CHAPTER 81
(CORRECTED COPY)

AN ACT concerning the modernization of the financial solvency regulation of insurers and amending and supplementing various parts of statutory law.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 1 of P.L.1970, c.22 (C.17:27A-1) is amended to read as follows:

C.17:27A-1 Definitions.

1. Definitions.

As used in P.L.1970, c.22 (C.17:27A-1 et seq.), the following terms shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

a. An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

b. The term "commissioner" shall mean the Commissioner of Banking and Insurance or the commissioner’s deputies.

c. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10% or more of the voting securities of any other person, provided that no such presumption of control shall of itself relieve any person so presumed to have control from any requirement of P.L.1970, c.22 (C.17:27A-1 et seq.). This presumption may be rebutted by a showing made in the manner provided by subsection j. of section 3 of P.L.1970, c.22 (C.17:27A-3) that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and an opportunity to be heard, and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

d. An "insurance holding company system" consists of two or more affiliated persons, one or more of which is an insurer.

e. The term "insurer" means any person or persons, corporation, partnership or company authorized by the laws of this State to transact the business of insurance or to operate a health maintenance organization in this State, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

f. A "person" is an individual, a corporation, a limited liability company, partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

g. (Deleted by amendment, P.L.1993, c.241).

h. A "subsidiary" of a specified person is an affiliate controlled by such person directly, or indirectly through one or more intermediaries.

i. The term "voting security" shall include any security convertible into or evidencing a right to acquire a voting security.

j. "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 but is not limited to the acquisition of voting securities, and assets, and bulk reinsurance and mergers.

k. "Health maintenance organization" means any person operating under a certificate of authority issued pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.).

l. “Enterprise risk” means any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer’s Risk-Based Capital to fall into company action level as set forth in administrative rules adopted by the commissioner which reflect the standards set forth in the Risk-Based Capital For Insurers Model Act adopted by the National Association of Insurance Commissioners or would cause the insurer to be in hazardous financial condition as defined in administrative rules adopted by the commissioner which reflect the standards set forth in the Model Regulation adopted by the National Association of Insurance Commissioners to define standards and the commissioner’s authority over companies deemed to be in a hazardous financial condition.

2. Section 2 of P.L.1970, c.22 (C.17:27A-2) is amended to read as follows:

C.17:27A-2 Acquisition of control of or merger with domestic insurer.

2. Acquisition of control of or merger with domestic insurer.

a. (1) Filing requirements. No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of such 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 agreement is entered into, or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the commissioner and has sent to such insurer, a statement containing the information required by this section and such offer, request, invitation, agreement or acquisition has been approved by the commissioner in the manner hereinafter prescribed.

For purposes of this subsection, a domestic insurer shall include any other person controlling a domestic insurer.

(2) For purposes of this subsection, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least 30 days prior to the cessation of control. The commissioner shall by regulation determine those instances in which the party seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in his or her discretion, determines that confidential treatment will interfere with enforcement of this subsection a. If the statement referred to in paragraph (1) of this subsection a. is otherwise filed, this paragraph (2) regarding notice of divestiture or acquisition shall not apply.

(3) With respect to a transaction subject to this subsection a., the acquiring person shall also file a pre-acquisition notification with the commissioner, which shall contain the information set forth in section 7 of P.L.1993, c.241 (C.17:27A-4.1). A failure to file the notification may be subject to penalties specified in paragraph (3) of subsection e. of section 7 of P.L.1993, c.241 (C.17:27A-4.1).

b. Content of statement. The statement to be filed with the commissioner hereunder shall be made under oath or affirmation and shall contain the following:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection a. is to be effected (hereinafter called "acquiring party"), and

(i) If such person is an individual, his principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past 10 years;

(ii) If such person is not an individual, a report of the nature of its business operations during the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by such person and such person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of such person, or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by subparagraph (i) 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 wherein 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, provided, however, that where a 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 such 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 such acquiring party (or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence), and similar unaudited information as of a date not earlier than 90 days prior to the filing of the statement.

(4) Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management.

(5) The number of shares of any security referred to in subsection a. which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection a., and a statement as to the method by which the fairness of the proposal was arrived at.

(6) The amount of each class of any security referred to in subsection a. which 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 subsection a. 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. Such

description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

(8) A description of the purchase of any security referred to in subsection a. during the 12 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 therefor.

(9) A description of any recommendations to purchase any security referred to in subsection a. made during the 12 calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such 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 subsection a., and (if distributed) of additional soliciting material relating thereto.

(11) The terms of any agreement, contract or understanding made or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection a. for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

(12) An agreement by the person required to file the statement referred to in subsection a. of this section that it will provide the annual enterprise risk report, specified in subsection k. of section 3 of P.L.1970, c.22 (C.17:27A-3), so long as control exists.

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

(14) Such additional information as the commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in subsection a. is a partnership, limited partnership, syndicate or other group, the commissioner may require that the information called for by paragraphs (1) through (14) shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member or person is a corporation or the person required to file the statement referred to in subsection a. is a corporation, the commissioner may require that the information called for by paragraphs (1) through (14) shall be given with respect to such corporation, each officer and director of such corporation, and each person who is directly or indirectly the beneficial owner of more than 10% of the outstanding voting securities of such corporation.

If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the commissioner and sent to such insurer within two business days after the person learns of such change.

c. Alternative filing materials. If any offer, request, invitation, agreement or acquisition referred to in subsection a. is proposed to be made by means of a registration statement under the Securities Act of 1933, 48 Stat. 74 (15 U.S.C. s.77a et seq.), or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, 48 Stat. 881 (15 U.S.C. s.78a et seq.), or under a State law requiring similar registration or

disclosure, the person required to file the statement referred to in subsection a. may utilize such documents in furnishing the information called for by that statement.

d. Approval by commissioner; hearings.

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

(i) After the change of control the domestic insurer referred to in subsection a. would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(ii) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this State or tend to create a monopoly therein. In applying the competitive standard of this subparagraph:

(a) The informational requirements of paragraph (1) of subsection c. and paragraph (2) of subsection d. of section 7 of P.L.1993, c.241 (C.17:27A-4.1) shall apply;

(b) The merger or other acquisition shall not be disapproved if the commissioner finds that any of the situations meeting the criteria provided by paragraph (3) of subsection d. of section 7 of P.L.1993, c.241 (C.17:27A-4.1) exist; and

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

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

(iv) The financial condition of any acquiring party is such that (a) the acquiring party has not been financially solvent on a generally accepted accounting principles basis, or if an insurer, on a statutory accounting basis, for the most recent three fiscal years immediately prior to the date of the proposed acquisition (or for the whole of such lesser period as such acquiring party and any predecessors thereof shall have been in existence); (b) the acquiring party has not generated net before-tax profits from its normal business operations for the latest two fiscal years immediately prior to the date of acquisition (or for the whole of such lesser period as such acquiring party and any predecessors thereof shall have been in existence); or (c) the acquisition debt of the acquiring party exceeds 50% of the purchase price of the insurer;

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

(vi) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

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

(2) The public hearing referred to in paragraph (1) shall be held within 60 days after the statement required by subsection a. is filed and at least 20 days' notice thereof shall be given by the commissioner to the person filing the statement and the insurer. Not less than seven days' notice of such public hearing shall be given by the person filing the statement to such other persons as may be designated by the commissioner. The hearing shall, at the commissioner's discretion, be conducted by the commissioner or his designee who shall report to the commissioner and advise him on the nature of the matter delegated. The commissioner shall make a determination or issue an order, based upon that advice and report, as he shall, in his discretion, determine, and that determination or order shall have the

same force and effect as if the commissioner had conducted that hearing personally. The commissioner shall make a determination within 45 business days after the conclusion of such hearing. At such hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the Superior Court of this State. All discovery proceedings shall be concluded not later than three days prior to the commencement of the public hearings.

(3) If the proposed acquisition of control requires the approval of more than one commissioner, the public hearing referred to in paragraph (2) may be held on a consolidated basis upon request of the person filing the statement referred to in subsection a. of this section. That person shall file the statement referred to in subsection a. of this section with the National Association of Insurance Commissioners within five days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the decision to opt out within 10 days of the receipt of the statement referred to in subsection a. of this section. A hearing conducted on a consolidated basis shall be public, if not conducted on the documents filed in accordance with the applicable state’s procedures for such hearings, and shall be held within the United States in accordance with the rules and procedures of the state hosting the consolidated hearing before the commissioners of the states in which the insurers are domiciled. The commissioners shall hear and receive evidence. A commissioner may attend the hearing, in person or by telecommunication.

(4) The commissioner may retain, at the acquiring person's expense, any attorneys, actuaries, accountants and other persons as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

e. (Deleted by amendment, P.L.1993, c.241.)

f. Exemptions. The provisions of this section shall not apply to:

(1) Any transaction which is subject to the provisions of R.S.17:27-1 et seq. or N.J.S.17B:18-60 et seq., concerning the merger or consolidation of two or more insurers; and

(2) Any offer, request, invitation, agreement or acquisition which the commissioner by order shall exempt therefrom as (a) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or (b) as otherwise not comprehended within the purposes of this section.

g. Violations. The following shall be violations of this section:

(1) The failure to file any statement, amendment, or other material required to be filed pursuant to subsection a. or b.; or

(2) Subject to subsection f., the effectuation of, or any attempt to effectuate, an acquisition of control of, divestiture of, or merger with, a domestic insurer unless the commissioner has given his approval thereto.

h. Jurisdiction; consent to service of process.

The courts of this State are hereby vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this State who files a statement with the commissioner under this section, and over all actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by such a person of the commissioner to be his true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all such lawful process shall

be served on the commissioner and transmitted by registered or certified mail by the commissioner to such person at his last known address.

3. Section 3 of P.L.1970, c.22 (C.17:27A-3) is amended to read as follows:

C.17:27A-3 Registration of insurers.

3. Registration of insurers.

a. Registration. Every insurer which is authorized to do business in this State and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in: this section; paragraph (1) of subsection a. and subsections b. and c. of section 4 of P.L.1970, c.22 (C.17:27A-4); and either paragraph (2) of subsection a. of section 4 of P.L.1970, c.22 (C.17:27A-4) or a substantially similar provision which requires that each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions, including change of or additions to ownership, within 15 days after the end of each month in which it learns of each such change or addition. Any insurer which is subject to registration under this section shall register within 60 days after the effective date of P.L.1993, c.241 or 15 days after it becomes subject to registration, whichever is later, and annually thereafter by April 1 of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within such extended time. The commissioner may require any authorized insurer which is a member of an insurance holding company system which is not subject to registration under this section to furnish a copy of the registration statement or other information filed by such insurance company with the insurance regulatory authority of domiciliary jurisdiction.

b. Information and form required. Every insurer subject to registration shall file a registration statement and a summary of the registration statement with the commissioner on a form provided by the commissioner, which shall contain current information about:

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

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

(3) The following agreements in force, relationships subsisting, and transactions currently outstanding or which have occurred during the last calendar year between such insurer and its affiliates:

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

(b) Purchases, sales, or exchanges of assets;

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

(d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(e) All management agreements, service contracts and all cost-sharing arrangements;

(f) Reinsurance agreements;

(g) Dividends and other distributions to shareholders, including the declarations and authorizations thereof; and

(h) Consolidated tax allocation agreements;

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(5) Financial statements of or within an insurance holding company system, including all affiliates, if requested by the commissioner. Financial statements shall include, but are not limited to, annual audited financial statements filed with the U.S. Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933, 15 U.S.C. s.77a et seq., or the Securities Exchange Act of 1934, 15 U.S.C. s.78a et seq. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC;

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

(7) Statements that the insurer’s 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

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

All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

c. Materiality. No information need be disclosed on the registration statement filed pursuant to subsection b. of this section if such information is not material for the purposes of this section. Unless the commissioner by rule, regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees or other contingent obligations involving 1/2 of 1% or less of an insurer's admitted assets as of December 31 next preceding shall not be deemed material for purposes of this section.

d. Amendments to registration statements. Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms provided by the commissioner within 15 days after the end of the month in which it learns of each such change or addition.

e. Information of insurers. Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, if that information is reasonably necessary to enable the insurer to comply with the provisions of P.L.1970, c.22 (C.17:27A-1 et seq.).

f. Termination of registration. The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

g. Consolidated filing. The commissioner may require or allow two or more affiliated insurers subject to registration hereunder to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

h. Alternative registration. The commissioner may allow an insurer which is authorized to do business in this State and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection a. and to file all information and material required to be filed under this section.

i. Exemptions. The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the commissioner by rule, regulation, or order shall exempt the same from the provisions of this section.

j. Disclaimer. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within 30 days following receipt of a complete disclaimer, notifies the filing party in writing that the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request a hearing. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved.

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

l. Violations. The failure to file a registration statement or any amendment thereto or enterprise risk filing required by this section within the time specified for such filing shall be a violation of this section.

4. Section 4 of P.L.1970, c.22 (C.17:27A-4) is amended to read as follows:

C.17:27A-4 Standards.

4. Standards.

a. Transactions within an insurance holding company system.

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

(a) The terms shall be fair and reasonable;

(b) Agreements for cost sharing services and management shall include such provisions as required by rules and regulations adopted by the commissioner;

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

(d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(e) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the precise 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

(f) The insurer's surplus as regards policyholders following any transaction with affiliates or dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(2) The following transactions, set forth in subparagraphs (a) through (g) of this paragraph (2) involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in subparagraphs (a) through (g) of this paragraph (2) may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into that transaction at least 30 days prior thereto, or such shorter period as the commissioner may permit, and the

commissioner has not disapproved it within that 30-day period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within 30 days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required.

(a) Sales, purchases, exchanges, loans or extensions of credit, guarantees or other contingent obligations, investments, or loans collateralized by the stock of a subsidiary or affiliate, provided such transactions equal or exceed: (i) with respect to insurers other than life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders, as of December 31 next preceding; (ii) with respect to life insurers, 3% of the insurer's admitted assets, as of December 31 next preceding;

(b) Loans or extensions of credit to any person who is not an affiliate, in which the insurer makes such loans or extensions of credit with the agreement or understanding that the proceeds of such 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 those loans or extensions of credit, provided those transactions are equal to or exceed: (i) with respect to insurers other than life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders, as of December 31 next preceding; (ii) with respect to life insurers, 3% of the insurer's admitted assets, as of December 31 next preceding;

(c) Reinsurance agreements or modifications thereto, including:

(i) All reinsurance pooling agreements; and

(ii) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer’s liabilities in any of the next three years, equals or exceeds 5% of the insurer's surplus as regards policyholders, as of December 31 next preceding, including those agreements which 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 those assets will be transferred to one or more affiliates of the insurer;

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

(e) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount shall not be subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer’s admitted assets or ten percent (10%) of surplus as regards policyholders as of the 31st day of December next preceding. Further, all guarantees which are not quantifiable as to amount shall be subject to the notice requirements of this paragraph;

(f) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer’s surplus to policyholders. Direct or indirect acquisitions in insurance affiliates that are subject to section 2 of P.L.1970, c.22 (C.17:27A-2), shall be exempt from this requirement; and

(g) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer's policyholders. Nothing herein contained shall be deemed to authorize or permit any transactions which, in the case of an insurer which is not a member of the same insurance holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would otherwise occur. If the commissioner determines that such separate transactions were entered into over any 12-month period for that purpose, he may exercise his authority under section 8 of P.L.1993, c.241 (C.17:27A-9.1).

(4) The commissioner, in reviewing transactions pursuant to paragraph (2) of this subsection, shall consider whether the transactions comply with the standards set forth in paragraph (1) of this subsection and whether they may adversely affect the interests of policyholders.

(5) The commissioner shall be notified within 30 days of any investment of the domestic insurer in any one corporation if the total investment in that corporation by the insurance holding company system exceeds 10% of that corporation's voting securities.

(6) The commissioner may by regulation specify certain types of transactions that need not be submitted for review under this subsection if he determines that those transactions would not have a significant impact on the financial condition or methods of operation of the insurer.

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

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

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

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

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

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

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

(7) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders;

(8) The surplus as regards policyholders maintained by other comparable insurers in respect of the factors enumerated in this subsection;

(9) The adequacy of the insurer's reserves;

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

(11) The quality of the insurer's earnings and the extent to which the reported earnings include extraordinary items.

c. Dividends and other distributions.

(1) A domestic insurer subject to registration under section 3 of P.L.1970, c.22 (C.17:27A-3) shall report to the commissioner any dividend or distribution to its shareholders within five business days following declaration and at least 30 days, after receipt of that report by the commissioner, prior to payment. For good cause shown, the commissioner may reduce the notification period prior to payment to a period of not less than 10 days. The commissioner shall limit or disallow the payment of any dividend or distribution if he determines that the insurer's surplus as regards policyholders is not

reasonable in relation to its outstanding liabilities and adequate to its financial needs pursuant to subsection b. of this section or if the insurer is otherwise found to be in a hazardous financial condition.

(2) (a) No domestic insurer subject to registration under section 3 shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until (i) 30 days after the commissioner has received notice of the declaration thereof and has not within such period disapproved such payment, or (ii) the commissioner shall have approved such payment within such 30-day period.

(b) For purposes of this paragraph, 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 12 months exceeds the greater of (i) 10% of such insurer's surplus as regards policyholders as of December 31 next preceding, or (ii) the net gain from operations of such insurer, if such insurer is a life insurer, or the net income, if such insurer is not a life insurer, not including realized capital gains, for the 12-month period ending December 31 next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

(c) Notwithstanding any other provision of law, a domestic insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval thereof, and such a declaration shall confer no rights upon shareholders until (i) 30 days after the commissioner has received notice of the declaration thereof and has not within such period disapproved such payment, or (ii) the commissioner shall have approved such payment within such 30-day period.

(3) Except for extraordinary dividends or distributions paid pursuant to paragraph (2) of this subsection, all dividends or distributions to shareholders shall be declared or paid by insurers subject to registration under section 3 of P.L.1970, c.22 (C.17:27A-3) from only earned surplus. For purposes of this paragraph, "earned surplus" means unassigned funds (surplus), as reported on the insurer's annual statement as of December 31 next preceding, less unrealized capital gains and revaluation of assets.

d. Management of domestic insurers subject to registration.

(1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with P.L.1970, c.22 (C.17:27A-1 et seq.).

(2) Nothing herein shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of paragraph (1) of subsection a. of this section.

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

(4) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with, the insurer and who are not beneficial owners of a controlling interest in the voting securities of the insurer or any such

entity. The committee shall be responsible for recommending the selection of independent certified public accountants, reviewing the insurer's financial condition, the scope and results of the independent audit and any internal audit, nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation, including bonuses or other special payments, of the principal officers.

(5) The provisions of paragraphs (3) and (4) of this subsection d. shall 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, is an entity having a board of directors and committees thereof that substantially meet the requirements of those paragraphs.

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

5. Section 7 of P.L.1993, c.241 (C.17:27A-4.1) is amended to read as follows:

C.17:27A-4.1 Definitions, regulations concerning acquisitions.

7. a. As used in this section only:

"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 but is not limited to the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers.

An "involved insurer" includes an insurer which either acquires or is acquired, is affiliated with an insurer which is an acquirer or is acquired, or is the result of a merger.

b. (1) Except as provided in paragraph (2) of this subsection, this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this State.

(2) This section shall not apply to the following:

(a) (Deleted by amendment, P.L.2014, c.81)

(b) A purchase of securities solely for investment purposes, so long as those securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this State. If a purchase of securities results in a presumption of control as defined in subsection c. of section 1 of P.L.1970, c.22 (C.17:27A-1), it is not solely for investment purposes unless the commissioner or other appropriate official of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and such disclaimer action or affirmative finding is communicated by the domiciliary commissioner or official to the commissioner of this State;

(c) The acquisition of already affiliated persons;

(d) An acquisition if, as an immediate result of the acquisition, the combined market share of the involved insurers would not exceed five percent of the total market, there would be no increase in the market, or

(i) the combined market share of the involved affiliated insurers would not exceed twelve percent of the total market, and

(ii) the market share increases by no more than two percent of the total market.

For the purpose of this subparagraph (d), "market" means direct written insurance premium in this State for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this State;

(e) An acquisition for which a pre-acquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business;

(f) An acquisition of an insurer whose domiciliary commissioner or other appropriate official affirmatively finds that: the insurer is in failing condition; there is a lack of feasible alternatives to improving that condition; the public benefits of improving that insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and such findings are communicated by the domiciliary commissioner or official to the commissioner of this State.

(g) 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 pre-acquisition notification is filed with the commissioner in accordance with paragraph (1) of subsection c. of this section 30 days prior to the proposed effective date of the acquisition. Such pre-acquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other paragraph of this subsection.

c. An acquisition covered by subsection b. of this section shall 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 commissioner shall give confidential treatment to information submitted under this subsection in the same manner as provided in section 6 of P.L.1970, c.22 (C.17:27A-6).

(1) The pre-acquisition notification shall be in such form and contain such information as prescribed by the commissioner relating to those markets which, under subparagraph (2)(d) of subsection b. of this section, cause the acquisition not to be exempted from the provisions of this section. The commissioner may require such additional material and information as he deems necessary. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this State, accompanied by a summary of the education and experience of that person indicating his ability to render an informed opinion.

(2) The waiting period required shall begin on the date of receipt by the commissioner of pre-acquisition notification and shall end on the earlier of the 30th day after the date of that notification, or termination of the waiting period by the commissioner. Prior to the end of the waiting period, the commissioner on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the 30th day after receipt of that additional information by the commissioner or termination of the waiting period by the commissioner.

d. (1) The commissioner may enter an order under paragraph (1) of subsection e. with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance of this State or, to tend to create a monopoly therein or if the insurer fails to file adequate information in compliance with subsection c.

(2) In determining whether a proposed acquisition would violate the competitive standard of paragraph (1) of this subsection, the commissioner shall consider the following:

(a) Any acquisition covered under subsection b. involving two or more insurers competing in the same market shall be prima facie evidence of violation of the competitive

standard 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, 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

Insurer A	Insurer B
15%	3% or more
19%	1% or more

For the purposes of this subparagraph (a), the insurer with the largest share of the market shall be deemed to be Insurer A. A highly concentrated market is one in which the share of the four largest insurers is seventy-five percent or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two insurers are involved, exceeding the total of the two columns in the table shall be prima facie evidence of violation of the competitive standards in paragraph (1) of this subsection.

(b) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven percent or more 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. Any acquisition or merger covered under subsection b. involving two or more insurers competing in the same market shall be prima facie evidence of a violation of the competitive standard in paragraph (1) of this subsection if:

(i) there is a significant trend toward increased concentration in the market;

(ii) one of the insurers involved is one of the insurers in a grouping of such large insurers showing the requisite increase in the market share; and

(iii) another involved insurer's market is two percent or more.

(c) Even though an acquisition is not prima facie violative of the competitive standard under subparagraphs (a) and (b) of this paragraph (2), the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under those subparagraphs, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subparagraph (c) include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

(d) For the purposes of this paragraph (2):

The term "insurer" includes any company or group of companies under common management, ownership or control;

The term "market" means the relevant product and geographical markets as determined by the commissioner. In determining the relevant product and geographical markets, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the National Association of Insurance Commissioners and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this State, and the relevant geographical market is assumed to be this State.

The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(3) An order may not be entered under paragraph (1) of subsection e. if:

(a) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from those economies exceed the public benefits which would arise from not lessening competition; or

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

e. (1) (a) If an acquisition violates the standards of this section, the commissioner may enter an order:

(i) requiring an involved insurer to cease and desist from doing business in this State with respect to the line or lines of insurance involved in the violation; or

(ii) denying the application of an acquired or acquiring insurer for a license to do business in this State.

(b) Such an order shall not be entered unless:

(i) there is a hearing,

(ii) notice of that hearing is issued prior to the end of the waiting period and not less than 15 days prior to the hearing; and

(iii) the hearing is concluded and the order is issued no later than 60 days after the end of the waiting period. Every order shall be accompanied by a written decision of the commissioner setting forth his findings of fact and conclusions of law.

(c) An order entered under this subsection shall not become final earlier than 30 days after it is issued, during which time the involved insurer may submit a plan to remedy the anti-competitive impact of the acquisition within a reasonable time. Based upon such plan or other information, the commissioner shall specify the conditions, if any, under which, and the time period during which, the aspects of the acquisition causing a violation of the standards of this section may be remedied and the order vacated or modified.

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

(2) Any person who violates a cease and desist order of the commissioner under paragraph (1) while such order is in effect, may after notice and hearing, be subject to a penalty of up to $10,000 for each day of violation, or suspension or revocation of that person's license, or both.

(3) Any insurer or other person who fails to make any filing required by this section shall be required to pay a penalty of up to $5,000 per violation.

f. Subsections b. and c. of section 8 of P.L.1970, c.22 (C.17:27A-8) and section 10 of P.L.1970, c.22 (C.17:27A-10) shall not apply to acquisitions covered under this section.

g. This section shall not limit the commissioner's authority to refuse to renew or revoke the certificate of authority of an insurer admitted to transact business in this State pursuant to R.S.17:32-1 et seq., or N.J.S.17B:23-1 et seq.

6. Section 5 of P.L.1970, c.22 (C.17:27A-5) is amended to read as follows:

C.17:27A-5 Examination.

5. Examination.

a. Power of commissioner. In addition to the powers which the commissioner has under other sections of Title 17 of the Revised Statutes and Title 17B of the New Jersey Statutes relating to the examination of insurers, the commissioner shall have the power to examine any insurer registered under section 3 of P.L.1970, c.22 (C.17:27A-3) and its affiliates to ascertain the financial condition of the insurer, 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.

The commissioner shall also have the power to order any insurer registered under section 3 to produce such records, books, or other information papers in the possession of the insurer or its affiliates as shall be necessary to ascertain the financial condition of the insurer or to determine compliance with P.L.1970, c.22 (C.17:27A-1 et seq.). In the event such insurer fails to comply with such order, the commissioner shall have the power to examine such affiliates to obtain such information.

In addition, to determine compliance with this section, the commissioner may order any insurer registered under section 3 of P.L.1970, c.22 (C.17:27A-3) to produce information not in the possession of the insurer if the insurer can obtain access to that information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the commissioner, the insurer shall provide to the commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of the information. Whenever it appears to the commissioner that the detailed explanation is without merit, the commissioner may require the insurer, after notice and opportunity for a hearing, to pay a penalty of up to $5,000 for each day’s delay, or may suspend or revoke the insurer’s certificate of authority.

b. (Deleted by amendment, P.L.1993, c.241.)

c. Use of consultants. The commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants and other persons as shall be necessary to assist in the conduct of the examination under subsection a. above. Any persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

d. Expenses. The reasonable expenses of the examination pursuant to subsection a. above shall be fixed and determined by the commissioner, and he shall collect them from the insurer examined, which shall pay them on presentation of an accounting of the expenses.

e. Compelling production. In the event the insurer fails to comply with an order issued pursuant to this section, the commissioner shall have the power to examine the affiliates to obtain the information. The commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce

documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the State. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in the Superior Court of New Jersey, which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined.

C.17:27A-5.1 Power of commissioner; expenses; supervisory college.

7. a. Power of commissioner. With respect to any insurer registered under section 3 of P.L.1970, c.22 (C.17:27A-3), and in accordance with subsection c. of this section, the commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with P.L.2014, c.81 (C.17:27A-5.1 et al.). The powers of the commissioner with respect to supervisory colleges include, but are not limited to, the following:

(1) Initiating the establishment of a supervisory college;

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

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

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

(5) Establishing a crisis management plan.

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

c. Supervisory college. In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with section 5 of P.L.1970, c.22 (C.17:27A-5), the commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The commissioner may enter into agreements in accordance with subsection c. of section 6 of P.L.1970, c.22, (C.17:27A-6) providing the basis for cooperation between the commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction.

C.17:27A-5.2 Group-wide supervision for international insurance groups.

8. Group-wide supervision for international insurance groups.

a. As used in this section, the following terms shall have the respective meanings hereinafter set forth, unless the context clearly indicates otherwise:

“Group-wide supervisor” means the chief insurance regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is from the jurisdiction determined or acknowledged by the commissioner under this section to have sufficient significant contacts with the international insurance group.

“International insurance group” means an insurance group operating internationally that includes an insurer registered under section 3 of P.L.1970, c.22 (C.17:27A-3).

b. The commissioner is authorized to act as the group-wide supervisor for any international insurance group if the international insurance group's ultimate controlling person is domiciled in this State. The commissioner may otherwise acknowledge another jurisdiction as the group-wide supervisor pursuant to the factors set forth in subsections c. and f. of this section whenever the international insurance group:

(1) Does not have substantial insurance operations in the United States;

(2) Has substantial insurance operations in the United States, but not in this State; or

(3) Has substantial insurance operations in the United States and this State, but the commissioner has determined that another jurisdiction is the appropriate group-wide supervisor.

c. In cooperation with other supervisors, the commissioner may determine that the commissioner is the appropriate group-wide supervisor for an international insurance group with substantial operations concentrated in this State or with substantial insurance operations conducted by subsidiary insurance companies domiciled in this State, where the ultimate controlling person is domiciled outside of this State, or the commissioner may acknowledge that another chief insurance regulatory official is the appropriate group-wide supervisor for the international insurance group. The commissioner shall consider the following factors and the relative scale of each when making a determination or acknowledgment under this subsection:

(1) The location where the international insurance group is based or the place of domicile of the ultimate controlling person of the international insurance group;

(2) The locations of the international insurance group's executive offices;

(3) The locations of origin of the insurance business of the international insurance group;

(4) The locations of the assets and liabilities of the international insurance group;

(5) The locations of the business operations and activities of the international insurance group; and

(6) If another chief insurance regulatory official is seeking to act as the lead group-wide supervisor whether that jurisdiction:

(a) provides the commissioner with reasonably reciprocal recognition and cooperation; and

(b) is accredited by the National Association of Insurance Commissioners (NAIC) or has substantially similar laws when compared to the insurance laws of this State, especially with regard to the provision of group-wide supervision, enterprise risk analysis and cooperation with other chief insurance regulatory officials.

However, when another chief insurance regulatory official is currently acting as the lead group-wide supervisor of an international insurance group and is acknowledged as such in the National Association of Insurance Commissioners (NAIC) Lead State Summary Report, the commissioner shall defer to that lead group-wide supervisor designation unless the commissioner determines that there has been a significant material change in the international insurance group that:

(i) results in the group’s insurers domiciled in this State holding the majority of the group’s assets or liabilities;

(ii) materially alters the operations or ownership of the group's insurers domiciled in this State; or

(iii) makes this State the jurisdiction with the group's largest premium volume or insured exposures.

In the event of a dispute as to the proper jurisdiction to act as lead group-wide supervisor, a determination by the commissioner not to defer to the current lead group-wide supervisor shall be made only after notice and a hearing, and such determination shall be accompanied by specific findings of fact and conclusions of law.

d. Pursuant to section 5 of P.L.1970, c.22 (C.17:27A-5), the commissioner is authorized to collect from any insurer registered pursuant to section 3 of P.L.1970, c.22 (C.17:27A-3) all information necessary to determine whether the commissioner may act as the group-wide supervisor or if the commissioner may acknowledge another insurance regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an international insurance group is subject to group-wide supervision by the commissioner, the commissioner shall notify the insurer registered pursuant to section 3 of P.L.1970, c.22 (C.17:27A-3) and the ultimate controlling person within the international insurance group. The international insurance group shall have not less than 30 days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish on the Department of Banking and Insurance website the identity of international insurance groups that the commissioner has determined are subject to its group-wide supervision.

e. If the commissioner is the group-wide supervisor for an international insurance group, the commissioner is authorized to engage in conducting and coordinating any of the following group-wide supervision activities:

(1) Assess the enterprise risks within the international insurance group, pursuant to section 5 of P.L.1970, c.22 (C.17:27A-5), to ensure that:

(a) The material financial condition and liquidity risks to the members of the international insurance group which are engaged in the business of insurance are identified by management.

(b) Reasonable and effective mitigation measures are in place.

(2) Request, from any member of an international insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the international insurance group regarding:

(a) Governance, risk assessment and management.

(b) Capital adequacy.

(c) Material intercompany transactions.

(3) Compel development and implementation of reasonable measures designed to assure that the international insurance group is able to timely recognize and mitigate material risks to members that are engaged in the business of insurance.

(4) Communicate with other insurance regulatory officials for members within the international insurance group and share relevant information subject to the confidentiality provisions of section 6 of P.L.1970, c.22 (C.17:27A-6), through supervisory colleges as set forth in section 7 of P.L.2014, c.81 (C.17:27A-5.1) or otherwise.

(5) Enter into agreements with or obtain documentation from any insurer registered under section 3 of P.L.1970, c.22 (C.17:27A-3), any member of the international insurance group and any other chief insurance regulatory officials for members, providing the basis for or otherwise clarifying the commissioner's role as group supervisor, including provisions for resolving disputes with other relevant supervisory authorities. Such agreements or

documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not incorporated in this State is doing business in this State or is otherwise subject to jurisdiction in this State.

(6) Other group-wide supervisory activities as considered appropriate by the commissioner.

f. If the commissioner acknowledges that a regulatory official from a jurisdiction which is not accredited by the National Association of Insurance Commissioners (NAIC) is the group-wide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group supervision undertaken by the group-wide supervisor, provided that:

(1) The commissioner’s cooperation is in compliance with the insurance laws of this State.

(2) The regulator also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other international insurance groups where applicable. Whenever such recognition and cooperation is not reasonably reciprocal, the commissioner is authorized to refuse recognition and cooperation.

g. The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under section 3 of P.L.1970, c.22 (C.17:27A-3), any affiliate of the insurer and other regulatory officials for members of the insurance group, which provide the basis for or otherwise clarify a regulatory official's role as group supervisor.

h. The commissioner may promulgate regulations pursuant to the “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.) necessary for the administration of this section. In determining whether to promulgate a regulation, the commissioner shall give appropriate consideration to model laws, model regulations and definitions or guidelines pertaining to group-wide supervision, if any, promulgated by the NAIC or other recognized insurance regulatory bodies or associations.

i. A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner’s participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

9. Section 6 of P.L.1970, c.22 (C.17:27A-6) is amended to read as follows:

C.17:27A-6 Confidential treatment.

6. Confidential treatment.

a. Documents, materials or other information in the possession or control of the department that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to section 5 of P.L.1970, c.22 (C.17:27A-5) and all information reported pursuant to paragraphs (12) and (13) of subsection b. of section 2 of P.L.1970, c.22 (C.17:27A-2), section 3 and section 4 of P.L.1970, c.22 (C.17:27A-3 and 17:27A-4) shall be confidential by law and privileged, shall not be subject to P.L.1963, c.73 (C.47:1A-1 et seq.), shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner’s official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the commissioner,

after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

b. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to P.L.1970, c.22 (C.17:27A-1 et seq.) shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection a. of this section.

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

(1) May, upon request, be required to share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection a. of this section, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners (NAIC) and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, including members of any supervisory college described in section 7 of P.L.2014, c.81 (C.17:27A-5.1), provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has verified in writing the legal authority to maintain confidentiality.

(2) Notwithstanding paragraph (1) of this subsection c., the commissioner may only share confidential and privileged documents, material, or information reported pursuant to subsection k. of section 3 of P.L.1970, c.22 (C.17:27A-3) with commissioners of states having statutes or regulations substantially similar to subsection a. of this section and who 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 NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(4) Shall enter into written agreements with the NAIC governing the sharing and use of information provided pursuant to P.L.2014, c.81 (C.17:27A-5.1 et al.) consistent with this subsection that shall:

(a) specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC and its affiliates and subsidiaries pursuant to P.L.2014, c.81 (C.17:27A-5.1 et al.), including procedures and protocols for sharing by the NAIC with other state, federal or international regulators;

(b) specify that ownership of information shared with the NAIC and its affiliates and subsidiaries pursuant to this subsection remains with the commissioner and the use by the NAIC of the information is subject to the direction of the commissioner;

(c) require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC pursuant to P.L.2014, c.81 (C.17:27A-5.1 et al.) is subject to a request or subpoena to the NAIC for disclosure or production; and

(d) require the NAIC and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the NAIC and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the NAIC and its affiliates and subsidiaries pursuant to P.L.1970, c.22 (C.17:27A-1 et

seq.), including with respect to the participation in supervisory colleges in accordance with section 7 of P.L.2014, c.81 (C.17:27A-5.1).

d. The sharing of information by the commissioner pursuant to this section shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of P.L.2014, c.81 (C.17:27A-5.1 et al.).

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

f. Documents, materials or other information in the possession or control of the NAIC pursuant to P.L.2014, c.81 (C.17:27A-5.1 et al.) shall be confidential by law and privileged, shall not be subject to P.L.1963, c.73 (C.47:1A-1 et seq.), shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

10. Section 8 of P.L.1993, c.241 (C.17:27A-9.1) is amended to read as follows:

C.17:27A-9.1 Violations; penalties.

8. a. Any insurer failing to file any registration statement as required by P.L.1970, c.22 (C.17:27A-1 et seq.) shall be required to pay a penalty of up to $5,000 for each day's delay.

b. Every director or officer of an insurance holding company system who violates, participates in, or assents to, or who shall permit any of the officers or agents of the insurer to engage in transactions or make investments which have not been properly reported or submitted pursuant to subsection a. of section 3 of P.L.1970, c.22 (C.17:27A-3) or paragraph (2) of subsection a., or subsection c. of section 4 of P.L.1970, c.22 (C.17:27A-4), or which otherwise violate P.L.1970, c.22 (C.17:27A-1 et seq.), shall pay, in their individual capacity, a penalty of up to $5,000 per violation.

c. Whenever it appears to the commissioner that any insurer subject to P.L.1970, c.22 (C.17:27A-1 et seq.) or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract which is subject to section 4 of P.L.1970, c.22 (C.17:27A-4) and which would not have been approved had such approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing the commissioner may also order the insurer to void any such contracts and restore the status quo if such action is in the best interest of the policyholders, creditors or the public.

d. Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed a willful violation of P.L.1970, c.22 (C.17:27A-1 et seq.), the commissioner may cause criminal proceedings to be instituted in the Superior Court against that insurer or the responsible director, officer, employee or agent thereof. An insurer which willfully violates that act may be fined up to $10,000 per violation. Any individual who willfully violates P.L.1970, c.22 (C.17:27A-1 et seq.) may be fined in his individual capacity up to $10,000 per violation or, be imprisoned for not less than one year and not more than three years, or both.

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 statements or false reports or false filings with the intent to deceive the commissioner in the performance of his duties under P.L.1970, c.22 (C.17:27A-1 et seq.), upon conviction thereof, may be imprisoned for not less than one year and not more than three years or fined up to $10,000

per violation, or both. Any fines imposed shall be paid by the officer, director, or employee in his individual capacity, if legally liable, or the insurer.

f. Whenever it appears to the commissioner that any person has committed a violation of section 2 of P.L.1970, c.22 (C.17:27A-2), which violation prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with P.L.1993, c.245 (C.17:51A-1 et seq.).

C.17:48-12.1 Definitions.

11. As used in sections 11 through 15 of P.L.2014, c.81 (C.17:48-12.1 through C.17:48-12.5):

"Commissioner" means the Commissioner of Banking and Insurance.

"Hospital service corporation" means an entity authorized to transact business in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.).

C.17:48-12.2 Increase in amount of capital or surplus required of hospital service corporation.

12. The commissioner may increase the amount of capital or surplus required of a hospital service corporation, or subsequently revise or redetermine that increase, using appropriate methods and procedures established by rules and regulations adopted by the commissioner, in order to provide adequate protection against risks affecting the hospital service corporation's financial condition that are not adequately or fully covered by its reserves or other assets, but under no circumstances shall a hospital service corporation's capital or surplus be less than the capital or surplus required pursuant to regulation as prescribed by the commissioner; provided, however, that any increase required by a subsequent revision or redetermination pursuant to this section, shall be made only after a departmental hearing, unless that hearing is waived by the affected hospital service corporation. All matters pertaining to a hearing or to an increase in capital or surplus pursuant to this section shall be confidential and not subject to subpoena or public inspection, except to the extent that the commissioner finds release of that information necessary to protect the public. The hearing shall be initiated within 20 days after written notice to the hospital service corporation. Any declaration regarding an increase required by a subsequent revision or redetermination shall contain findings specifying the factors deemed significant in regard to the particular hospital service corporation, and shall set forth the reasons supporting the increase of capital or surplus ordered by the commissioner. In determining any increase, revision or redetermination in the amount of capital or surplus, the commissioner shall consider the risks of:

a. Increases or decreases in the frequency and severity of losses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates that the hospital service corporation charged for coverage and above or below those reasonably expected under normal conditions;

b. Increases or decreases in expenses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates the hospital service corporation charged for coverage and above or below those reasonably expected under normal conditions;

c. Increases or decreases in the value of, or return on, invested assets under normal operating conditions, as well as increases or decreases in those values, above or below those levels anticipated under normal conditions;

d. Changes in economic, social or market conditions that could adversely or favorably affect the financial condition of the hospital service corporation, including conditions that would make liquidity more or less important than contemplated and would prevent or facilitate timely investments or force or prohibit untimely sales of assets; and

e. Any other contingencies, including reinsurance and unfunded or extra contractual obligations, which may affect the hospital service corporation's financial condition.

C.17:48-12.3 Determination of increase, revision or redetermination; factors.

13. In determining any increase, revision or redetermination in the capital or surplus of a hospital service corporation pursuant to the provisions of section 12 of P.L.2014, c.81 (C.17:48-12.2) the commissioner shall take into account the following factors:

a. Methods and techniques used to measure risk exposure and variability;

b. The information available relating to the magnitude of the various risks described in section 12 of P.L.2014, c.81 (C.17:48-12.2);

c. The extent to which risks described in section 12 of P.L.2014, c.81 (C.17:48-12.2) are independent or interrelated, and whether any dependency is direct or inverse;

d. The extent to which the hospital service corporation has provided protection against contingencies in ways other than the establishment of surplus, including, but not limited to: redundancy of premiums; margin in reserves and liabilities; adjustability of contracts pursuant to the terms of the contracts; voluntary or mandatory investment valuation reserves; reinsurance; the use of conservative actuarial assumptions to provide a margin of security; reserve adjustments after rate increases for policies written at earlier and less adequate rates; contingency or catastrophe reserves; and diversification of assets and underwriting risk; and

e. Any other relevant factors, including the National Association of Insurance Commissioners' reports and independent judgments of the soundness of the hospital service corporation's financial condition, as evidenced by the rating and reports of reliable professional financial services.

C.17:48-12.4 Suspension, revocation to do business.

14. The commissioner may suspend or revoke the authority to do business in this State of any hospital service corporation that does not comply with the provisions of sections 11 through 15 of P.L.2014, c.81 (C.17:48-12.1 through C.17:48-12.5).

C.17:48-12.5 Rules, regulations.

15. The commissioner may promulgate regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C. 52:14B-1 et seq.) necessary to effectuate the purposes of sections 11 through 15 of P.L.2014, c.81 (C.17:48-12.1 through C.17:48-12.5). Such rules and regulations shall be consistent with the standards for risk based capital for health organizations adopted by the National Association of Insurance Commissioners.

C.17:48A-19.1 Definitions.

16. As used in sections 16 through 20 of P.L.2014, c.81 (C.17:48A-19.1 through C.17:48A-19.5):

“Commissioner” means the Commissioner of Banking and Insurance.

“Medical service corporation” means an entity authorized to transact business in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.).

C.17:48A-19.2 Increase in amount of capital or surplus required of medical service corporation.

17. The commissioner may increase the amount of capital or surplus required of a medical service corporation, or subsequently revise or redetermine that increase, using appropriate methods and procedures established by rules and regulations adopted by the commissioner, in order to provide adequate protection against risks affecting the medical service corporation's financial condition that are not adequately or fully covered by its reserves or other assets, but under no circumstances shall a medical service corporation's capital or surplus be less than the capital or surplus required pursuant to regulation as prescribed by the commissioner; provided, however, that any increase required by a subsequent revision or redetermination pursuant to this section, shall be made only after a departmental hearing, unless that hearing is waived by the affected medical service corporation. All matters pertaining to a hearing or to an increase in capital or surplus pursuant to this section shall be confidential and not subject to subpoena or public inspection, except to the extent that the commissioner finds release of that information necessary to protect the public. The hearing shall be initiated within 20 days after written notice to the medical service corporation. Any declaration regarding an increase required by a subsequent revision or redetermination shall contain findings specifying the factors deemed significant in regard to the particular medical service corporation, and shall set forth the reasons supporting the increase of capital or surplus ordered by the commissioner. In determining any increase, revision or redetermination in the amount of capital or surplus, the commissioner shall consider the risks of:

a. Increases or decreases in the frequency and severity of losses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates that the medical service corporation charged for coverage and above or below those reasonably expected under normal conditions;

b. Increases or decreases in expenses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates the medical service corporation charged for coverage and above or below those reasonably expected under normal conditions;

c. Increases or decreases in the value of, or return on, invested assets under normal operating conditions, as well as increases or decreases in those values, above or below those levels anticipated under normal conditions;

d. Changes in economic, social or market conditions that could adversely or favorably affect the financial condition of the medical service corporation, including conditions that would make liquidity more or less important than contemplated and would prevent or facilitate timely investments or force or prohibit untimely sales of assets; and

e. Any other contingencies, including reinsurance and unfunded or extra contractual obligations, which may affect the medical service corporation's financial condition.

C.17:48A-19.3 Determination of increase, revision or redetermination; factors.

18. In determining any increase, revision or redetermination in the capital or surplus of a medical service corporation pursuant to the provisions of section 17 of P.L.2014, c.81 (C.17:48A-19.2) the commissioner shall take into account the following factors:

a. Methods and techniques used to measure risk exposure and variability;

b. The information available relating to the magnitude of the various risks described in section 17 of P.L.2014, c.81 (C.17:48A-19.2);

c. The extent to which risks described in section 17 of P.L.2014, c.81 (C.17:48A-19.2) are independent or interrelated, and whether any dependency is direct or inverse;

d. The extent to which the medical service corporation has provided protection against contingencies in ways other than the establishment of surplus, including, but not limited to: redundancy of premiums; margin in reserves and liabilities; adjustability of contracts pursuant to the terms of the contracts; voluntary or mandatory investment valuation reserves; reinsurance; the use of conservative actuarial assumptions to provide a margin of security; reserve adjustments after rate increases for policies written at earlier and less adequate rates; contingency or catastrophe reserves; and diversification of assets and underwriting risk; and

e. Any other relevant factors, including the National Association of Insurance Commissioners' reports and independent judgments of the soundness of the medical service corporation's financial condition, as evidenced by the rating and reports of reliable professional financial services.

C.17:48A-19.4 Suspension, revocation of authority to do business.

19. The commissioner may suspend or revoke the authority to do business in this State of any medical service corporation that does not comply with the provisions of sections 16 through 20 of P.L.2014, c.81 (C.17:48A-19.1 through C.17:48A-19.5).

C.17:48A-19.5 Rules, regulations.

20. The commissioner may promulgate regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to effectuate the purposes of sections 16 through 20 of P.L.2014, c.81 (C.17:48A-19.1 through C.17:48A-19.5). Such rules and regulations shall be consistent with the standards for risk based capital for health organizations adopted by the National Association of Insurance Commissioners.

C.17:48C-28.1 Definitions.

21. As used in sections 21 through 25 of P.L.2014, c.81 (C.17:48C-28.1 through C.17:48C-28.5):

“Commissioner” means the Commissioner of Banking and Insurance.

“Dental service corporation” means an entity authorized to transact business in this State pursuant to P.L.1968, c.305 (C.17:48C-1 et seq.).

C.17:48C-28.2 Increase in amount of capital or surplus required of dental service corporation.

22. The commissioner may increase the amount of capital or surplus required of a dental service corporation, or subsequently revise or redetermine that increase, using appropriate methods and procedures established by rules and regulations adopted by the commissioner, in order to provide adequate protection against risks affecting the dental service corporation's financial condition that are not adequately or fully covered by its reserves or other assets, but under no circumstances shall a dental service corporation's capital or surplus be less than the capital or surplus required pursuant to regulation as prescribed by the commissioner; provided, however, that any increase required by a subsequent revision or redetermination pursuant to this section shall be made only after a departmental hearing, unless that hearing is waived by the affected dental service corporation. All matters pertaining to a hearing or to an increase in capital or surplus pursuant to this section shall be confidential and not subject

to subpoena or public inspection, except to the extent that the commissioner finds release of that information necessary to protect the public. The hearing shall be initiated within 20 days after written notice to the dental service corporation. Any declaration regarding an increase required by a subsequent revision or redetermination shall contain findings specifying the factors deemed significant in regard to the particular dental service corporation, and shall set forth the reasons supporting the increase of capital or surplus ordered by the commissioner. In determining any increase, revision or redetermination in the amount of capital or surplus, the commissioner shall consider the risks of:

a. Increases or decreases in the frequency and severity of losses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates that the dental service corporation charged for coverage and above or below those reasonably expected under normal conditions;

b. Increases or decreases in expenses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates the dental service corporation charged for coverage and above or below those reasonably expected under normal conditions;

c. Increases or decreases in the value of, or return on, invested assets under normal operating conditions, as well as increases or decreases in those values, above or below those levels anticipated under normal conditions;

d. Changes in economic, social or market conditions that could adversely or favorably affect the financial condition of the dental service corporation, including conditions that would make liquidity more or less important than contemplated and would prevent or facilitate timely investments or force or prohibit untimely sales of assets; and

e. Any other contingencies, including reinsurance and unfunded or extra contractual obligations, which may affect the dental service corporation's financial condition.

C.17:48C-28.3 Determination of increase, revision or redetermination; factors.

23. In determining any increase, revision or redetermination in the capital or surplus of a dental service corporation pursuant to the provisions of section 22 of P.L.2014, c.81 (C.17:48C-28.2) the commissioner shall take into account the following factors:

a. Methods and techniques used to measure risk exposure and variability;

b. The information available relating to the magnitude of the various risks described in section 22 of P.L.2014, c.81 (C.17:48C-28.2);

c. The extent to which risks described in section 22 of P.L.2014, c.81 (C.17:48C-28.2) are independent or interrelated, and whether any dependency is direct or inverse;

d. The extent to which the dental service corporation has provided protection against contingencies in ways other than the establishment of surplus, including, but not limited to: redundancy of premiums; margin in reserves and liabilities; adjustability of contracts pursuant to the terms of the contracts; voluntary or mandatory investment valuation reserves; reinsurance; the use of conservative actuarial assumptions to provide a margin of security; reserve adjustments after rate increases for policies written at earlier and less adequate rates; contingency or catastrophe reserves; and diversification of assets and underwriting risk; and

e. Any other relevant factors, including the National Association of Insurance Commissioners' reports and independent judgments of the soundness of the dental service corporation's financial condition, as evidenced by the rating and reports of reliable professional financial services.

C.17:48C-28.4 Suspension, revocation of authority to do business.

24. The commissioner may suspend or revoke the authority to do business in this State of any dental service corporation that does not comply with the provisions of sections 21 through 25 of P.L.2014, c.81 (C.17:48C-28.1 through C.17:48C-28.5).

C.17:48C-28.5 Rules, regulations.

25. The commissioner may promulgate regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to effectuate the purposes of sections 21 through 25 of P.L.2014, c.81 (C.17:48C-28.1 through C.17:48C-28.5). Such rules and regulations shall be consistent with the standards for risk based capital for health organizations adopted by the National Association of Insurance Commissioners.

C.17:48D-11.1 Definitions.

26. As used in sections 26 through 30 of P.L.2014, c.81 (C.17:48D-11.1 through C.17:48D-11.5):

“Commissioner” means the Commissioner of Banking and Insurance.

“Dental plan organization” means an entity authorized to transact business in this State pursuant to P.L.1979, c.478 (C.17:48D-1 et seq.).

C.17:48D-11.2 Increase in amount of capital or surplus required of dental plan organization.

27. The commissioner may increase the amount of capital or surplus required of a dental plan organization, or subsequently revise or redetermine that increase, using appropriate methods and procedures established by rules and regulations adopted by the commissioner, in order to provide adequate protection against risks affecting the dental plan organization's financial condition that are not adequately or fully covered by its reserves or other assets, but under no circumstances shall a dental plan organization's capital or surplus be less than the capital or surplus required pursuant to regulation as prescribed by the commissioner; provided, however, that any increase required by a subsequent revision or redetermination pursuant to this section shall be made only after a departmental hearing, unless that hearing is waived by the affected dental plan organization. All matters pertaining to a hearing or to an increase in capital or surplus pursuant to this section shall be confidential and not subject to subpoena or public inspection, except to the extent that the commissioner finds release of that information necessary to protect the public. The hearing shall be initiated within 20 days after written notice to the dental plan organization. Any declaration regarding an increase required by a subsequent revision or redetermination shall contain findings specifying the factors deemed significant in regard to the particular dental plan organization, and shall set forth the reasons supporting the increase of capital or surplus ordered by the commissioner. In determining any increase, revision or redetermination in the amount of capital or surplus, the commissioner shall consider the risks of:

a. Increases or decreases in the frequency and severity of losses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates that the dental plan organization charged for coverage and above or below those reasonably expected under normal conditions;

b. Increases or decreases in expenses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates the dental plan organization charged for coverage and above or below those reasonably expected under normal conditions;

c. Increases or decreases in the value of, or return on, invested assets under normal operating conditions, as well as increases or decreases in those values, above or below those levels anticipated under normal conditions;

d. Changes in economic, social or market conditions that could adversely or favorably affect the financial condition of the dental plan organization, including conditions that would make liquidity more or less important than contemplated and would prevent or facilitate timely investments or force or prohibit untimely sales of assets; and

e. Any other contingencies, including reinsurance and unfunded or extra contractual obligations, which may affect the dental plan organization's financial condition.

C.17:48D-11.3 Determination of increase, revision or redetermination; factors.

28. In determining any increase, revision or redetermination in the capital or surplus of a dental plan organization pursuant to the provisions of section 27 of P.L.2014, c.81 (C.17:48D-11.2) the commissioner shall take into account the following factors:

a. Methods and techniques used to measure risk exposure and variability;

b. The information available relating to the magnitude of the various risks described in section 27 of P.L.2014, c.81 (C.17:48D-11.2);

c. The extent to which risks described in section 27 of P.L.2014, c.81 (C.17:48D-11.2) are independent or interrelated, and whether any dependency is direct or inverse;

d. The extent to which the dental plan organization has provided protection against contingencies in ways other than the establishment of surplus, including, but not limited to: redundancy of premiums; margin in reserves and liabilities; adjustability of contracts pursuant to the terms of the contracts; voluntary or mandatory investment valuation reserves; reinsurance; the use of conservative actuarial assumptions to provide a margin of security; reserve adjustments after rate increases for policies written at earlier and less adequate rates; contingency or catastrophe reserves; and diversification of assets and underwriting risk; and

e. Any other relevant factors, including the National Association of Insurance Commissioners' reports and independent judgments of the soundness of the dental plan organization's financial condition, as evidenced by the rating and reports of reliable professional financial services.

C.17:48D-11.4 Suspension, revocation of authority to do business.

29. The commissioner may suspend or revoke the authority to do business in this State of any dental plan organization that does not comply with the provisions of sections 26 through 30 of P.L.2014, c.81 (C.17:48D-11.1 through C.17:48D-11.5).

C.17:48D-11.5 Rules, regulations.

30. The commissioner may promulgate regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to effectuate the purposes of sections 26 through 30 of P.L.2014, c.81 (C.17:48D-11.1 through C.17:48D-11.5). Such rules and regulations shall be consistent with the standards for risk based capital for health organizations adopted by the National Association of Insurance Commissioners.

C.17:48E-37.1 Definitions.

31. As used in sections 31 through 35 of P.L.2014, c.81 (C.17:48E-37.1 through C.17:48E-37.5):

“Commissioner” means the Commissioner of Banking and Insurance.

"Health service corporation" means an entity authorized to transact business in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.).

C.17:48E-37.2 Increase in amount of capital or surplus required of health service corporation.

32. The commissioner may increase the amount of capital or surplus required of a health service corporation, or subsequently revise or redetermine that increase, using appropriate methods and procedures established by rules and regulations adopted by the commissioner, in order to provide adequate protection against risks affecting the health service corporation's financial condition that are not adequately or fully covered by its reserves or other assets, but under no circumstances shall a health service corporation's capital or surplus be less than the capital or surplus required pursuant to regulation as prescribed by the commissioner; provided, however, that any increase required by a subsequent revision or redetermination pursuant to this section shall be made only after a departmental hearing, unless that hearing is waived by the affected health service corporation. All matters pertaining to a hearing or to an increase in capital or surplus pursuant to this section shall be confidential and not subject to subpoena or public inspection, except to the extent that the commissioner finds release of that information necessary to protect the public. The hearing shall be initiated within 20 days after written notice to the health service corporation. Any declaration regarding an increase required by a subsequent revision or redetermination shall contain findings specifying the factors deemed significant in regard to the particular health service corporation, and shall set forth the reasons supporting the increase of capital or surplus ordered by the commissioner. In determining any increase, revision or redetermination in the amount of capital or surplus, the commissioner shall consider the risks of:

a. Increases or decreases in the frequency and severity of losses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates that the health service corporation charged for coverage and above or below those reasonably expected under normal conditions;

b. Increases or decreases in expenses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates the health service corporation charged for coverage and above or below those reasonably expected under normal conditions;

c. Increases or decreases in the value of, or return on, invested assets under normal operating conditions, as well as increases or decreases in those values, above or below those levels anticipated under normal conditions;

d. Changes in economic, social or market conditions that could adversely or favorably affect the financial condition of the health service corporation, including conditions that would make liquidity more or less important than contemplated and would prevent or facilitate timely investments or force or prohibit untimely sales of assets; and

e. Any other contingencies, including reinsurance and unfunded or extra contractual obligations, which may affect the health service corporation's financial condition.

C.17:48E-37.3 Determination of increase, revision or redetermination; factors.

33. In determining any increase, revision or redetermination in the capital or surplus of a health service corporation pursuant to the provisions of section 32 of P.L.2014, c.81 (C.17:48E-37.2) the commissioner shall take into account the following factors:

a. Methods and techniques used to measure risk exposure and variability;

b. The information available relating to the magnitude of the various risks described in section 32 of P.L.2014, c.81 (C.17:48E-37.2);

c. The extent to which risks described in section 32 of P.L.2014, c.81 (C.17:48E-37.2) are independent or interrelated, and whether any dependency is direct or inverse;

d. The extent to which the health service corporation has provided protection against contingencies in ways other than the establishment of surplus, including, but not limited to: redundancy of premiums; margin in reserves and liabilities; adjustability of contracts pursuant to the terms of the contracts; voluntary or mandatory investment valuation reserves; reinsurance; the use of conservative actuarial assumptions to provide a margin of security; reserve adjustments after rate increases for policies written at earlier and less adequate rates; contingency or catastrophe reserves; and diversification of assets and underwriting risk; and

e. Any other relevant factors, including the National Association of Insurance Commissioners' reports and independent judgments of the soundness of the health service corporation's financial condition, as evidenced by the rating and reports of reliable professional financial services.

C.17:48E-37.4 Suspension, revocation of authority to do business.

34. The commissioner may suspend or revoke the authority to do business in this State of any health service corporation that does not comply with the provisions of sections 31 through 35 of P.L.2014, c.81 (C.17:48E-37.1 through C.17:48E-37.5).

C.17:48E-37.5 Rules, regulations.

35. The commissioner may promulgate regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to effectuate the purposes of sections 31 through 35 of P.L.2014, c.81 (C.17:48E-37.1 through C.17:48E-37.5). Such rules and regulations shall be consistent with the standards for risk based capital for health organizations adopted by the National Association of Insurance Commissioners.

C.17:48F-17.1 Definitions.

36. As used in sections 36 through 40 of P.L.2014, c.81 (C.17:48F-17.1 through C.17:48F-17.5):

“Commissioner” means the Commissioner of Banking and Insurance.

“Prepaid prescription service organization” means an entity authorized to transact business in this State pursuant to P.L.1997, c.380 (C.17:48F-1 et seq.).

C.17:48F-17.2 Increase in amount of capital or surplus required of prepaid prescription service organization.

37. The commissioner may increase the amount of capital or surplus required of a prepaid prescription service organization, or subsequently revise or redetermine that increase, using appropriate methods and procedures established by rules and regulations adopted by the commissioner, in order to provide adequate protection against risks affecting the prepaid prescription service organization's financial condition that are not adequately or fully covered by its reserves or other assets, but under no circumstances shall a prepaid prescription service organization's capital or surplus be less than the capital or surplus required pursuant to regulation as prescribed by the commissioner; provided, however, that any increase required by a subsequent revision or redetermination pursuant to this section shall be made only after a departmental hearing, unless that hearing is waived by the affected prepaid prescription service organization. All matters pertaining to a hearing or to an

increase in capital or surplus pursuant to this section shall be confidential and not subject to subpoena or public inspection, except to the extent that the commissioner finds release of that information necessary to protect the public. The hearing shall be initiated within 20 days after written notice to the prepaid prescription service organization. Any declaration regarding an increase required by a subsequent revision or redetermination shall contain findings specifying the factors deemed significant in regard to the particular prepaid prescription service organization, and shall set forth the reasons supporting the increase of capital or surplus ordered by the commissioner. In determining any increase, revision or redetermination in the amount of capital or surplus, the commissioner shall consider the risks of:

a. Increases or decreases in the frequency and severity of losses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates that the prepaid prescription service organization charged for coverage and above or below those reasonably expected under normal conditions;

b. Increases or decreases in expenses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates the prepaid prescription service organization charged for coverage and above or below those reasonably expected under normal conditions;

c. Increases or decreases in the value of, or return on, invested assets under normal operating conditions, as well as increases or decreases in those values, above or below those levels anticipated under normal conditions;

d. Changes in economic, social or market conditions that could adversely or favorably affect the financial condition of the prepaid prescription service organization, including conditions that would make liquidity more or less important than contemplated and would prevent or facilitate timely investments or force or prohibit untimely sales of assets; and

e. Any other contingencies, including reinsurance and unfunded or extra contractual obligations, which may affect the prepaid prescription service organization's financial condition.

C.17:48F-17.3 Determination of increase, revision or redetermination; factors.

38. In determining any increase, revision or redetermination in the capital or surplus of a prepaid prescription service organization pursuant to the provisions of section 37 of P.L.2014, c.81 (C.17:48F-17.2) the commissioner shall take into account the following factors:

a. Methods and techniques used to measure risk exposure and variability;

b. The information available relating to the magnitude of the various risks described in section 37 of P.L.2014, c.81 (C.17:48F-17.2);

c. The extent to which risks described in section 37 of P.L.2014, c.81 (C.17:48F-17.2) are independent or interrelated, and whether any dependency is direct or inverse;

d. The extent to which the prepaid prescription services organization has provided protection against contingencies in ways other than the establishment of surplus, including, but not limited to: redundancy of premiums; margin in reserves and liabilities; adjustability of contracts pursuant to the terms of the contracts; voluntary or mandatory investment valuation reserves; reinsurance; the use of conservative actuarial assumptions to provide a margin of security; reserve adjustments after rate increases for policies written at earlier and less adequate rates; contingency or catastrophe reserves; and diversification of assets and underwriting risk; and

e. Any other relevant factors, including the National Association of Insurance Commissioners' reports and independent judgments of the soundness of the prepaid prescription service organization's financial condition, as evidenced by the rating and reports of reliable professional financial services.

C.17:48F-17.4 Suspension, revocation of authority to do business.

39. The commissioner may suspend or revoke the authority to do business in this State of any prepaid prescription services organization that does not comply with the provisions of sections 36 through 40 of P.L.2014, c.81 (C.17:48F-17.1 through C.17:48F-17.5).

C.17:48F-17.5 Rules, regulations.

40. The commissioner may promulgate regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to effectuate the purposes of sections 36 through 40 of P.L.2014, c.81 (C.17:48F-17.1 through C.17:48F-17.5). Such rules and regulations shall be consistent with the standards for risk based capital for health organizations adopted by the National Association of Insurance Commissioners.

C.17:48H-22.1 Definitions.

41. As used in sections 41 through 45 of P.L.2014, c.81 (C.17:48H-22.1 through C.17:48H-22.5):

“Commissioner” means the Commissioner of Banking and Insurance.

“Licensed organized delivery system” means an entity authorized to transact business in this State as a licensed organized delivery system pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

C.17:48H-22.2 Increase in amount of capital or surplus required of licensed organized delivery system.

42. The commissioner may increase the amount of capital or surplus required of a licensed organized delivery system, or subsequently revise or redetermine that increase, using appropriate methods and procedures established by rules and regulations adopted by the commissioner, in order to provide adequate protection against risks affecting the licensed organized delivery system's financial condition that are not adequately or fully covered by its reserves or other assets, but under no circumstances shall a licensed organized delivery system's capital or surplus be less than the capital or surplus required pursuant to regulation as prescribed by the commissioner; provided, however, that any increase required by a subsequent revision or redetermination pursuant to this section shall be made only after a departmental hearing, unless that hearing is waived by the affected licensed organized delivery system. All matters pertaining to a hearing or to an increase in capital or surplus pursuant to this section shall be confidential and not subject to subpoena or public inspection, except to the extent that the commissioner finds release of that information necessary to protect the public. The hearing shall be initiated within 20 days after written notice to the licensed organized delivery system. Any declaration regarding an increase required by a subsequent revision or redetermination shall contain findings specifying the factors deemed significant in regard to the particular licensed organized delivery system, and shall set forth the reasons supporting the increase of capital or surplus ordered by the commissioner. In determining any increase, revision or redetermination in the amount of capital or surplus, the commissioner shall consider the risks of:

a. Increases or decreases in the frequency and severity of losses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates that the licensed organized delivery system charged for coverage and above or below those reasonably expected under normal conditions;

b. Increases or decreases in expenses under normal operating conditions, as well as increases or decreases in those values, above or below the levels contemplated by the rates the licensed organized delivery system charged for coverage and above or below those reasonably expected under normal conditions;

c. Increases or decreases in the value of, or return on, invested assets under normal operating conditions, as well as increases or decreases in those values, above or below those levels anticipated under normal conditions;

d. Changes in economic, social or market conditions that could adversely or favorably affect the financial condition of the licensed organized delivery system, including conditions that would make liquidity more or less important than contemplated and would prevent or facilitate timely investments or force or prohibit untimely sales of assets; and

e. Any other contingencies, including reinsurance and unfunded or extra contractual obligations, which may affect the licensed organized delivery system's financial condition.

C.17:48H-22.3 Determination of increase, revision or redetermination; factors.

43. In determining any increase, revision or redetermination in the capital or surplus of a licensed organized delivery system pursuant to the provisions of section 42 of P.L.2014, c.81 (C.17:48H-22.2) the commissioner shall take into account the following factors:

a. Methods and techniques used to measure risk exposure and variability;

b. The information available relating to the magnitude of the various risks described in section 42 of P.L.2014, c.81 (C.17:48H-22.2);

c. The extent to which risks described in section 42 of P.L.2014, c.81 (C.17:48H-22.2) are independent or interrelated, and whether any dependency is direct or inverse;

d. The extent to which the licensed organized delivery system has provided protection against contingencies in ways other than the establishment of surplus, including, but not limited to: redundancy of premiums; margin in reserves and liabilities; adjustability of contracts pursuant to the terms of the contracts; voluntary or mandatory investment valuation reserves; reinsurance; the use of conservative actuarial assumptions to provide a margin of security; reserve adjustments after rate increases for policies written at earlier and less adequate rates; contingency or catastrophe reserves; and diversification of assets and underwriting risk; and

e. Any other relevant factors, including the National Association of Insurance Commissioners' reports and independent judgments of the soundness of the licensed organized delivery system's financial condition, as evidenced by the rating and reports of reliable professional financial services.

C.17:48H-22.4 Suspension, revocation of authority to do business.

44. The commissioner may suspend or revoke the authority to do business in this State of any licensed organized delivery system that does not comply with the provisions of sections 41 through 45 of P.L.2014, c.81 (C.17:48H-22.1 through C.17:48H-22.5).

C.17:48H-22.5 Rules, regulations.

45. The commissioner may promulgate regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to effectuate the purposes of

sections 41 through 45 of P.L.2014, c.81 (C.17:48H-22.1 through C.17:48H-22.5). Such rules and regulations shall be consistent with the standards for risk based capital for health organizations adopted by the National Association of Insurance Commissioners.

C.17:23-27 Purpose of sections C.17:23-27 through C.17:23-37.

46. a. The purpose of sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) is to provide the requirements for maintaining a risk management framework and completing an Own Risk and Solvency Assessment (ORSA) and provide guidance and instructions for filing an ORSA Summary Report with the Commissioner of Banking and Insurance.

b. The requirements of sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) shall apply to all insurers domiciled in this State unless exempt pursuant to section 51 of P.L.2014, c.81 (C.17:23-32).

c. The Legislature finds and declares that the ORSA Summary Report shall contain confidential and sensitive information related to an insurer or insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information will include proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. It is the intent of this Legislature that, notwithstanding any other law to the contrary, the ORSA Summary Report shall be a confidential document filed with the commissioner, that the ORSA Summary Report shall be shared only as stated herein and to assist the commissioner in the performance of his or her duties, and that in no event shall the ORSA Summary Report be subject to public disclosure.

C.17:23-28 Definitions.

47. For the purposes of sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37):

"Commissioner" means the Commissioner of Banking and Insurance.

"Insurance group" for the purpose of conducting an ORSA, means those insurers and affiliates included within an insurance holding company system as defined in P.L.1970, c.22 (C.17:27A-1 et seq.).

"Insurer" shall have the same meaning as set forth in section 2 of P.L.1993, c.236 (C.17:23-21), except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

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

"ORSA Guidance Manual" means the current version of the *Own Risk and Solvency Assessment Guidance Manual* developed and adopted by the National Association of Insurance Commissioners (NAIC) and as amended from time to time. A change in the ORSA Guidance Manual shall be effective on the January 1 following the calendar year in which the changes have been adopted by the NAIC.

"ORSA Summary Report" means a confidential high-level summary of an insurer or insurance group's ORSA.

C.17:23-29 Maintenance of risk management framework.

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

C.17:23-30 ORSA conducted, process.

49. Except as provided in section 51 of P.L.2014, c.81 (C.17:23-32), an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

C.17:23-31 Submission of ORSA Summary Report.

50. a. Upon the commissioner's request, and no more than once each year, an insurer shall submit to the commissioner an ORSA Summary Report or any combination of reports that together contain the information described in the ORSA Guidance Manual applicable to the insurer or the insurance group of which it is a member. Notwithstanding any request from the commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report or reports required by this subsection if the commissioner is the lead state commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

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

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

C.17:23-32 Exemptions.

51. a. An insurer shall be exempt from the requirements of sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37), if:

(1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, less than $500,000,000; and

(2) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, less than $1,000,000,000.

b. If an insurer qualifies for exemption pursuant to paragraph (1) of subsection a. of this section, but the insurance group of which the insurer is a member does not qualify for exemption pursuant to paragraph (2) of subsection a. of this section, then the ORSA Summary Report that may be required pursuant to section 50 of P.L.2014, c.81 (C.17:23-31), shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA Summary Report for any combination of insurers so long as any combination of reports includes every insurer within the insurance group.

c. If an insurer does not qualify for exemption pursuant to paragraph (1) of subsection a. of this section, but the insurance group of which it is a member qualifies for exemption pursuant to paragraph (2) of subsection a. of this section, then the only ORSA Summary Report that may be required pursuant to section 50 of P.L.2014, c.81 (C.17:23-31) shall be the report applicable to that insurer.

d. An insurer that does not qualify for exemption pursuant to subsection a. of this section may apply to the commissioner for a waiver from the requirements of sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

e. Notwithstanding the exemptions stated in this section:

(1) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

(2) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report if:

(a) the insurer has risk-based capital for a company action level event as set forth in applicable regulations of this State governing risk-based capital;

(b) meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in applicable regulations of this State defining standards and commissioner's authority over companies deemed to be in hazardous financial condition; or

(c) otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

f. If an insurer that qualifies for an exemption pursuant to subsection a. of this section subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one year following the year in which the threshold is exceeded to comply with the requirements of sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37).

C.17:23-33 Preparation, review of ORSA Summary Report.

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

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

C.17:23-34 Documents, materials deemed proprietary and containing trade secrets.

53. a. Documents, materials or other information, including the ORSA Summary Report, in the possession of or control of the Department of Banking and Insurance that are obtained by, created by or disclosed to the commissioner or any other person pursuant to sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37), shall be recognized by this State as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to P.L.1963, c.71 (C.47:1A-1 et seq.), shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer.

b. Neither the commissioner nor any person who received documents, materials or other ORSA-related information, through examination or otherwise, while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection a. of this section.

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

(1) May, upon request, share documents, materials or other ORSA-related information, including the confidential and privileged documents, materials or information subject to subsection a. of this section, including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in section 7 of P.L.2014, c.81 (C.17:27A-5.1), with the National Association of Insurance Commissioners (NAIC) and with any third-party consultants designated by the commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality; and

(2) May receive documents, materials or other ORSA-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as defined in section 7 of P.L.2014, c.81 (C.17:27A-5.1), and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

(3) Shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37), consistent with this subsection c. that shall:

(a) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to sections 46 through

56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37), including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(b) Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) remains with the commissioner, and the NAIC's or a third-party consultant's use of the information is subject to the direction of the commissioner;

(c) Prohibit the NAIC or third-party consultant from storing the information shared pursuant to sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) in a permanent database after the underlying analysis is completed;

(d) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production;

(e) Require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37); and

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

d. The sharing of information and documents by the commissioner pursuant to sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37).

e. No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other ORSA-related information shall occur as a result of disclosure of such ORSA-related information or documents to the commissioner pursuant to this section or as a result of sharing as authorized in sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37).

f. Documents, materials or other information in the possession or control of the NAIC or a third-party consultants pursuant to sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) shall be confidential by law and privileged, shall not be subject to P.L.1963, c.71 (C.47:1A-1 et seq.), shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

C.17:23-35 Failure to file ORSA Summary Report; penalty.

54. Any insurer failing, without just cause, to timely file the ORSA Summary Report as required in sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) shall be required, after notice and opportunity for a hearing, to pay a penalty of up to $5,000 for each day's delay, to be recovered by the commissioner and the penalty so recovered shall be paid into the General Fund of this State.

C.17:23-36 Severability.

55. If any provision of sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37), or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) which can be given effect without the invalid provision or application, and to that end the provisions of sections 46 through 56 of P.L.2014, c.81 (C.17:23-27 through C.17:23-37) are severable.

C.17:23-37 First filing of ORSA Summary Report in 2015.

56. The first filing of the ORSA Summary Report shall be in 2015 pursuant to section 50 of P.L.2014, c.81 (C.17:23-31).

57. Section 6 of P.L.1996, c.45 (C.17:1-15) is amended to read as follows:

C.17:1-15 Duties, authority of commissioner.

6. The commissioner, as administrator and chief executive officer of the department, shall:

a. Administer the work of the department;

b. Appoint and remove officers and other personnel employed within the department, subject to the provisions of Title 11A of the New Jersey Statutes, and other applicable statutes, except as otherwise specifically provided;

c. Perform, exercise and discharge the functions, powers and duties of the department through those divisions established by law or as the commissioner deems necessary;

d. Organize the work of the department pursuant to the structure or organizational units the commissioner determines to be necessary for efficient and effective operation, and which are not inconsistent with the provisions of this 1996 amendatory and supplementary act;

e. Formulate, adopt, issue and promulgate, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), in the name of the department, rules and regulations authorized by law for the efficient conduct of the work and general administration of the department, and the appropriate regulation of the institutions, companies, agencies, boards, commissions, and other entities within its jurisdiction, including licensees, officers and employees as authorized by law;

f. Determine all matters of policy within the commissioner's jurisdiction;

g. Institute or cause to be instituted the legal proceedings or processes necessary to enforce properly and give effect to any of the commissioner's powers or duties;

h. Make a report each year to the Governor and to the Legislature of the department's operations for the preceding fiscal year, and render such other reports as the Governor shall from time to time request, or as may be required by law;

i. Appoint advisory committees which may be desirable to advise and assist the department or a division in carrying out its functions and duties;

j. Have the power, in addition to any powers prescribed by law, to order any person violating any provision of Title 17 of the Revised Statutes or Title 17B of the New Jersey Statutes to cease and desist from engaging in such conduct;

k. Perform such other functions as may be prescribed by law in this act or by any other law; and

l. Maintain suitable headquarters for the department and such other quarters as the commissioner shall deem necessary to the proper functioning of the department.

C.17B:19-1.1 Definitions.

58. For the purposes of chapter 19 of Title 17B of the New Jersey Statutes, N.J.S.17B:25-19, and sections 58, 60, 63, 64, 65 and 66 of P.L.2014, c.81 (C.17B:19-1.1, C.17B:19-2.1, C.17B:19-11, C.17B:19-12, C.17B:19-13 and C.17B:19-14) the following definitions shall apply on or after the operative date of the valuation manual:

"Accident and health insurance" means a contract that incorporates morbidity risk and provides protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

"Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in subsection e. of section 2 of P.L.1995, c.339 (C.17B:19-10).

"Company" means an entity, which:

(1) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this State and has at least one such policy in force or on claim; or

(2) 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 this State.

"Deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

"Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

"NAIC" means the National Association of Insurance Commissioners.

"Policyholder behavior" means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to sections 58, 60, 63, 64, 65 and 66 of P.L.2014, c.81 (C.17B:19-1.1, C.17B:19-2.1, C.17B:19-11, C.17B:19-12, C.17B:19-13 and C.17B:19-14) including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

"Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with section 64 of P.L.2014, c.81 (C.17B:19-12) as specified in the valuation manual.

"Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

"Tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

"Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in sections 58, 60, 63, 64, 65 and 66 of P.L.2014, c.81 (C.17B:19-1.1, C.17B:19-2.1, C.17B:19-11, C.17B:19-12, C.17B:19-13 and C.17B:19-14) or as subsequently amended.

59. N.J.S.17B:19-2 is amended to read as follows:

Annual valuation of reserve liabilities for outstanding policies; foreign and alien insurers.

17B:19-2. The commissioner 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 doing business in this State issued prior to the operative date of the valuation manual, except that in the case of an alien insurer, such valuation shall be limited to its United States business, and 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 the calculation of such reserves. All valuations made by him or by his authority shall be upon the net premium basis or such modifications thereof as are provided by law. In calculating such reserves, he may use group methods and approximate averages for fractions of a year or otherwise and, with the concurrence of the insurer, make classifications of benefits by years of issue according to such relevant factors as the date as of which the rated age of the insured is determined, the date as of which the benefits have been provided or the premium rates have been changed, or, for policies under which premium rates are guaranteed for a limited period of time, the most recent date as of which the insurer had the right to modify those premium rates. In lieu of the valuation of the reserves herein required of any foreign or alien insurer, he 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 standards provided by law and if the official of such state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the commissioner 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.

Any such insurer which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standards provided by law may, with the approval of the commissioner, adopt any lower standard of valuation, but not lower than the minimum standards so provided.

Except in the case of policies for which the reserve liabilities are valued on the basis of the provisions of the standard valuation law contained in N.J.S.17B:19-8 or policies issued on or after the operative date of the valuation manual, all valuations made by the commissioner or by his authority shall be upon the net premium basis, or such modification thereof as hereinafter expressly provided; and all policies issued prior to January 1, 1901, shall be valued according to the actuaries' table of mortality, with compound interest at the rate of 4% per annum, except in cases where a life insurer elects or has elected to have the policies or any class thereof valued according to the American Experience table of mortality, or according to the American Men Ultimate table of mortality, with compound interest at the rate of either 3% or 3 1/2 % per annum or with the approval of the commissioner at a rate of less than 3% per annum; and all policies issued on or after January 1, 1901, shall be valued according to the American Experience table of mortality, with compound interest at the rate of 3 1/2 % per annum, except in cases where a life insurer elects or has elected to have such policies or any class thereof valued according to the American Experience table of mortality with compound interest at a rate of less than 3 1/2% per annum but not less than 3% per annum or with the approval of the commissioner at a rate of less than 3% per annum; and except in cases where any life insurer with the approval of the commissioner may elect or shall have elected to have its ordinary policies or any class thereof valued according to the American Men Ultimate table of mortality, with compound interest at a rate which is not more than 3 1/2% per annum. The minimum standard for the valuation of group term

insurance policies under which premium rates are not guaranteed for a period in excess of 5 years shall be the American Men Ultimate table of mortality with interest at 3 1/2 % per annum. The commissioner may vary the standards of interest and mortality in the case of annuities and industrial policies and of invalid lives and other extra hazards. When the actual premium charged for an insurance policy is less than the net premium for the insurance, computed according to the table of mortality, and the rate of interest prescribed herein, the value of the policy shall be increased by the value of an annuity, the amount of which shall equal the difference between the premiums and the term of which in years shall equal the number of future annual payments receivable on the insurance after the date of valuation.

Reserves for all policies and contracts to which the foregoing standards apply may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by this section.

C.17B:19-2.1 Annual valuation of reserve liabilities.

60. The commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any State or other jurisdiction when the valuation complies with the minimum standard provided in sections 58, 60, 63, 64, 65 and 66 of P.L.2014, c.81 (C.17B:19-1.1, C.17B:19-2.1, C.17B:19-11, C.17B:19-12, C.17B:19-13 and C.17B:19-14). The provisions set forth in sections 63 and 64 of P.L.2014, c.81 (C.17B:19-11 and C.17B:19-12) shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

61. N.J.S.17B:19-5 is amended to read as follows:

Calculations of policy and loss reserves for accident and health insurance.

17B:19-5. The commissioner shall annually make or cause to be made or shall annually require the insurer to make calculations of policy and loss reserves for accident and health insurance written by insurers authorized to write accident and health insurance in this State as defined in N.J.S.17B:17-4. The commissioner shall promulgate regulations establishing the minimum standards applicable to the valuation of accident and health insurance reserves.

62. Section 2 of P.L.1995, c.339 (C.17B:19-10) is amended to read as follows:

C.17B:19-10 Reserves, related actuarial items; annual opinion of qualified actuary.

2. a. For years ending prior to the operative date of the valuation manual, every insurer authorized to transact life, health or annuity business and every fraternal benefit society doing business in this State shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation are: computed appropriately; based on assumptions which satisfy contractual provisions; and consistent with prior reported amounts and comply with applicable laws of this State. The commissioner shall define by regulation the specifics of this opinion and add such other items deemed to be necessary to its scope.

b. (1) Every insurer authorized to transact life, health or annuity business and every fraternal benefit society, except as exempted by the commissioner by regulation, shall also annually include in the opinion required pursuant to subsection a. 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 commissioner by regulation, when considered in light of the assets held by the insurer or society 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 or society's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

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

c. Each opinion required pursuant to subsection b. of this section shall be governed by the following provisions:

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

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

d. Every opinion shall be governed by the following provisions:

(1) The opinion shall be submitted with the annual statement reflecting the valuation of reserves for each year ending on or after December 31, 1995.

(2) The opinion shall apply to all policies or contracts in force, including individual and group health insurance plans, in form and substance acceptable to the commissioner 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 commissioner may by regulation prescribe.

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

(5) (Deleted by amendment, P.L.2014, c.81)

(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, the fraternal benefit society and the commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion.

(7) Disciplinary action by the commissioner against the insurer, fraternal benefit society or the qualified actuary shall be defined in regulation by the commissioner.

(8) (Deleted by amendment, P.L.2014, c.81)

e. On or after the operative date of the valuation manual, every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this State and subject to regulation by the commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this State. The valuation manual will prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

f. Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this State and subject to regulation by the commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by subsection e. of this section, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including 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 company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

g. Each opinion required by subsection e. of this section shall be governed by the following provisions:

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

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

h. Every opinion required by subsection e. of this section shall be governed by the following provisions:

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

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

(3) The opinion shall apply to all policies and contracts subject to subsection f. of this section, plus other actuarial liabilities as may be specified in the valuation manual.

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

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

(6) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person, other than the insurance company and the commissioner,

for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion.

(7) Disciplinary action by the commissioner against the company or the appointed actuary shall be prescribed and defined in regulations by the commissioner.

C.17B:19-11 Standards for policies issued on or after operative date of valuation manual.

63. a. For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under section 60 of P.L.2014, c.81 (C.17B:19-2.1) except as provided under subsection e. or g. of this section.

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

(1) The valuation manual has been adopted by the NAIC by an affirmative vote of at least 42 members, or three-fourths of the members voting, whichever is greater.

(2) The NAIC Model Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by States representing greater than 75% of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

(3) The NAIC Model Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions: The 50 States of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

c. Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when all of the following have occurred:

(1) The change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

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

(b) Members of the NAIC representing jurisdictions totaling greater than 75% of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subparagraph (a) of paragraph (1) of this subsection: life, accident and health annual statements, health annual statements, or fraternal annual statements.

(2) No later than 30 days before the operative date of the valuation manual or any changes thereto adopted by the NAIC, the commissioner shall by order notify all companies as defined in section 58 of P.L.2014, c.81 (C.17B:19-1.1) of the adoption and its operative date. Failure to provide this notice shall not delay the operative date of the valuation manual or any changes thereto.

d. The valuation manual must specify all of the following:

(1) Minimum valuation standards for and definitions of the policies or contracts subject to section 60 of P.L.2014, c.81 (C.17B:19-2.1). Such minimum valuation standards shall be:

(a) The commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to section 60 of P.L.2014, c.81 (C.17B:19-2.1);

(b) The commissioner's annuity reserve valuation method for annuity contracts subject to section 60 of P.L.2014, c.81 (C.17B:19-2.1); and

(c) Minimum reserves for all other policies or contracts subject to section 60 of P.L.2014, c.81 (C.17B:19-2.1);

(2) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in subsection a. of section 64 of P.L.2014, c.81 (C.17B:19-12) and the minimum valuation standards consistent with those requirements;

(3) For policies and contracts subject to a principle-based valuation under section 64 of P.L.2014, c.81 (C.17B:19-12):

(a) Requirements for the format of reports to the commissioner under paragraph (3) of subsection b. of section 64 of P.L.2014, c.81 (C.17B:19-12) and which shall include information necessary to determine if the valuation is appropriate and in compliance with sections 58, 60, 63, 64, 65 and 66 of P.L.2014, c.81 (C.17B:19-1.1, C.17B:19-2.1, C.17B:19-11, C.17B:19-12, C.17B:19-13 and C.17B:19-14);

(b) Assumptions shall be prescribed for risks over which the company does not have significant control or influence**.**

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

(4) For policies not subject to a principle-based valuation under section 64 of P.L.2014, c.81 (C.17B:19-12) the minimum valuation standard shall either:

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

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

(5) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls; and

(6) The data and form of the data required under section 65 of P.L.2014, c.81 (C.17B:19-13) with whom the data must be submitted, and may specify other requirements, including data analyses and reporting of analyses.

e. In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with sections 58, 60, 63, 64, 65 and 66 of P.L.2014, c.81 (C.17B:19-1.1, C.17B:19-2.1, C.17B:19-11, C.17B:19-12, C.17B:19-13 and C.17B:19-14), then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the commissioner by regulation.

f. The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in sections 58, 60, 63, 64, 65 and 66 of P.L.2014, c.81 (C.17B:19-1.1, C.17B:19-2.1, C.17B:19-11, C.17B:19-12, C.17B:19-13 and C.17B:19-14). The commissioner may rely upon the opinion, regarding provisions contained within sections 58, 60, 63, 64, 65 and 66 of P.L.2014, c.81 (C.17B:19-1.1, C.17B:19-2.1, C.17B:19-11, C.17B:19-12, C.17B:19-13 and C.17B:19-14), of a qualified actuary engaged by the commissioner of another state, district or territory of the United States.

As used in this subsection f., the term "engage" includes employment and contracting.

g. The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of

the valuation manual or sections 58, 60, 63, 64, 65 and 66 of P.L.2014, c.81 (C.17B:19-1.1, C.17B:19-2.1, C.17B:19-11, C.17B:19-12, C.17B:19-13 and C.17B:19-14); and the company shall adjust the reserves as required by the commissioner. The commissioner may suspend or revoke the authority to do business in this State of any company and impose a fine, after notice and a hearing, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) if it fails to comply with any provision of law obligatory upon it under sections 58, 60, 63, 64, 65 and 66 of P.L.2014, c.81 (C.17B:19-1.1, C.17B:19-2.1, C.17B:19-11, C.17B:19-12, C.17B:19-13 and C.17B:19-14).

C.17B:19-12 Establishment of reserves using principle-based valuation.

64. a. A company shall establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(1) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk.

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

(3) Incorporate assumptions that are derived in one of the following manners:

(a) The assumption is prescribed in the valuation manual.

(b) For assumptions that are not prescribed, the assumptions shall:

(i) Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

(ii) To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

(4) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

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

(1) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(2) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

(3) Develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

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

C.17B:19-13 Submission of certain data.

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

C.17B:19-14 “Confidential information.”

66. a. For purposes of this section “confidential information” means:

(1) A memorandum in support of an opinion submitted under section 2 of P.L.1995, c.339 (C.17B:19-10) and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such a memorandum;

(2) All documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under subsection f. of section 63 of P.L.2014, c.81 (C.17B:19-11); provided, however, that if an examination report or other material prepared in connection with an examination made under N.J.S.17B:21-1 is not held as private and confidential information under N.J.S.17B:21-1, an examination report or other material prepared in connection with an examination made under subsection f. of section 63 of P.L.2014, c.81 (C.17B:19-11) shall not be confidential information to the same extent as if such examination report or other material had been prepared under N.J.S.17B:21-1;

(3) Any reports, documents, materials and other information developed by a company in support of, or in connection with, an annual certification by the company under subsection b. of section 64 of P.L.2014, c.81 (C.17B:19-12) evaluating the effectiveness of the company’s internal controls with respect to a principle-based valuation and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such reports, documents, materials and other information;

(4) Any principle-based valuation report developed under paragraph (3) of subsection b. of section 64 of P.L.2014, c.81 (C.17B:19-12) and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with that report; and

(5) Any documents, materials, data and other information submitted by a company under section 65 of P.L.2014, c.81 (C.17B:19-13), collectively, “experience data,” and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner, together with any “experience data,” the “experience materials,” and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such experience materials.

b. (1) Except as provided in this section, a company’s confidential information is confidential by law and privileged, and shall not be subject to P.L.1963, c.73 (C.47:1A-1 et seq.), shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, that the commissioner is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner’s official duties.

(2) Neither the commissioner nor any person who received confidential information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential information.

(3) In order to assist in the performance of the commissioner's duties, the commissioner may share confidential information: (a) with other state, federal and international regulatory agencies and with the National Association of Insurance Commissioners (NAIC) and its affiliates and subsidiaries; and (b) in the case of confidential information specified in paragraphs (1) and (2) of subsection a. of this section only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings; and (c) with state, federal and international law enforcement officials; in the case of (a) and (b), provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data and other information in the same manner and to the same extent as required for the commissioner.

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

(5) The commissioner may enter into agreements governing sharing and use of information consistent with this section.

(6) No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in paragraph (3) of this subsection b.

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

(8) For purposes of this section "regulatory agency," "law enforcement agency" and the "NAIC" shall include, but shall not be limited to, their employees, agents, consultants and contractors.

c. Notwithstanding subsection b. of this section, any confidential information specified in paragraphs (1) and (4) of subsection a. of this section:

(1) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under section 2 of P.L.1995, c.339 (C.17B:19-10) or principle-based valuation report developed under subsection b. of section 64 of P.L.2014, c.81 (C.17B:19-12) by reason of an action required by sections 58, 60, 63, 64, 65 and 66 of P.L.2014, c.81 (C.17B:19-1.1, C.17B:19-2.1, C.17B:19-11, C.17B:19-12, C.17B:19-13 and C.17B:19-14) or by regulations promulgated hereunder;

(2) May otherwise be released by the commissioner with the written consent of the company; and

(3) Once any portion of a memorandum in support of an opinion submitted under section 2 of P.L.1995, c.339 (C.17B:19-10) or a principle-based valuation report developed under subsection b. of section 64 of P.L.2014, c.81 (C.17B:19-12) is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

67. N.J.S.17B:25-19 is amended to read as follows:

Standard nonforfeiture law for life insurance.

17B:25-19. This section shall be known as the standard nonforfeiture law for life insurance.

a. No policy of life insurance, except as stated in subsection l., shall be delivered or issued for delivery in this State unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the commissioner 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 k. of this section:

(1) That, in the event of default in any premium payment, the insurer will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of 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 60 days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(2) That, upon surrender of the policy within 60 days after the due date of any premium payment in default after premiums have been paid for at least 3 full years in the case of ordinary insurance or 5 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 60 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 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 30 days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

(5) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality tables and interest rates used in calculating the cash surrender values and the mortality tables and interest rates used in calculating 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 20 policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy.

(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 cash surrender values and paid-up nonforfeiture 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 foregoing provisions 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 6 months after demand therefor with surrender of the policy.

b. (Deleted by amendment; P.L.1981, c.285.)

c. Any cash surrender value available under any policy referred to in subsection a. in the event of default in a premium payment due on any policy anniversary, whether or not required by subsection a., shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of (1) the then present value of the adjusted premiums as defined in subsection g., corresponding to premiums which would have fallen due on and after such anniversary, and (2) the amount of any indebtedness to the insurer on the policy.

Provided, however, that for any policy issued on or after the operative date provided for in paragraph (xi) of subsection h. of N.J.S.17B:25-19, 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 of this subsection shall be an amount not less than the sum of the cash surrender value as defined in that paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in that paragraph for a policy which 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 provided for in paragraph (xi) of subsection h., 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 71, the cash surrender value referred to in the first paragraph of this subsection shall be an amount not less than the sum of the cash surrender value as defined in that paragraph for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in that paragraph for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

Any cash surrender value available within 30 days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or nor required by subsection a., 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.

d. Any paid-up nonforfeiture benefit available under any policy referred to in subsection a. 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 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.

e. (Deleted by amendment; P.L.1981, c.285.)

f. (Deleted by amendment; P.L.1981, c.285.)

g. This subsection shall not apply to policies issued on or after the operative date of subsection h. as defined therein. Except as provided in the third paragraph of this subsection, the adjusted premiums for any policy referred to in subsection a. shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of (1) the then present value of the future guaranteed benefits provided for by the policy; (2) 2% of the amount of insurance, if the insurance be uniform in amount or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (3) 40% of the adjusted premium for the first policy year; (4) 25% of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less; provided, however, that in applying the percentages specified in (3) and (4) above, no adjusted premium shall be deemed to exceed 4% 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.

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 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age 10 were the amount provided by such policy at age 10.

The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (a) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (b) the adjusted premiums for such term insurance, the foregoing items (a) and (b) being calculated separately and as specified in the first two paragraphs of this subsection except that, for the purpose of (2), (3) and (4) of the first such paragraph, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a).

All adjusted premiums and present values referred to in this subsection shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table. Notwithstanding this provision, for any category of ordinary insurance such calculations may be made, at the option of the insurer, on the basis of the Approved Standard Ordinary Mortality Table; provided, further, that for any category of

ordinary insurance issued on female risks adjusted premiums and present values may be calculated, at the option of the insurer with approval of the commissioner, according to an age not more than 6 years younger than the actual age of the insured. Such calculations for all policies of industrial insurance shall be made on the basis of the Commissioners 1961 Standard Industrial Mortality Table.

All calculations shall be made on the basis of the applicable rates of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits not exceeding 5 1/2 % per annum. 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 the rates shown in the Commissioners 1958 Extended Term Insurance Table if the adjusted premiums for the policy are calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table, may be not more than 130% of the rates shown in the Approved Standard Ordinary Mortality Table if the adjusted premiums for the policy are calculated on the basis of said table, and may be not more than the rates shown in the Commissioners 1961 Industrial Extended Term Insurance Table if the adjusted premiums for the policy are calculated on the basis of the Commissioners 1961 Standard Industrial Mortality 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 commissioner.

h. (i) This subsection h. shall apply to all policies issued on or after the operative date established by paragraph (xi) of this subsection h. Except as provided in paragraph (vii) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of the policy, of all 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) 1% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and (C) 125% of the nonforfeiture net level premium as defined in paragraph (ii). Provided, however, that in applying the percentage specified in (C) above no nonforfeiture net level premium shall be deemed to exceed 4% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

(ii) 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.

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

change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(iv) Except as otherwise provided in paragraph (vii) 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.

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

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

(A) equals the sum of 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 occurred, and 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 or change on which a premium falls due.

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

(viii) For purposes of this subsection, the term “operative date of the valuation manual” means the January 1 of the first calendar year that the valuation manual as defined in section 58 of P.L.2014, c.81 (C.17B:19-1.1) is effective. All adjusted premiums and present values referred to in this subsection 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 10-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 paragraph (ix) of this subsection for policies issued in that calendar year. Provided, however, that:

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 section, for policies issued in the immediately preceding calendar year.

Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection a., 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.

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 not lower than that specified in the policy for calculating cash surrender values.

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 for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.

For insurance issued on a substandard basis, the calculation of such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.

For policies issued prior to the operative date of the valuation manual, any Commissioners Standard ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without 10-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table.

For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners Standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the commissioner approves by regulation any Commissioners Standard ordinary mortality table 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 supersedes the minimum nonforfeiture standard provided by the valuation manual.

For policies issued prior to the operative date of the valuation manual, any Commissioners Standard industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the commissioner 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.

For policies issued on or after the operative date of the valuation manual the valuation manual shall provide the Commissioners Standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the commissioner approves by regulation any Commissioners Standard industrial mortality table 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 supersedes the minimum nonforfeiture standard provided by the valuation manual.

(ix) For purposes of this subsection, the term “operative date of the valuation manual” means the January 1 of the first calendar year that the valuation manual as defined in section 58 of P.L.2014, c.81 (C.17B:19-1.1) is effective.

The nonforfeiture interest rate is defined below:

(1) For policies 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 125% of the calendar year statutory valuation interest rate for such policy as defined in the standard valuation law, paragraph (x) of subsection a. of N.J.S.17B:19-8, rounded to nearer 1/4 of 1%.

(2) For policies issued on or after the operative date of the valuation manual the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

(x) Notwithstanding any other provisions in this code (Title 17B) to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy forms which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(xi) After the effective date of this subsection, any insurer may file with the commissioner a written notice of its election to comply, with respect to any category of insurance, with the provisions of this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for that category of insurance for such insurer. If an insurer makes no such election with respect to any category of insurance, the operative date of this subsection for that category of insurance issued by such insurer shall be January 1, 1989.

i. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in the preceding subsections of this section, then:

the commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by the preceding subsections of this section;

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

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 standard nonforfeiture law for life insurance, as determined by regulations promulgated by the commissioner.

j. 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 or contract anniversary. All values referred to in subsections c., d., g., h. and i. 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 c., additional benefits payable (1) in the event of death or dismemberment by accident or accidental means, (2) in the event of total and permanent disability, (3) as reversionary annuity or deferred reversionary annuity benefits, (4) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply, (5) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is 26, 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 (6) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits. Notwithstanding the provisions of subsection c., additional benefits providing the privilege to purchase additional insurance benefits at some future time without furnishing evidence of insurability, and premiums therefor, may, with the consent of the commissioner, 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.

k. This subsection 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 does not differ by more than 2/10 of 1% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 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 would have been provided 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 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 c. or subsection g., whichever is applicable shall be the same as are the effects specified in subsection c. or subsection g., whichever is applicable on the cash surrender values defined therein.

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 g. or h., whichever is applicable. Except as required by the next succeeding sentence of this paragraph, such percentage:

shall 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 2/10 of 1% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and

shall be such that no percentage after the later of the two policy anniversaries specified in the preceding item may apply to fewer than 5 consecutive policy years.

Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection g., or h., 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 sections of this amendatory and supplementary act. 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 a manner consistent with that specified for determining the appropriate minimum amounts in subsections a., c., d., g., h. and i. 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 (1) through (6) in subsection j. shall conform with the principles of this subsection.

l. This section shall not apply to any of the following:

- reinsurance,
- group insurance,
- annuity contract,
- single premium pure endowment contract or single premium reversionary annuity contract,
- term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy,
- term policy of decreasing amount which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections g. and h. is less than the adjusted premium so calculated on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy,
- policy which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections c., g., and h. exceeds 2 1/2 % of the amount of insurance at the beginning of the same policy year,
- policy which shall be delivered outside this State through an agent or other representative of the insurer issuing the policy.

For the purposes of determining the applicability of this section, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

68. This act shall take effect immediately except that sections 58 through 67 of this act shall remain inoperative until the operative date of the valuation manual as provided in those sections.

Approved December 26, 2014.