~~] that each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any other person, or to make any other material change in its business or corporate structure or management;

(5) the number of shares of any security [~~which~~] that each acquiring party proposes to acquire, the terms of the offer, request, invitation, agreement or acquisition and a statement as to the method by which the fairness of the proposal was determined;

(6) the amount of each class of any security referred to in Section 59A-37-4 NMSA 1978 [~~which~~] that is beneficially owned or concerning which there is a right to

acquire beneficial ownership by each acquiring party;

(7) a full description of any contracts, arrangements or understandings with respect to any security referred to in Section 59A-37-4 NMSA 1978 in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements or understandings have been entered into;

(8) a description of the purchase of any security referred to in Section 59A-37-4 NMSA 1978 during the twelve calendar months preceding the filing of the statement by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid;

(9) a description of any recommendations to purchase any security referred to in Section 59A-37-4 NMSA 1978 made during the twelve calendar months preceding the filing of the statement by any acquiring party or by anyone based upon interviews or at the suggestion of any acquiring party;

(10) copies of all tender offers for, requests or invitations for tenders of exchange offers for and agreements to acquire or exchange any securities referred to in Section 59A-37-4 NMSA 1978 and, if distributed, of additional

soliciting material relating thereto;

(11) the terms of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in Section 59A-37-4 NMSA 1978 for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto; [~~and~~]

(12) an agreement by the person required to file the statement that the person will provide, for as long as the person has control, an annual report pursuant to Section 44 of this 2013 act;

(13) acknowledgment by the person required to file the statement that the person and all subsidiaries within the person's control in the insurance holding company system will provide information to the superintendent upon request and as necessary to evaluate the enterprise risk to the insurer; and

[~~(12)~~] (14) such additional information as the superintendent may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders and securityholders of the insurer or in the public interest.

B. If the person required to file the statement referred to in Section 59A-37-4 NMSA 1978 is a partnership, limited partnership, syndicate or other group, the superintendent may require that the information called for by

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Subsection A of this section shall be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group and each person who controls the partner or member. If any partner, member or person is a corporation or the person required to file the statement referred to in Section 59A-37-4 NMSA 1978 is a corporation, the superintendent may require that the information called for by Subsection A of this section shall be given with respect to the corporation, each officer and director of the corporation and each person who is directly or indirectly the beneficial owner of more than ten percent of the outstanding voting securities of the corporation.

C. If any material change occurs in the facts set forth in the statement filed with the superintendent and sent to [~~such~~] the insurer pursuant to Section 59A-37-4 NMSA 1978, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the superintendent and sent to the insurer within two business days after the person learns of the change, and the insurer shall send the amendment to its shareholders without delay.

D. If any offer, request, invitation, agreement or acquisition referred to in Section 59A-37-4 NMSA 1978 is proposed to be made by means of a registration statement under the federal Securities Act of 1933, as amended, or in circumstances requiring the disclosure of similar information under the federal Securities Exchange Act of 1934, as amended, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in Section 59A-37-4 NMSA 1978 may utilize such documents in furnishing the information called for by that statement."

SECTION 33. Section 59A-37-6 NMSA 1978 (being Laws 1984, Chapter 127, Section 621, as amended) is amended to read:

"59A-37-6. APPROVAL BY SUPERINTENDENT--REVIEW.--

A. The superintendent shall approve any merger or other acquisition of control referred to in Section 59A-37-4 NMSA 1978 unless, after a public hearing [~~thereon, he~~] on it, the superintendent finds that:

(1) after the change of control, the domestic insurer would not be able to satisfy the requirements for the issuance of a certificate of authority to write the line or lines of insurance for which it is presently authorized;

(2) the effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in [~~this state~~] New Mexico or tend to create a monopoly [~~therein~~] in insurance. In applying this paragraph:

(a) the informational requirements of Paragraph (1) of Subsection C of Section 43 of this 2013 act, and the standards of Paragraph (1) of Subsection D of that section, apply;

(b) the superintendent shall approve the merger or acquisition if the superintendent finds that any of the situations meeting the criteria provided in Paragraph (2) of Subsection D of Section 43 of this 2013 act exist; and

(c) the superintendent may condition the approval of the merger or acquisition on the removal, to take place within a specified period of time, of the circumstances that formed the basis for disapproval;

(3) the financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interests of its policyholders or the interests of any remaining security holders who are unaffiliated with the acquiring party;

(4) the plans or proposals [~~which~~] that the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any other 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;

(5) 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;

(6) the applicable provisions of Chapter 59A, Article 34 NMSA 1978 would be violated; or

(7) the acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

B. The superintendent may retain at the acquiring party's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the superintendent's staff that are reasonably necessary to assist the superintendent to review the proposed acquisition of control.

C. The superintendent shall ensure, by imposition of conditions, if necessary, that New Mexico charitable assets are protected and preserved for the benefit of the people of New Mexico.

D. The public hearing held pursuant to Subsection A of this section shall be held within thirty days after the statement required by Section 59A-37-4 NMSA 1978 is filed, and the superintendent shall notify the person filing the statement at least twenty days before the hearing. The person filing the statement shall notify the insurer, and other persons whom the superintendent designates, no fewer than seven days before the hearing. The superintendent shall make a determination within the sixty days before the effective date of the proposed transaction. At the hearing, the person filing the statement, the insurer, a person to whom notice of hearing was sent and any other person whose interests may be affected shall be entitled to present evidence, examine and cross-examine witnesses, offer oral and written arguments and conduct discovery proceedings according to the rules of civil procedure for the district courts. All discovery proceedings shall conclude no later than three days before the public hearing.

E. If the proposed acquisition of control requires the approval of one or more insurance supervisory officials in other states, and if requested by the person filing the statement required by Section 59A-37-4 NMSA 1978, the public hearing held pursuant to Subsection A of this section may be conducted as a consolidated hearing. Within five days of a person's request for a consolidated hearing, that person shall file the statement referred to in Section 59A-37-4 NMSA 1978 with the national association of insurance commissioners. If the superintendent or an insurance supervisory official of another state elects not to participate in a consolidated hearing, then within ten days of receipt of the statement required by Section 59A-37-4 NMSA 1978, the superintendent or insurance supervisory official shall provide notice to the applicant of that person's election not to participate. A consolidated hearing shall be public and held within the United States before the insurance supervisory officials of the states in which the insurers are domiciled. Participating insurance supervisory officials shall hear and receive evidence. The superintendent may attend the hearing in person or by telecommunication.

F. For the change of control of a domestic insurer, a determination by the superintendent that the person acquiring control of the insurer must maintain or restore the capital of the insurer to the level required by the laws and rules of New Mexico shall be made no later than sixty days after the date of notice of the change of control submitted pursuant to Subsection A of Section 59A-37-4 NMSA 1978."

SECTION 34. Section 59A-37-9 NMSA 1978 (being Laws 1984, Chapter 127, Section 624) is amended to read:

"59A-37-9. VIOLATIONS.--

A. The following acts shall be violations of Sections [~~619 through 621 of this article~~] 59A-37-4 through 59A-37-6 NMSA 1978:

[~~A.~~] (1) the failure to file any statement, amendment or other material required to be filed pursuant to [~~Sections 619 or 620 of this article~~] Section 59A-37-4 or 59A-37-5 NMSA 1978; or

[~~B.~~] (2) the effectuation or any attempt to effectuate an acquisition of control of a domestic insurer unless the superintendent has given [~~his~~] approval [~~thereto~~] to it.

B. The failure to timely file a registration statement, a summary of the registration statement or an enterprise risk filing required by Sections 59A-37-11 through

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59A-37-19.2 NMSA 1978 and Section 44 of this 2013 act is a violation of Sections 59A-37-11 through 59A-37-19.2 NMSA 1978 and Section 44 of this 2013 act."

SECTION 35. Section 59A-37-12 NMSA 1978 (being Laws 1984, Chapter 127, Section 627, as amended) is amended to read:

"59A-37-12. REGISTRATION--INFORMATION--FORM.--Every insurer subject to registration shall file a registration statement on a form [~~provided by the superintendent~~] and in a format prescribed by the national association of insurance commissioners, which shall [~~contain current information about~~] include:

A. information about the current capital structure, general financing condition, ownership and management of the insurer and any person controlling the insurer;

B. the identity of every current member of the insurance holding company system;

C. the following agreements in force, relationships subsisting and transactions currently outstanding between such insurer and its affiliates:

(1) loans, other investments or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(2) purchases, sales or exchanges of assets;

(3) transactions not in the ordinary course of business;

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(4) guarantees or undertakings for the benefit of an affiliate [~~which~~] that 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;

(5) all management and service contracts and all cost-sharing arrangements;

(6) reinsurance agreements;

(7) dividends and other distributions to shareholders; and

(8) consolidated tax allocation agreements;

D. information about any existing 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; [~~and~~]

E. if requested by the superintendent, financial statements of or within an insurance holding company system and its affiliates. Financial statements may include existing annual audited financial statements filed with the federal securities and exchange commission pursuant to the federal Securities Act of 1933, as amended, or the federal Securities Exchange Act of 1934, as amended. An insurer may satisfy the requirement to file financial statements pursuant to this subsection by providing the superintendent with the most recent parent corporation financial statements that have been filed

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with the securities and exchange commission;

[~~E.~~] F. other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the superintendent;

G. statements that the insurer's board of directors is responsible for and oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented and continue to maintain and monitor corporate governance and internal control procedures; and

H. other information required by a rule that was promulgated by the superintendent."

SECTION 36. Section 59A-37-13 NMSA 1978 (being Laws 1984, Chapter 127, Section 628) is amended to read:

"59A-37-13. MATERIALITY.--No information need be disclosed on the registration statement filed pursuant to Sections [~~619 and 620 of this article~~] 59A-37-4 and 59A-37-5 NMSA 1978 if such information is not material for the purposes of [~~Section 626 through 634 of this article~~] Sections 59A-37-11 through 59A-37-19 NMSA 1978. Unless the superintendent by rule, regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, [~~or~~] investments or guarantees involving one-half of one percent or less of an insurer's admitted assets as of the most recent December 31

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[~~next preceding~~] shall not be deemed material for the purposes of such section."

SECTION 37. Section 59A-37-19 NMSA 1978 (being Laws 1984, Chapter 127, Section 634) is amended to read:

"59A-37-19. DISCLAIMER.--Any person may file with the superintendent a disclaimer of affiliation with any authorized insurer or [~~such~~] a disclaimer may be filed by [~~such~~] the authorized insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming an affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report [~~which~~] that may arise out of the insurer's relationship with [~~such~~] the person unless and until the superintendent, within thirty days after the receipt of a complete disclaimer, disallows the disclaimer. The superintendent shall disallow such a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support the disallowance."

SECTION 38. Section 59A-37-20 NMSA 1978 (being Laws 1993, Chapter 320, Section 83) is amended to read:

"59A-37-20. TRANSACTIONS WITH AFFILIATES.--

A. Transactions within a holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(1) the terms shall be fair and reasonable;

(2) agreements for cost-sharing services and management shall include the provisions required by rule promulgated by the superintendent;

[~~(2)~~] (3) charges or fees for services performed shall be reasonable;

[~~(3)~~] (4) expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

[~~(4)~~] (5) the books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

[~~(5)~~] (6) the insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

B. The following transactions involving a domestic insurer and any person in its holding company system, including amendments and modifications of affiliate agreements previously filed pursuant to this section that are subject to the materiality standards of this subsection, may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into such transactions at least thirty days prior thereto, or such shorter period as the superintendent may permit, and the superintendent has not disapproved it within that period:

(1) sales, purchases, exchanges, loans or extensions of credit, guarantees or investments, provided the transactions are equal to or exceed:

(a) with respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders as of the most recent December 31 [~~next preceding~~]; or

(b) with respect to life insurers, three percent of the insurer's admitted assets as of the most recent December 31 [~~next preceding~~];

(2) loans or extensions of credit to any person who is not an affiliate, where the insurer makes 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 making the loans or extensions of credit, provided the transactions are equal to or exceed:

(a) with respect to nonlife insurers,

the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders as of the most recent December 31 [~~next preceding~~]; or

(b) with respect to life insurers, three percent of the insurer's admitted assets as of December 31 next preceding;

(3) reinsurance agreements or modifications [~~thereto~~] to those agreements, including reinsurance pooling agreements or agreements in which the reinsurance premium or a change in the insurer's liabilities, or projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds five percent of the insurer's surplus as regards policyholders, as of the most recent December 31 [~~next preceding~~], including those agreements [~~which~~] that may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of such assets will be transferred to one or more affiliates of the insurer;

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

(5) guarantees made by a domestic insurer if the amount of the guarantee can be quantified and is greater than one-half of one percent of the insurer's admitted assets

or ten percent of surplus as regards policyholders as of the most recent December 31, whichever is less. A guarantee whose amount cannot be quantified is subject to the notice requirements of this subsection;

(6) direct or indirect acquisitions or investments in a person who controls the insurer or in an affiliate of the insurer in an amount that, together with its present holdings in the investments, exceeds two and one-half percent of the insurer's surplus as regards policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Section 59A-37-3 NMSA 1978 or that are authorized pursuant to another section of the Insurance Code or in nonsubsidiary insurance affiliates that are subject to the provisions of The Insurance Holding Company Law are exempt from this requirement; and

[~~(5)~~] (7) any material transactions specified by regulation [~~which~~] that the superintendent determines may adversely affect the interests of the insurer's policyholders.

Notice to the superintendent for amendments or modifications shall provide the reasons for the change and a description of the change's financial impact on the domestic insurer. Within thirty days after the termination of a previously filed agreement, a person shall notify the superintendent of that event. The superintendent shall respond by indicating the type of filing, if any, that the person must

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file.

Nothing contained in this subsection shall be deemed to authorize or permit any transactions [~~which~~] that, in the case of an insurer not a member of the same holding company system, would be otherwise contrary to law.

C. A domestic insurer may not enter into transactions [~~which~~] that are part of a plan or series of like transactions with persons within the 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 superintendent determines that such separate transactions were entered into over any twelve-month period for that purpose, [~~he~~] the superintendent may exercise [~~his~~] authority under Section 59A-37-26 NMSA 1978.

D. The superintendent, in reviewing transactions pursuant to Subsection B of this section, shall consider whether the transactions comply with the standards set forth in Subsection A of this section and whether they may adversely affect the interests of policyholders.

E. The superintendent shall be notified within thirty days of any investment of the domestic insurer in any one corporation if the total investment in [~~such~~] the corporation by the insurance holding company system exceeds ten percent of the corporation's voting securities."

SECTION 39. Section 59A-37-22 NMSA 1978 (being Laws

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1984, Chapter 127, Section 637, as amended) is amended to read:

"59A-37-22. DIVIDENDS AND OTHER DISTRIBUTIONS.--

A. No domestic stock insurer shall declare or distribute any dividend to shareholders, other than a pro rata distribution of any class of the insurer's own securities, except out of earned surplus. For purposes of this section, "earned surplus" means the portion of the surplus that represents the net earnings, gains or profits, after deduction of all losses, that have not been distributed to the shareholders as dividends or transferred to stated capital or capital surplus or applied to other purposes permitted by law, but does not include twenty-five percent of the unrealized appreciation of assets.

B. No domestic insurer shall pay an extraordinary dividend or make any other extraordinary distribution to its shareholders until:

(1) thirty days after the superintendent has received notice of the declaration thereof and has not within such period disapproved such payment; or

(2) the superintendent shall have approved such payment within the thirty-day period.

C. For the purposes of Sections 59A-37-20 through 59A-37-22 NMSA 1978, 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 months exceeds the lesser of ten percent of the insurer's surplus as regards policyholders as of the most recent December 31 [~~next preceding~~] or the net gain from operations of the insurer after dividends to policyholders and federal income taxes and before realized capital gains and losses, if the insurer is either a life insurer or a health maintenance organization, or the net [~~investment~~] 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 own securities.

D. In determining whether a dividend or distribution is extraordinary:

(1) an insurer other than a life insurer or a health maintenance organization may carry forward net income from the previous [~~three~~] two calendar years that has not already been paid out as dividends, which carry-forward shall be computed by taking the net income from the second and third [~~and fourth~~] preceding calendar years, not including realized capital gains, less dividends paid in the [~~third~~] second and immediate preceding calendar years; and

(2) a life insurer or a health maintenance organization may carry forward net gains from operations, not

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including realized capital gains from the previous two calendar years, that have not already been paid out as dividends, which carry-forward shall be computed by taking the net gain from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

E. Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution [~~which~~] that is conditioned upon the superintendent's approval thereof, and such a declaration shall confer no rights upon shareholders until the superintendent has:

(1) [~~the superintendent has~~] approved the payment of the dividend or distribution; or

(2) [~~the superintendent has~~] not disapproved the payment within thirty days after [~~he~~] the superintendent has received notice of the declaration."

SECTION 40. Section 59A-37-23 NMSA 1978 (being Laws 1984, Chapter 127, Section 638, as amended) is amended to read:

"59A-37-23. EXAMINATIONS.--

A. Pursuant to general powers of investigation and examination vested in the superintendent under Chapter 59A, Article 4 NMSA 1978, the superintendent may order [~~any~~] an insurer registered under Section 59A-37-11 NMSA 1978 to produce such records, books or other information papers in the possession of the insurer or its affiliates as are necessary to ascertain the insurer's financial condition, [~~or its~~] including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis or the insurer's compliance with [~~Chapter 59A, Article 37 NMSA 1978~~] The Insurance Company Holding Law. If the insurer fails to comply with the order, the superintendent may examine its affiliates to obtain the information.

B. The examination shall be conducted and otherwise be subject to applicable provisions of Chapter 59A, Article 4 NMSA 1978.

C. To determine compliance with The Insurance Holding Company Law, the superintendent may require that an insurer registered pursuant to Section 59A-37-11 NMSA 1978 produce information not possessed by the insurer if the insurer can access that information through a contractual relationship, statutory obligation or other valid method. If the insurer cannot obtain the information that the superintendent requests, the insurer shall provide the superintendent with a detailed explanation of the reasons for that inability and the identity of the holder of information. If the superintendent believes that the explanation lacks merit, the superintendent may require, after notice and a hearing, that the insurer pay a penalty of five hundred dollars ($500) for each day that the

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production of information is delayed, or the superintendent may suspend or revoke the insurer's license."

SECTION 41. Section 59A-37-24 NMSA 1978 (being Laws 1984, Chapter 127, Section 639) is amended to read:

"59A-37-24. CONFIDENTIAL TREATMENT.--

A. All [~~information~~] documents, [~~and copies thereof~~] materials or other information in the possession or control of the office of superintendent of insurance that are obtained by or disclosed to the superintendent or any other person in the course of an examination or investigation made pursuant to Sections [~~635 through 637 of this article~~] 59A-37-20 through 59A-37-22 NMSA 1978, and all information reported pursuant to Section [~~619 of this article~~] 59A-37-4 NMSA 1978, shall be [~~given~~] confidential [~~treatment~~] by law and privileged, shall not be subject to the Inspection of Public Records Act, shall not be subject to subpoena and are not subject to discovery or admissible in evidence in a private civil action. The superintendent may use the documents, materials or other information in a regulatory or legal action brought in the course of the superintendent's official duties. The documents, materials or other information shall not be made public by the superintendent or any other person without the prior written consent of the insurer to which it pertains unless the superintendent, after giving the insurer and its affiliates [~~who~~] that would be affected [~~thereby~~] by them,

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notice and an opportunity to be heard, determines that the interests of the policyholders, shareholders or the public will be served by the publication [~~thereof~~] of them, in which [~~event he~~] case the superintendent may publish all or any part [~~thereof~~] of them in [~~such~~] the manner [~~as he~~] the superintendent deems appropriate.

B. Neither the superintendent nor a person who receives documents, materials or other information while acting pursuant to the authority of the superintendent or with whom such documents, materials or other information are shared pursuant to The Insurance Holding Company Law shall be permitted or required in a private civil action to testify on the confidential documents, materials or information identified in Subsection A of this section.

C. To assist in the performance of the superintendent's duties, the superintendent:

(1) may share documents, materials or other information, including the confidential and privileged documents, materials or information identified in Subsection A of this section, with other state, federal and international regulatory agencies, with the national association of insurance commissioners, its affiliates or its subsidiaries and with state, federal and international law enforcement authorities, including members of a supervisory college described in Section 46 of this 2013 act, if the recipient agrees in writing to

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maintain the confidentiality and privilege of the document, materials or other information and has cited in writing the legal authority to maintain the confidentiality;

(2) in the case of confidential and privileged documents, materials or information reported pursuant to Section 44 of this 2013 act, and notwithstanding Paragraph (1) of this subsection, may share that information only with insurance supervisory officials of states that have statutes or regulations substantially similar to Subsection A of this section and that have agreed in writing not to disclose that information;

(3) may receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the national association of insurance commissioners, its affiliates or its subsidiaries and from regulatory and law enforcement officials of foreign or domestic jurisdictions but shall maintain as confidential or privileged documents, materials or other information received with notice or the understanding that the content is confidential or privileged pursuant to the laws of the jurisdiction from which the information originates; and

(4) shall, pursuant to The Insurance Holding Company Law, enter into written agreements with the national association of insurance commissioners that govern the sharing and use of information, that are consistent with this

subsection and that:

(a) specify protocols for maintaining the confidentiality and security of information shared with the national association of insurance commissioners, its affiliates or its subsidiaries, including protocols for the sharing between the national association of insurance commissioners and other state, federal or international regulators;

(b) provide that the superintendent retains ownership and governs the use of information shared with the national association of insurance commissioners, its affiliates or its subsidiaries;

(c) require that the national association of insurance commissioners promptly notify an insurer whose confidential information it possesses when that information is the subject of a request or subpoena for disclosure or production; and

(d) require that, in a judicial or administrative action in which the national association of insurance commissioners, its affiliates or its subsidiaries must disclose shared confidential information about the insurer, the national association of insurance commissioners, its affiliates or its subsidiaries consent to intervention by the insurer.

D. The sharing of information by the superintendent pursuant to The Insurance Holding Company Law is not a delegation of regulatory authority or rulemaking. The superintendent alone is responsible for the administration, execution and enforcement of the provisions of The Insurance Holding Company Law.

E. The disclosure of documents, materials or information to the superintendent pursuant to this section or the sharing authorized by Subsection C of this section does not constitute a waiver of an applicable privilege or a claim of confidentiality.

F. Documents, materials or other information in the possession or control of the national association of insurance commissioners pursuant to The Insurance Holding Company Law is confidential by law and privileged, not subject to the Inspection of Public Records Act, not subject to subpoena and, in a private civil action, not subject to discovery or admissible in evidence."

SECTION 42. Section 59A-37-26 NMSA 1978 (being Laws 1984, Chapter 127, Section 641, as amended) is amended to read:

"59A-37-26. ENFORCEMENT, CRIMINAL PROCEEDINGS--PENALTY.--

A. Any insurer failing, without just cause, to file any registration statement as required in [~~Chapter 59A, Article 37 NMSA 1978~~] The Insurance Holding Company Law shall be required, after notice and hearing, to pay a penalty of fifty dollars ($50.00) for each day's delay, not to exceed a total

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penalty of ten thousand dollars ($10,000). The superintendent may reduce the penalty if the insurer demonstrates to the superintendent that the imposition of the penalty would constitute a financial hardship to the insurer.

B. Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly permits any officer or agent of the insurer to engage in transactions or make investments [~~which~~] that have not been properly reported or submitted pursuant to Section 59A-37-11 NMSA 1978, Subsection B of Section 59A-37-20 NMSA 1978 or Section 59A-37-22 NMSA 1978, or [~~which~~] that violate [~~Chapter 59A, Article 37 NMSA 1978~~] The Insurance Company Holding Law, shall pay, in their individual capacity, a penalty of not more than ten thousand dollars ($10,000) per violation, after notice and hearing before the superintendent. In determining the amount of the penalty, the superintendent shall take into account the appropriateness of the penalty with respect to the gravity of the violation the history of previous violations and such other matters as justice may require.

C. Whenever it appears to the superintendent that any insurer subject to the provisions of [~~Chapter 59A, Article 37 NMSA 1978~~] The Insurance Holding Company Law or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract [~~which~~] that is subject

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to the provisions of Sections 59A-37-20 through 59A-37-22 NMSA 1978 and [~~which~~] that would not have been approved had the approval been requested, the superintendent may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing, the superintendent may also order the insurer to void any contracts and restore the status quo if the action is in the best interest of the policyholders, creditors or the public.

D. Whenever it appears to the superintendent that [~~any~~] an insurer or any director, officer, employee or agent thereof has committed a willful violation of [~~Chapter 59A, Article 37 NMSA 1978~~] The Insurance Holding Company Law, the superintendent may cause criminal proceedings to be instituted in the district court for the county in which the principal office of the insurer is located or, if [~~such~~] the insurer has no such office in the state, then in the district court for Santa Fe county against the insurer or the responsible director, officer, employee or agent thereof. Any insurer [~~which~~] that willfully violates that [~~article~~] law may be fined not more than twenty thousand dollars ($20,000). Any individual who willfully violates that [~~article~~] law may be fined not more than ten thousand dollars ($10,000).

E. Any officer, director or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false

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statements or false reports or false filings with the intent to deceive the superintendent in the performance of [~~his~~] the superintendent's duties under [~~Chapter 59A, Article 37 NMSA 1978~~] The Insurance Holding Company Law, upon conviction thereof, shall be imprisoned for not more than twenty years or fined not more than one million dollars ($1,000,000), or both. Any fines imposed shall be paid by the officer, director or employee in [~~his~~] the officer's, director's or employee's individual capacity.

F. If the superintendent suspects that a person has violated a provision of Sections 59A-37-4 through 59A-37-10 NMSA 1978, and if that violation prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation alone may provide the basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with the Insurers Conservation, Rehabilitation and Liquidation Law."

SECTION 43. A new section of The Insurance Holding Company Law is enacted to read:

"[NEW MATERIAL] ACQUISITIONS THAT WOULD LESSEN COMPETITION.--

A. As used in this section:

(1) "acquisition" means an agreement, arrangement or activity whose consummation results in a person

directly or indirectly acquiring the control of another person and includes the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers; and

(2) "involved insurer" includes an insurer that acquires or is acquired, is affiliated with an acquirer or acquired or is the result of a merger.

B. Except as provided in this subsection, this section applies to an acquisition in which there is a change of control of an insurer authorized to do business in New Mexico. This section does not apply to:

(1) a purchase of securities made solely for investment purposes if the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in an insurance market in New Mexico. If a purchase of securities results in a presumption of control as provided in Subsection C of Section 59A-37-2 NMSA 1978, this section applies to the purchase unless the insurance supervisory official of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the domiciliary insurance supervisory official communicates that disclaimer action or affirmative finding to the superintendent;

(2) 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

the acquisition would otherwise not be excluded from this section by the provisions of another paragraph of this subsection and if the acquiring party to the acquisition files with the superintendent a notification in accordance with Paragraph (1) of Subsection C of this section at least thirty days prior to the proposed effective date of the acquisition;

(3) the acquisition of an already affiliated person;

(4) where "market" means the direct written insurance premium in New Mexico for a line of business contained in the annual statement required to be filed by an insurer licensed to do business in New Mexico, an acquisition if, as an immediate result of the acquisition:

(a) the combined market share of the involved insurers would not exceed five percent of the total market in any market;

(b) no market share would increase; or

(c) the combined market share of the involved insurers would not exceed twelve percent, and the market share would not increase by more than two percent, of the total market in any market;

(5) an acquisition for which a pre-acquisition notification would be required by the provisions of this section solely because of its effect on the ocean marine insurance line of business; and

(6) an acquisition of an insurer whose domiciliary insurance supervisory official finds that the insurer is in failing condition, that there is no feasible way to improve the condition and that the benefit to the public of improving the insurer's condition through the acquisition exceeds the benefit to the public that would arise from not lessening competition; provided that the findings are communicated to the superintendent by the domiciliary insurance supervisory official.

C. An acquisition identified in Subsection B of this section may be subject to an order pursuant to Subsection E of this section, unless the acquiring person files a pre-acquisition notification and the waiting period has expired. The acquired person may file a pre-acquisition notification. The superintendent shall treat as confidential information submitted pursuant to this subsection in the same manner as provided in Section 59A-37-24 NMSA 1978.

(1) Pre-acquisition notification shall contain the information and be in the form prescribed by the national association of insurance commissioners relating to the markets that, pursuant to Paragraph (4) of Subsection B of this section, subject the acquisition to the provisions of this section. The superintendent may require the submission of additional materials and information that the superintendent deems necessary to determine whether the proposed acquisition,

if consummated, would violate the competitive standard identified in Subsection D of this section. Among other materials, the superintendent may require the submission of an economist's opinion relating to the competitive impact of the acquisition in New Mexico along with an addendum addressing the economist's educational background, experience and ability to render an informed opinion.

(2) A waiting period shall begin on the date that the superintendent receives a pre-acquisition notification and shall end on the thirtieth day after the date of receipt or upon the superintendent's termination of the waiting period, whichever is earlier. Prior to the end of the waiting period, the superintendent, through one request, may require the submission of additional information relevant to the proposed acquisition. A request for the submission of additional information shall trigger a new waiting period that begins on the date of receipt of the additional information and ends on the thirtieth day after that receipt or upon the superintendent's termination of the waiting period, whichever is earlier.

D. The superintendent may enter an order pursuant to Subsection E of this section if there is substantial evidence that the acquisition may substantially lessen competition in a line of insurance in New Mexico or that the acquisition would tend to create a monopoly or if the insurer

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fails to file adequate information in compliance with Subsection C of this section.

(1) In determining whether a proposed acquisition would violate the competitive standard identified in this subsection, the superintendent shall consider that:

(a) an acquisition identified in Subsection B of this section that involves two or more insurers competing in the same market is prima facie evidence of a violation of the competitive standard: 1) if the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more; or

2) if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more;

(b) for the purposes of Subparagraph (a) of this paragraph, a highly concentrated market is one in which the share of the four largest insurers is seventy-five percent or more of the market; the insurer with the largest share of the market shall be deemed to be Insurer A; a percentage not shown in a table is interpolated in proportion to the percentages shown; and if more than two insurers are involved in the acquisition, exceeding the total of the two columns in the table is prima facie evidence of a violation of the competitive standard of this subsection;

(c) there is a significant trend toward increased concentration when the aggregate market share of a grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven or more percent of the market over a period of time extending from any base year five to ten years prior to the acquisition up to the time of the acquisition. An acquisition or a merger identified in Subsection B of this section that involves two or more insurers competing in the same market is prima facie evidence of a violation of the competitive standard of this subsection if: 1) there is a significant trend toward increased concentration in the market; 2) an involved insurer is in a grouping of large insurers showing the requisite increase in the market share; and 3) another involved insurer's market is two percent or more;

(d) for the purposes of this subsection:

1) "insurer" includes a company and a group of companies under common management, ownership or control; 2) "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the superintendent shall give due consideration to, among other things, existing definitions or guidelines promulgated by the national association of insurance commissioners and information submitted by the 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, such line being that used in the annual statement required to be filed by insurers doing business in New Mexico, and the relevant geographical market is assumed to be New Mexico; and 3) the superintendent bears the burden of showing prima facie evidence of a violation of the competitive standard; and

(e) an acquisition that is not prima facie evidence of a violation of the competitive standard pursuant to Subparagraphs (a) and (b) of this paragraph may establish the requisite anti-competitive effect based on other substantial evidence. Using other substantial evidence, a party may establish the absence of the requisite anti-competitive effect for an acquisition that violates the competitive standard pursuant to Subparagraphs (a) and (b) of Paragraph (2) of this subsection. In making a determination pursuant to this subparagraph, the superintendent shall consider relevant factors, including: 1) market shares; 2) volatility of the ranking of market leaders; 3) the number of competitors; 4) concentration; 5) the trend of concentration in the industry; and 6) the ease of entry and exit into the market.

(2) An order shall not be entered pursuant to Subsection E of this section if:

(a) the acquisition would yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in another way and the benefit to the public that would arise from those economies would exceed the benefits to the public that would arise from not lessening competition; or

(b) the acquisition would substantially increase the availability of insurance and the benefits to the public of the increase would exceed the benefits to the public that would arise from not lessening competition.

E. If an acquisition violates the standards of this section, the superintendent may enter an order requiring an involved insurer to cease and desist from doing business in New Mexico with respect to the line or lines of insurance involved in the violation or an order denying the application of an acquired or acquiring insurer for a license to do business in New Mexico. The superintendent shall only enter an order if notice of a hearing was issued before the end of the waiting period, but not less than fifteen days prior to the hearing, and the hearing has concluded. The superintendent shall not enter an order more than sixty days after the insurer filed with the superintendent pre-acquisition notification. A written decision by the superintendent that sets forth findings of fact and conclusions of law shall accompany an order. An order is void if the acquisition is not consummated.

(1) After notice and a hearing, the superintendent may fine a person who violates a valid cease-and-desist order no more than ten thousand dollars ($10,000) per day of the violation or suspend or revoke the person's license, or both.

(2) The superintendent may fine an insurer or other person who fails to make a filing required by this section and fails to demonstrate a good faith effort to comply with a filing requirement no more than fifty thousand dollars ($50,000).

F. Subsections B and C of Section 59A-37-25 NMSA 1978 and Subsection A of Section 59A-37-27 NMSA 1978 do not apply to an acquisition identified in Subsection B of this section."

SECTION 44. A new section of The Insurance Holding Company Law is enacted to read:

"[NEW MATERIAL] ENTERPRISE RISK FILING.--The person who predominantly controls an insurer that is subject to registration shall file an enterprise risk report each year. The report shall reflect that person's knowledge and belief of the material risks within the insurance holding company system that pose enterprise risk to the insurer. The report shall be filed with the lead state insurance supervisory official of the insurance holding company system and in compliance with the relevant procedures outlined in the financial analysis handbook adopted by the national association of insurance commissioners."

SECTION 45. A new section of The Insurance Holding Company Law is enacted to read:

"[NEW MATERIAL] MANAGEMENT OF DOMESTIC INSURERS SUBJECT TO REGISTRATION.--

A. The control of a domestic insurer by a person does not relieve the insurer's officers and directors of an obligation or a liability to which they are otherwise subject by law. An insurer shall be managed so that its separate operating identity is consistent with The Insurance Holding Company Law.

B. Nothing in this section precludes a domestic insurer from participating in a common management function, a cooperative or the joint use of personnel if that participation meets the standards of Subsection A of Section 59A-37-20 NMSA 1978.

C. At least two-thirds of the directors and two-thirds of the members of each committee of the board of directors of a domestic insurer shall not be officers or employees of the insurer or of an entity that controls, is controlled by or is under common control with the insurer and shall not be beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one person in that group of two-thirds of the directors shall be present prior to the transaction of business at a meeting of the board of directors or a committee of the board of directors.

D. The board of directors of a domestic insurer shall establish at least one committee composed solely of directors who are not officers or employees of the insurer or of an entity that controls, is controlled by or is under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. The committee or committees shall:

(1) nominate the candidates for director, who shall be elected by the shareholders or policyholders;

(2) evaluate the performance of officers deemed to be principal officers of the insurer; and

(3) recommend to the board of directors the selection and compensation of the principal officers.

E. The provisions of Subsections C and D of this section do not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company or a publicly held corporation, has a board of directors and committees of the board of directors that meet the requirements of Subsections C and D of this section.

F. An insurer whose annual direct written and assumed premium, excluding premiums reinsured with the federal crop insurance corporation and the national flood insurance program, is less than three hundred million dollars ($300,000,000) may apply to the superintendent for a waiver from the requirements of this section. An insurer whose circumstances are unusual may apply to the superintendent for a waiver from the requirements of this section. In determining whether the insurer qualifies for a waiver, the superintendent may consider, among other factors, the insurer's type of business entity, the volume of its business written, the availability of qualified board members and its ownership or organizational structure."

SECTION 46. A new section of The Insurance Holding Company Law is enacted to read:

"[NEW MATERIAL] SUPERVISORY COLLEGES.--

A. In order to determine compliance with The Insurance Holding Company Law by an insurer registered pursuant to Section 59A-37-11 NMSA 1978, the superintendent may participate in a supervisory college for a domestic insurer that is part of an insurance holding company system with

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international operations. Concerning a supervisory college, the superintendent may:

(1) initiate its establishment;

(2) clarify its membership and the participation of other supervisors;

(3) clarify its functions and the role of other regulators, including the establishment of a group-wide supervisor;

(4) coordinate its ongoing activities, including planning meetings, supervision and processes for information sharing; and

(5) establish a crisis management plan.

B. A registered insurer subject to this section shall pay the reasonable expenses, including for travel, associated with the superintendent's participation in a supervisory college pursuant to Subsection C of this section. A supervisory college may be convened as a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates. The superintendent may establish a regular assessment to the insurer for the payment of these expenses.

C. In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes of an insurer, and as part of the examination of individual insurers pursuant to Section 59A-37-23 NMSA 1978, the superintendent may participate in a supervisory college with other regulators charged with the supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The superintendent may enter into agreements in accordance with Subsection C of Section 59A-37-24 NMSA 1978 that provide the basis for cooperation between the superintendent 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 superintendent to regulate or supervise the insurer or its affiliates within its jurisdiction."

SECTION 47. Section 59A-41-24 NMSA 1978 (being Laws 1984, Chapter 127, Section 716, as amended) is amended to read:

"59A-41-24. HAZARDOUS FINANCIAL CONDITION--DETERMINATION.--

A. For the purposes of Sections 59A-41-25 and 59A-41-26 NMSA 1978, an insurer may be deemed to be in a hazardous financial condition when the superintendent has determined, after notice and hearing, that the loss experience of the insurer, when reviewed in conjunction with the kinds and characteristics of risks insured, or the insurer's financial condition, or its ownership, or the ratio of its annual premium volume in relation to its policyholders' surplus, would make further assumption of risks by the insurer hazardous to those persons doing business with the insurer or to the general public.

B. The following items may be considered by the superintendent to determine whether the continued operation of [~~any~~] an insurer transacting an insurance business in [~~this state~~] New Mexico is hazardous to the policyholders, the creditors or the general public:

(1) adverse findings reported in financial condition and market conduct examination reports, audit reports and actuarial opinions, reports or summaries;

(2) the national association of insurance commissioners insurance regulatory information system and its [~~related~~] other financial analysis solvency tools and reports;

(3) ratios of commission expense, general insurance expense, policy benefits and reserve increases to annual premium and net investment income;

(4) [~~the value, liquidity or diversity of the insurer's asset portfolio when viewed in light of current economic conditions with regard to assuring the company's ability to meet its outstanding obligations as they mature~~] whether, according to currently accepted actuarial standards of practice, the insurer has made adequate provision for the anticipated cash flows required by the insurer's contractual obligations and related expenses, when considered in light of the insurer's assets and investment earnings on assets held for

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reserves and related actuarial items and the considerations anticipated to be received and retained through the insurer's policies and contracts;

(5) the [~~adequacy, reliability and soundness of~~] ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer [~~and the ability of the assuming reinsurer to perform under its reinsurance agreements~~];

(6) whether the insurer's operating loss in the last twelve-month period or any shorter period of time, including net capital gain or loss, change in non-admitted assets and cash dividends paid to shareholders [~~in comparison to such~~] is greater than fifty percent of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

(7) whether the insurer's operating loss, excluding net capital gains, in the last twelve months or a shorter period of time is greater than twenty percent of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

[~~(7)~~] (8) whether [~~any affiliate, subsidiary or~~] a reinsurer, an obligor or an entity within the insurer's

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insurance holding company system is insolvent, threatened with insolvency or delinquent in payment of its monetary or other [~~obligation~~] obligations and that, in the superintendent's opinion, might affect the solvency of the insurer;

[~~(8)~~] (9) contingent liabilities, pledges or guaranties [~~which~~] that individually or collectively involve a total amount that, in the superintendent's opinion, may affect the solvency of the insurer;

[~~(9)~~] (10) whether any person having control of an insurer is delinquent in transmitting or paying net premiums to [~~such~~] the insurer;

[~~(10)~~] (11) the age and collectibility of receivables;

[~~(11)~~] (12) whether the management of an insurer, including officers, directors or any other person who directly or indirectly controls the operation of [~~such~~] the insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position;

[~~(12)~~] (13) whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false or misleading information concerning an inquiry;

(14) whether the insurer, for a reason not satisfactory to the superintendent, has failed to meet

financial and holding company filing requirements;

[~~(13)~~] (15) whether management of an insurer has filed with any regulatory authority or released to lending institutions or to the general public any false or misleading financial statements or has made a false or misleading entry or has omitted an entry of material amount in the books of the insurer;

[~~(14)~~] (16) whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;

[~~(15)~~] (17) whether the [~~company~~] insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems;

(18) whether management of the insurer has established reserves that do not meet the minimum standards established by New Mexico's insurance laws and rules and by statutory accounting standards, sound actuarial principles and standards of practice;

(19) whether management of the insurer persistently engages in material under-reserving that results in adverse development;

(20) whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets or capital gains, or both, do not provide

sufficient value, liquidity or diversity to ensure that the insurer can meet its outstanding obligations as they mature;

[~~(16)~~] (21) risk-based capital reports and other information obtained pursuant to the Risk-Based Capital Act; or

[~~(17)~~] (22) such other material information and data as the superintendent may deem relevant.

C. For the purposes of making a determination of an insurer's financial condition under this section, the superintendent may:

(1) disregard any credit or amount receivable resulting from transactions with a reinsurer [~~which~~] that is insolvent, impaired or otherwise subject to a delinquency proceeding;

(2) make appropriate adjustments, including disallowance, to asset values attributable to investments in or transactions with parents, subsidiaries or affiliates that are consistent with the national association of insurance commissioners' accounting practices and procedures manual and with state laws and rules;

(3) refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

(4) increase the insurer's liability in an

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amount equal to any contingent liability, pledge or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve-month period."

SECTION 48. Section 59A-41-25 NMSA 1978 (being Laws 1984, Chapter 127, Section 717, as amended) is amended to read:

"59A-41-25. REQUIREMENTS OF INSURER IN HAZARDOUS FINANCIAL CONDITION.--

A. Whenever [~~he~~] the superintendent finds an insurer authorized to transact insurance in [~~this state~~] New Mexico to be in hazardous financial condition, as referred to in Section 59A-41-24 NMSA 1978, the superintendent may order the insurer to take such action as [~~he~~] the superintendent deems reasonably necessary to rectify the hazardous condition, including [~~but not limited to one or more of the following measures~~] requiring the insurer to:

(1) [~~require the insurer to~~] reduce, suspend or limit the volume of [~~new~~] business being accepted [~~to an amount, for the period of time, and in a manner prescribed in the superintendent's order~~] or renewed;

(2) [~~require submission of~~] submit its reinsurance contracts for approval and make such further requirements as to the insurer's reinsurance arrangements as the superintendent deems necessary;

(3) [~~require the insurer to~~] bulk-reinsure all

or any part of its New Mexico business with another insurer authorized to transact such business in [~~this state~~] New Mexico;

(4) [~~require a contribution to~~] increase the insurer's capital and surplus on such terms, in such amount and in such manner as the superintendent deems necessary;

(5) [~~require the insurer to~~] maintain with the superintendent a special deposit in cash or securities eligible for investment of funds of a like domestic insurer under Chapter 59A, Article 9 NMSA 1978 and in amount not less than the lesser of:

(a) the amounts required to be maintained as: 1) reserves for losses and loss adjustment expenses on New Mexico business; and 2) reserves for unearned premiums on New Mexico business. In determining the amount of deposit required, the reserves for losses, loss adjustment expenses and unearned premiums shall be reduced only for reinsurance ceded to authorized or accredited reinsurers [~~which~~] that maintain with an independent custodian cash or marketable securities in amount not less than the sum of the reinsurer's reserves for losses, loss adjustment expenses and unearned premiums as to reinsurance assumed; or

(b) five hundred thousand dollars ($500,000).

Any deposit required by this paragraph shall be for the protection and benefit only of New Mexico policyholders or claimants, or both, and shall not be withdrawn until the superintendent terminates the requirement of the deposit. This paragraph shall not apply as to any domestic insurer, and Subparagraph (b) of this paragraph shall not apply as to any life insurer;

(6) [~~require the insurer to~~] reduce general insurance and commission expenses by specified methods;

(7) [~~require the insurer to~~] suspend or limit the declaration and payment of dividends to its stockholders or to its policyholders;

(8) [~~require the insurer to~~] file reports in a form acceptable to the superintendent concerning the market value of an insurer's assets;

(9) [~~require the insurer to~~] limit or withdraw from certain investments or discontinue certain investment practices to the extent the superintendent deems necessary;

(10) [~~require the insurer to~~] document the adequacy of premium rates in relation to the risks insured; [~~or~~]

(11) [~~require the insurer to~~] file, in addition to regular annual statements, interim financial reports on the form adopted by the national association of insurance commissioners or on such format as required by the superintendent;

(12) correct corporate governance practice deficiencies and adopt and use governance practices acceptable to the superintendent;

(13) provide to the superintendent a business plan in order to continue to transact business in the state; or

(14) notwithstanding another provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for a non-life insurance product written by the insurer that the superintendent considers necessary to improve the financial condition of the insurer.

B. The insurer may request a hearing to review the order in accordance with Chapter 59A, Article 4 NMSA 1978; however, the superintendent shall give written notice of the hearing not less than ten days in advance of the hearing, and the hearing shall be held privately unless the insurer requests a public hearing, in which case the hearing shall be public."

SECTION 49. Section 59A-42-3 NMSA 1978 (being Laws 2012, Chapter 9, Section 6) is amended to read:

"59A-42-3. DEFINITIONS.--As used in the Life and Health Insurance Guaranty Association Act:

A. "account" means either of the two accounts maintained pursuant to Section 59A-42-5 NMSA 1978;

B. "association" means the life and health insurance guaranty association created pursuant to Section 59A-42-5 NMSA 1978;

C. "authorized assessment", or the term "authorized" when used in the context of assessments, means that a resolution by the board has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed;

D. "benefit plan" means a specific employee, a union or an association of natural persons benefit plan;

E. "board" means the board of directors organized pursuant to Section 59A-42-6 NMSA 1978;

F. "called assessment", or the term "called" when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers;

G. "contractual obligation" means an obligation under a policy or contract or a certificate under a group policy or contract, or portion thereof, for which coverage is provided pursuant to Section 59A-42-4 NMSA 1978;

H. "covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided pursuant to Section 59A-42-4 NMSA 1978;

I. "domiciliary state" means the state in which an insurer is incorporated or organized or, as to an alien insurer, the state in which at commencement of delinquency proceedings the larger amount of the insurer's assets are held in trust or on deposit for the benefit of its policyholders and creditors in the United States;

J. "extra-contractual claims" includes claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney fees and costs;

K. "impaired insurer" means a member insurer that, after the effective date of the Life and Health Insurance Guaranty Association Act, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

L. "insolvent insurer" means a member insurer that, after the effective date of the Life and Health Insurance Guaranty Association Act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

M. "member insurer" means an insurer that is licensed or that holds a certificate of authority to transact in this state insurance for which coverage is provided pursuant to Section 59A-42-4 NMSA 1978 and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(1) a [~~hospital or medical service organization~~] health care plan, whether profit or nonprofit;

(2) a health maintenance organization;

(3) a prepaid dental plan;

[~~(3)~~] (4) a fraternal benefit society;

[~~(4)~~] (5) a mandatory state pooling plan;

[~~(5)~~] (6) a mutual assessment company or other person that operates on an assessment basis;

[~~(6)~~] (7) an insurance exchange;

[~~(7)~~] (8) a charitable organization that is in good standing with the superintendent pursuant to Section 59A-1-16.1 NMSA 1978;

[~~(8)~~] (9) any insurer that was insolvent or unable to fulfill its contractual obligations as of April 9, 1975; or

[~~(9)~~] (10) an entity similar to any of the above;

N. "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, incorporated, or its successor;

O. "owner" of a policy or contract, "policy owner" and "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the

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terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms "owner", "policy owner" and "contract owner" do not include persons with a mere beneficial interest in a policy or contract;

P. "plan sponsor" means:

(1) the employer in the case of a benefit plan established or maintained by a single employer;

(2) the employee organization in the case of a benefit plan established or maintained by an employee organization; or

(3) the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan in the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations;

Q. "premiums" means amounts or considerations, by whatever name used, received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. "Premiums" does not include:

(1) amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided pursuant to Subsection E of Section 59A-42-4 NMSA 1978, except that assessable premiums shall not be reduced on account of

Paragraph (3) of Subsection E of Section 59A-42-4 NMSA 1978, relating to interest limitations, or Paragraph (2) of Subsection F of Section 59A-42-4 NMSA 1978, relating to limitations, with respect to one individual, one participant or one contract owner;

(2) premiums in excess of five million dollars ($5,000,000) on an unallocated annuity contract not issued under a governmental retirement benefit plan, or its trustee, established pursuant to Section 401, 403(b) or 457 of the federal Internal Revenue Code of 1986; or

(3) with respect to multiple non-group policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars ($5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner;

R. "principal place of business" means:

(1) in the case of a plan sponsor or a person other than a natural person, the single state in which the natural person who establishes a policy for the direction, control and coordination of the operations of the entity as a whole primarily exercises that function, as determined by the association in its reasonable judgment by considering the

following factors:

(a) the state in which the primary executive and administrative headquarters of the entity is located;

(b) the state in which the principal office of the chief executive officer of the entity is located;

(c) the state in which the board, or similar governing person or persons, of the entity conducts the majority of its meetings;

(d) the state in which the executive or management committee of the board, or similar governing person or persons, of the entity conducts the majority of its meetings;

(e) the state from which the management of the overall operations of the entity is directed; and

(f) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors in this subsection; but

(g) in the case of a plan sponsor, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor; and

(2) in the case of a plan sponsor of a benefit

plan described in Paragraph (3) of Subsection P of this section, the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question;

S. "receivership court" means the court in the insolvent or impaired insurer's domiciliary state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer;

T. "resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, which, in the case of a person other than a natural person, shall be its principal place of business. Citizens of the United States that are either residents of foreign countries or residents of United States possessions, territories or protectorates that do not have an association similar to the association created by the Life and Health Insurance Guaranty Association Act shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts;

U. "structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant;

V. "supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract; and

W. "unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by an insurer under the contract or certificate."

SECTION 50. Section 59A-42A-7 NMSA 1978 (being Laws 1997, Chapter 107, Section 7) is amended to read:

"59A-42A-7. EXAMINATION--ANNUAL STATEMENT.--

A. The association is subject to and responsible to pay the cost of examination by the superintendent [~~of insurance~~] on a periodic basis, pursuant to Chapter 59A, Article 4 NMSA 1978.

B. Not later than March [~~31~~] 1 of each year, the board shall submit to the superintendent an [~~audited financial report for the preceding calendar year in a form approved by the superintendent~~] annual statement in accordance with the

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requirements of Section 59A-5-29 NMSA 1978 and a risk-based capital report in accordance with the requirements of Section 59A-5A-3 NMSA 1978."

SECTION 51. Section 59A-46-9 NMSA 1978 (being Laws 1993, Chapter 266, Section 9) is amended to read:

"59A-46-9. ANNUAL REPORT.--

A. Every health maintenance organization shall annually, on or before the first day of March, file a report, verified by at least two principal officers, with the superintendent covering the preceding calendar year.

B. The report shall be on forms prescribed by the superintendent and shall include:

(1) a financial statement of the organization prepared pursuant to forms prescribed by the superintendent, including its balance sheet and receipts and disbursements for the preceding year;

(2) any material changes in the information submitted pursuant to Subsection C of Section 59A-46-3 NMSA 1978;

(3) the number of persons enrolled during the year and the number of enrollees as of the end of the year; and

(4) such other reasonable information materially relating to the performance of the health maintenance organization as is necessary to enable the superintendent to carry out [~~his~~] the superintendent's duties

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under the Insurance Code.

C. In addition, the health maintenance organization shall file by the dates indicated:

(1) [~~audited financial statements as of the end of the preceding calendar year on or before June 1 or within one hundred twenty days following the end of its fiscal year, whichever is later~~] on or before March 1, an annual statement in accordance with the requirements of Section 59A-5-29 NMSA 1978 and a risk-based capital report in accordance with the requirements of Section 59A-5A-3 NMSA 1978;

(2) a list of the providers who have executed a contract that complies with Subsection [~~D~~] E of Section 59A-46-13 NMSA 1978 on or before March 1; and

(3) a description of the grievance procedures and the total number of grievances handled through such procedures, a compilation of the causes underlying those grievances and a summary of the final disposition of those grievances, on or before March 1.

D. The superintendent may require such additional reports as are deemed necessary and appropriate to enable the superintendent to carry out [~~his~~] the superintendent's duties under the Health Maintenance Organization Law."

SECTION 52. Section 59A-47-14 NMSA 1978 (being Laws 1984, Chapter 127, Section 879.12) is amended to read:

"59A-47-14. ANNUAL STATEMENT.--As prerequisite to

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continuance of its certificate of authority, each health care plan shall on or before March [~~1st~~] <u>1</u> each year file with the superintendent and with the national association of insurance [~~superintendents its financial statement for the year ending December 31st immediately preceding on form as prescribed and furnished without charge by the superintendent. The form shall conform as nearly as may be to the form of annual statement of insurers as from time to time adopted by the national association of insurance superintendents. The statement shall be verified by the oaths of the president and secretary of the health care plan, or in the absence of either of them, by other principal officers~~] <u>commissioners an annual statement in accordance with the requirements of Section 59A-5-29 NMSA 1978 and a risk-based capital report in accordance with the requirements of Section 59A-5A-3 NMSA 1978</u>."

SECTION 53. Section 59A-48-10 NMSA 1978 (being Laws 1984, Chapter 127, Section 889) is amended to read:

"59A-48-10. ANNUAL REPORT TO SUPERINTENDENT.--

A. Every prepaid dental plan organization annually on or before the first day of March shall file with the superintendent a report covering its activities for the preceding calendar year in form as prescribed by the superintendent, verified by at least two [~~(2)~~] principal officers of the corporation. A copy of the report shall be sent by the prepaid dental plan organization to the [~~director~~

~~of the health services division of the health and environment~~] department of health.

B. Such reports shall be on forms prescribed by the superintendent and shall include:

(1) [~~a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified as required by the form of the annual report~~] an annual statement in accordance with the requirements of Section 59A-5-29 NMSA 1978 and a risk-based capital report in accordance with the requirements of Section 59A-5A-3 NMSA 1978;

(2) any material changes in the information;

(3) the number of persons who become members during the year, the number of members as of the end of the year and the number of memberships terminated during the year;

(4) the costs of all care provided and the number of units of care provided; and

(5) such other information relating to the performance of the prepaid dental plan organization as is necessary to enable the superintendent to carry out the duties prescribed by [~~this article~~] The Prepaid Dental Plan Law.

C. The fee for filing the annual report shall be as specified in Section [~~101 (fee schedule) of the Insurance Code~~] 59A-6-1 NMSA 1978."

SECTION 54. SEVERABILITY.--If any part or application of the provisions of this act is held invalid, the remainder or its application to other situations or persons shall not be affected.

SECTION 55. CONTINGENT DELAYED REPEAL.--If Sections 16 through 28 of this act have not taken effect by January 1, 2020, those sections are repealed.

SECTION 56. EFFECTIVE DATE--CONTINGENCY--NOTIFICATION.--

A. The effective date of the provisions of Sections 16 through 28 of this act is the January 1 of the first calendar year following the first July 1 after which the superintendent of insurance certifies to the New Mexico compilation commission and the director of the legislative council service that:

(1) the most recent version of the manual of valuation instructions adopted by the national association of insurance commissioners has been adopted by the national association of insurance commissioners by an affirmative vote of at least forty-two members or three-fourths of the members voting, whichever is greater;

(2) the Standard Valuation Law of the national association of insurance commissioners, as amended in 2009, or legislation including substantially similar terms and provisions, has been enacted by states that collectively represent more than seventy-five percent of written direct premiums, as reported in the life, accident and health, health

and fraternal annual statements submitted for 2008; and

(3) the Standard Valuation Law of the national association of insurance commissioners, as amended in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two of the following fifty-five jurisdictions:

(a) the fifty states of the United States;

(b) American Samoa;

(c) the Virgin Islands of the United States;

(d) the District of Columbia;

(e) Guam; and

(f) Puerto Rico.

B. The effective date of the provisions of Sections 1 through 15 and 29 through 54 of this act is July 1, 2013.