EXHIBIT 1

STATE OF OHIO
DEPARTMENT OF INSURANCE
50 West Town Street, 3rd Floor, Suite 300
Columbus, Ohio 43215

IN THE MATTER OF PUBLIC HEARING FOR THE AMENDMENT OF OHIO ADMINISTRATIVE CODE SECTIONS 3901-1-07, 3901-1-13, 3901-1-24, 3901-1-48, 3901-1-54, 3901-3-19, AND 3901-7-04	:	NOTICE OF PUBLIC HEARING
IN THE MATTER OF PUBLIC HEARING FOR THE RESCISSION OF OHIO ADMINISTRATIVE CODE SECTION 3901-3-13 AND THE PROMULGATION OF OHIO ADMINISTRATIVE CODE SECTION 3901-3-13	:	NOTICE OF PUBLIC HEARING

Pursuant to section 119.03 of the Ohio Revised Code, the Superintendent of Insurance, State of Ohio, will hold a public hearing at 10:00 a.m., on Thursday, January 6, 2022, to consider the amendment of Ohio Administrative Code sections 3901-1-07 Unfair trade practices, 3901-1-13 Mortgage guaranty insurance, 3901-1-24 Public insurance adjusters, 3901-1-48 "Ohio mine subsidence insurance underwriting association" and "mine subsidence insurance fund" plan of operation, 3901-1-54 Unfair property/casualty claims settlement practices, 3901-3-19 Corporate governance annual disclosure, and 3901-7-04 Permitting the recognition of preferred mortality tables for use in determining minimum reserve liabilities. In addition, to consider the rescission and promulgation of Ohio Administrative Code section 3901-3-13 Health insurance reserves. Due to the COVID-19 pandemic and social distancing concerns, the hearing will be conducted remotely by video conferencing coordinated by the Ohio Department of Insurance ("Department"). Instructions and a web link and/or telephone number for accessing the hearing will be provided on the Department's web site, www.insurance.ohio.gov. Alternatively, a request for the web link and/or telephone number may be submitted to ecomment@insurance.ohio.gov.

The purpose of rule 3901-1-07 is to define certain additional unfair trade practices and to set forth required procedures in connection therewith. Sections 3901.20 and 3901.21 of the Revised Code respectively prohibit unfair or deceptive practices in the business of insurance and define certain acts or practices as unfair or deceptive. Section 3901.21 of the Revised Code also provides that the enumeration of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement that section.

Rule 3901-1-07 is being reviewed as part of the agency five-year rule review. Recommended amendments include amendments to formatting and correct spelling errors.

The purpose of rule 3901-1-13 is to implement division (A)(24) of section 3929.01 of the Revised Code, as it pertains to the writing and servicing of mortgage guaranty insurance as defined in (C)(1) of the rule.

Rule 3901-1-13 is being reviewed as part of the agency five-year rule review. The recommended amendments are technical - updates references to federal programs and offices.

The purpose of rule 3901-1-24 is to regulate the conduct of public insurance adjusters; the rule also provides authority for the removal of licensure due to violation.

Rule 3901-1-24 is being reviewed as part of the agency five-year rule review. Recommended amendments remove gender specific language.

The purpose of rule 3901-1-48 is to implement requirements established in ORC to establish the "Ohio Mine Subsidence Underwriting Association," provide for the transfer of risk from member insurers to the association, and create the "Mine Subsidence Insurance Fund."

Rule 3901-1-48 is being reviewed as part of the agency five-year rule review. Recommended amendments remove the superintendent from the board of governors, this reflects changes to the Ohio Revised Code in 2017, and grammatical amendments.

The purpose of rule 3901-1-54 is to set forth uniform minimum standards for the investigation and disposition of property and casualty claims arising under insurance contracts or certificates issued to residents of Ohio. It is not intended to cover claims involving workers' compensation, or fidelity, suretyship, and boiler and machinery insurance. The provisions of this rule are intended to define procedures and practices which constitute unfair claims practices.

Rule 3901-1-54 is being reviewed as part of the agency five-year rule review. The recommended amendment will correct a citation in (C)(9) of the rule.

The purpose of rule 3901-3-13 is to establish the minimum reserve standards for all individual and group health insurance coverages, including single premium credit disability insurance, as required by division (Q) of section 3903.723 of the Revised Code.

Rule 3901-3-13 is being reviewed as part of the agency five-year rule review. Recommended amendments to this rule will incorporate the latest version of the NAIC model. Updates to the model do not implement new requirements, but rather provide the updated standards for recent plan years, and those moving forward. Due to the amount of proposed amendments, the rule will be filed as rescind and ultimately filed as a new rule.

The purpose of rule 3901-3-19 is to establish the procedures for filing, and the required content of, the corporate governance annual disclosure, deemed necessary by the superintendent pursuant to sections 3901.072 to 3901.078 of the Revised Code.

Rule 3901-3-19 is being reviewed as part of the agency five-year rule review. The proposed amendment will correct a citation in paragraph (B).

The purpose of rule 3901-7-04 is to establish ownership and licensing standards for title insurance agents and agencies in accordance with division (B) of section 3953.21 of the Revised Code, which prohibits certain persons from acting as agents for a title insurance company.

Rule 3901-7-04 is being reviewed as part of the agency five-year rule review. The proposed amendment will correct a citation in the definition of "person."

Requests for copies of these rules should be addressed to Tina Chubb, Ohio Department of Insurance, 50 West Town Street, 3rd Floor, Suite 300, Columbus, Ohio 43215, or proposed rules can be viewed online at www.insurance.ohio.gov.

Kyla Dembowski, Staff Attorney
3901-3-13

Connie Lodge, Staff Attorney
3901-1-07, 3901-1-13, 3901-1-24, 3901-1-48

Sean Sheridan, Staff Attorney
3901-3-19

Matt Walsh, Staff Attorney
3901-1-54, 3901-7-04

EXHIBIT 2

Rule Summary and Fiscal Analysis
Part A - General Questions

Rule Number: 3901-1-07

Rule Type: Amendment

Rule Title/Tagline: Unfair trade practices.

Agency Name: Department of Insurance

Division:

Address: 50 W Town Street Suite 300 Columbus OH 43215

Contact: Tina Chubb **Phone:** (614) 728-1044

Email: Tina.Chubb@insurance.ohio.gov

I. Rule Summary

1. **Is this a five year rule review?** Yes

   A. **What is the rule's five year review date?** 11/30/2021

2. **Is this rule the result of recent legislation?** No

3. **What statute is this rule being promulgated under?** 119.03

4. **What statute(s) grant rule writing authority?** 3901.041

5. **What statute(s) does the rule implement or amplify?** 3901.20, 3901.21

6. **What are the reasons for proposing the rule?**

   This rule is being reviewed as a part of the agency five year rule review.

7. **Summarize the rule's content, and if this is an amended rule, also summarize the rule's changes.**

   The purpose of this rule is to define certain additional unfair trade practices and to set forth required procedures in connection therewith. Sections 3901.20 and 3901.21 of the Revised Code respectively prohibit unfair or deceptive practices in the business of insurance and define certain acts or practices as unfair or deceptive. Section 3901.21 of the Revised Code also provides that the enumeration of specific unfair or deceptive

acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement that section.

Recommended amendments include amendments to formatting and correct spelling errors.

8. **Does the rule incorporate material by reference?** No

9. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

   Not Applicable

10. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

    Not Applicable

II. Fiscal Analysis

11. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

    This will have no impact on revenues or expenditures.

    $0.00

    Not applicable.

12. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

    The rule further defines unfair & deceptive acts, and does not impose compliance costs. However, if an insurer violates the unfair and deceptive practices statute and requirements of the rule, the Superintendent may issue a cease and desist order and impose other administrative penalties such as license revocation and/or order to pay back payments received as a result of the violation.

13. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

14. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

15. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

    Not applicable.

III. Common Sense Initiative (CSI) Questions

16. **Was this rule filed with the Common Sense Initiative Office?** Yes

17. **Does this rule have an adverse impact on business?** No

    A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

    B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** No

    This rule amplifies ORC by providing further explanation in defined practices deemed unfair & deceptive, penalties are applied in statute.

    C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** No

    D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restrictions (This section only applies to agencies indicated in R.C. 121.95 (A))

18. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

    A. **How many new regulatory restrictions do you propose adding?**

    Not Applicable

    B. **How many existing regulatory restrictions do you propose removing?**

Not Applicable

EXHIBIT 3

3901-1-07 **Unfair trade practices.**

~~(A) Authority~~

~~Section 3901.041 of the Revised Code provides that the superintendent of insurance shall adopt, amend, and rescind rules and make adjudications necessary to discharge his duties and exercise his powers under Title 39 of the Revised Code.~~

~~(B) Purpose~~

~~Sections 3901.20 and 3901.21 of the Revised Code respectively prohibit unfair or deceptive practices in the business of insurance and define certain acts or practices as unfair or deceptive. Section 3901.21 of the Revised Code also provides that the enumeration of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement that section. The purpose of this rule is to define certain additional unfair trade practices and to set forth required procedures in connection therewith.~~

(A) Purpose

The purpose of this rule is to define certain additional unfair trade practices and to set forth required procedures in connection therewith. Sections 3901.20 and 3901.21 of the Revised Code respectively prohibit unfair or deceptive practices in the business of insurance and define certain acts or practices as unfair or deceptive. Section 3901.21 of the Revised Code also provides that the enumeration of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement that section.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under section 3901.041 of the Revised Code. Section 3901.041 of the Revised Code provides that the superintendent of insurance shall adopt, amend, and rescind rules and make adjudications necessary to discharge the superintendent's duties and exercise that person's powers under Title 39 of the Revised Code.

(C) Defined unfair practices

It shall be deemed an unfair or deceptive practice to commit or perform with such frequency as to indicate a general business practice any of the following:

(1) Knowingly ~~mispresenting~~ misrepresenting to claimants pertinent facts or policy provisions relating to coverage at issue;

(a) Misrepresenting a pertinent policy provision by making any payment, settlement, or offer of first party benefits, which, without explanation, does not include all amounts which should be included according to the claim filed by the first party claimant and investigated by the insurer;

(b) Denying a claim on the grounds of a specific policy provision, condition, or exclusion without reference to such provision, condition, or exclusion;

(2) Failing to acknowledge pertinent communications with respect to claims arising under insurance policies in writing, or by other means so long as an appropriate notation is made in the claim file of the insurer, within fifteen days of receiving notice of a claim in writing or otherwise;

(3) Failing to make an appropriate reply within twenty-one days of all other pertinent communications and/or any inquiries of the department of insurance respecting a claim;

(4) Failing to adopt and implement reasonable procedures to commence an investigation of any claim filed by either a first party or third party claimant, or by such claimant's authorized representative, within twenty-one days of receipt of notice of claim;

(5) Failing to mail or furnish claimant or the claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of such claimant, within fifteen days of receiving notice of claim, unless the insurer, based on the information then in its possession does not yet know all such requirements, then such notification shall be sent, within a reasonable time;

(6) Not offering first party or third party claimants, or their authorized representatives who have made claims which are fair and reasonable and in which liability has become reasonably clear, amounts which are fair and reasonable as shown by the insurer's investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions;

(7) Compelling insureds to institute suits to recover amounts due under its policies by offering substantially less ~~then~~ than the amounts ultimately recovered in suits brought by them when such insureds have made claims for amounts reasonably similar to the amounts ultimately recovered;

(8) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(9) Attempting settlement or compromise of claims on the basis of applications which were altered without notice to, or knowledge, or consent of insureds;

(10) Attempting to settle or compromise claims for less than the amount which the insureds had been led reasonably to believe they were entitled to, by written or printed advertising material accompanying or made part of an application;

(11) Attempting to delay the investigation or payment of claims by requiring an insured and his physician to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(12) Failing to advise the first party claimant or the claimant's authorized representative, in writing or by other means so long as an appropriate notation is made in the claim file of the insurer, of the acceptance or rejection of the claim, within twenty-one days after receipt by the insurer of a properly executed proof of loss;

(a) Failing to notify such claimant or the claimant's authorized representative, within twenty-one days after receipt of such proof of loss, that the insurer needs more time to determine whether the claim should be accepted or rejected;

(b) Failing to send a letter to such claimant or, the claimant's authorized representative, stating the need for further time to investigate the claim, if such claim remains unsettled ninety days from the date of the initial letter setting forth the need for further time to investigate;

(c) Failing to send to such claimant or authorized representative every ninety days after the first ninety-day claim investigation period, a letter setting forth the reasons additional time is needed for investigation, unless the delay is caused by factors beyond the insurer's control;

(13) Failing to advise such claimant or claimant's authorized representative, of the amount offered, if such claim is accepted in whole or in part;

(14) Refusing payments of claims solely on the basis of the insured's request to do so without making an independent evaluation of the insured's liability based upon all available information;

(15) Failing to adopt and implement reasonable standards for the proper handling of written communications, primarily expressing grievances, received by the insurer from insureds or claimants;

(16) Failing to pay any amount finally agreed upon in settlement of all or part of any claim or authorized repairs to be made upon final agreement not later than five days from the receipt of such agreement by the insurer at the place from which the payment or authorization is to be made or from the date of the performance by the claimant of any condition set by such agreement, whichever is later.

(17) For purposes of this rule, the following definitions shall apply;

(a) "Investigation" shall mean all activities of the company related directly or indirectly to the determining of liabilities under the coverages afforded by the policy. This shall include, but not be limited to, a bona fide effort to contact all insureds and claimants within a reasonable period after notification of loss. Evidence of a bona fide effort must be maintained in the file. The investigation shall be deemed concluded upon the company's affirmation or denial of liability.

(b) "Notice of Claim" as applied to an insurer shall include notification given to an agent of an insurer.

(c) "Settlement of claims" shall mean all activities of the company related directly or indirectly to the determination of the extent of damages due under coverages afforded by the policy. This shall include, but not be limited to, the requiring or preparing of repair estimates.

(d) "Days" means calendar days. However, when the last day of a time limit stated in this rule falls on a Saturday, Sunday or holiday, the time limit is extended to the next immediate following day that is not a Saturday, Sunday or holiday.

(D) Severability

If any paragraph, term, or provision of this rule be adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other paragraph, term, or provision of this rule, but the remaining paragraphs, terms, and provisions shall be in and continue in full force and effect.

Effective:

Five Year Review (FYR) Dates: 11/30/2021

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	3901.041
Rule Amplifies:	3901.20, 3901.21
Prior Effective Dates:	04/01/1975, 04/05/2007

EXHIBIT 4

Ohio | Common Sense Initiative

Mike DeWine, Governor | **Jon Husted**, Lt. Governor | **Sean McCullough**, Director

Business Impact Analysis

Agency Name: ***Ohio Department of Insurance***
Rule Contact Name: ***Loretta Medved***
Rule Contact Information: ***614-644-0239***
loretta.medved@insurance.ohio.gov

Regulation/Package Title *(a general description of the rules' substantive content)*:
Unfair and Deceptive Practices Rules

Rule Number(s): ***3901-1-07, 3901-1-08, 3901-1-54***

Date of Submission for CSI Review: ***August 2, 2021***
Public Comment Period End Date: ***August 16, 2021, 12:00AM***

Rule Type/Number of Rules:

- ☐ New/ rules
- ☒ Amended/ ***2*** rules (FYR? ***2021***)
- ☒ No Change/ ***1*** ***p*** rules (FYR? ***2021***)
- ☐ Rescinded/ rules (FYR?)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 requires agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the Agency determined the rule(s) create?

   The rule(s):

   - ☐ a. Requires a license, permit, or any other prior authorization to engage in or operate a line of business.
   - ☐ b. Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.
   - ☒ c. Requires specific expenditures or the report of information as a condition of compliance.
   - ☐ d. Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 3901-1-07: Enumerates specific practices that would be considered unfair and/or deceptive. The provisions of this rule pertain to all lines of insurance, although they are focused heavily on property and casualty (P&C). The rule enacts settlement standards for patterns and practices of deceptive actions, rather than occurrences on a specific claim. Technical amendments restructure the rule for uniformity with other department rules and correct a spelling error.

   Rule 3901-1-08: By adopting the National Association of Insurance Commissioners' (NAIC) "Military Sales Practices Model Regulation," the rule further defines Ohio's unfair trade practices in the business of insurance to include dishonest and predatory practices involving the sale of certain life insurance products, including annuities, to active military members of the United States Armed Forces and their families. The rule also sets acceptable standards for the sale and solicitation of the defined insurance products and adds special protections for enlisted service members. There are no proposed amendments.

   Rule 3901-1-54: Sets forth uniform minimum standards by adopting NAIC model regulation for the investigation and disposition of P&C claims. The rule defines procedures and practices which constitute unfair claims practice and provides specific settlement standards on an individual claims basis. The proposed technical amendment will correct a ciatation in paragraph (C)(9).

3. Please list the Ohio statute(s) that authorize the Agency to adopt the rule(s) and the statute(s) that amplify that authority.

   Rule 3901-1-07: Sections 3901.041, 3901.20 and 3901.21 of the Revised Code.

   Rule 3901-1-08: Sections 3901.041, 3901.20 and 3901.21 of the Revised Code.

   Rule 3901-1-54: Sections 3901.041 and 3901.19 to 3901.26 of the Revised Code.

4. Does the regulation implement a federal requirement? ☐ Yes ☒ No
   Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   ☐ Yes ☒ No
   If yes, please briefly explain the source and substance of the federal requirement.

   Not applicable.

5. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   Not applicable.

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   Rule 3901-1-07: The Unfair trade practices rule enumerates specific acts, which would be unfair & deceptive to consumers. This is a consumer protection rule and works to prevent insurance companies from developing a pattern of misleading practices.

   Rule 3901-1-08: The public purpose is to protect active duty service members from dishonest and predatory insurance sales practices by identifying certain practices as false, misleading or deceptive.

   Rule 3901-1-54: The rule provides consumer protection by setting clear requirements for insurance companies to follow in settling claim disputes.

7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

   Successful outcomes of both the unfair and deceptive practice statute and these rules are evident in a reduction in instances or allegations of unfair practices occurring within Ohio's insurance market place. Success is measured both through regular financial and market conduct reviews, as well as thorough review and investigation of consumer complaints submitted to the department.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931? ☐ Yes ☒ No

   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

Not applicable.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation. *If applicable, please include the date and medium by which the stakeholders were initially contacted.*

In spring 2021 the department reached out to industry stakeholders including the Ohio Insurance Institute (OII) regarding substantive amendments to rule 3901-1-54. Currently both industry and the department identify sections of rule 3901-1-54 that have the potential to strike a better balance of regulatory application. Conversations are ongoing and were not concluded in time for the filing of the 2021 five year rule review. For the purposes of this filing, only technical amendments are proposed. Stakeholders continue to engage with the department and did not raise any concern over the proposed technical amendments.

Additionally, in June 2021, an email requesting comment on this group of rules was sent to various stakeholders, interested parties, trade associations and companies. Specifically, the department reached out to the Ohio Land Title Association, the Ohio Insurance Institute (OII), the Association of Ohio Life Insurance Companies (AOLIC), the American Council of Life Insurance (ACLI), the National Association of Insurance and Financial Advisors (NAIFA), Ohio Association of Health Plans (OAHP) and the Ohio Insurance Agents Association Inc., among others. Additionally, these rules were also posted on the department's web site for review.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

No comments were received during or after the two week comment period. The department will continue conversations with industry regarding the potential for future substantive amendments.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

The rules are based on statutory prohibitions against unfair and deceptive practices, as well as model rules developed by the National Association of Insurance Commissioners (NAIC). The NAIC model rules are developed through a committee review process that considers market practices, consumer protections and industry and regulator input.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

There were no alternative regulations considered because the rules' purposes are to clarify the statutory prohibitions involved.

13. Did the Agency specifically consider a performance-based regulation? Please explain.
Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

No. Performance-based rules would not apply as the purpose of these rules are to clarify prohibited practices.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

The Ohio Department of Insurance is the sole agency regulating insurance and there are no duplicative rules.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

The rules have been in place and the insurance industry is aware of the prohibitions against unfair and deceptive practices. The regulations are applied consistently through oversight and any market conduct reviews performed. Proposed amendments are technical in nature and will not require any implementation for the regulated community.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:
    a. Identify the scope of the impacted business community;
    b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and
    c. Quantify the expected adverse impact from the regulation.
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a.

Rule 3901-1-07 impacts insurers authorized in all lines of insurance.

Rule 3901-1-08 impacts insurers authorized to sell life insurance and that sell life insurance or annuity products to active military members.

Rule 3901-1-54 impacts insurers authorized to sell property and casualty insurance.

b. -

c. All three rules clarify certain prohibited acts and therefore, no adverse impact for insurers that comply. If, however, an insurer violates the unfair and deceptive practices statute and requirements of any of the rules the insurer may be required to report information to the superintendent for purposes of an investigation. Additionally, the superintendent may issue a cease and desist order and impose other administrative penalties such as license revocation and/or order to pay back payments received as a result of the violation.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Unfair and deceptive practices are clearly prohibited in statute, and are critical to consumer protection. The rules clarify those prohibited practices to both serve as a clear guide for insurers and to facilitate the department's clear ability and authority to protect consumers against market misconduct and deceptive sales practices.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Prohibitions against unfair and deceptive practices are required consistently no matter the size or structure of the company. There are no alternative compliance requirements appropriate or necessary for small companies as the prohibitions do not relate to size of company.

19. How will the Agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Any actions or interventions the department must take under the rules' prohibitions are not punitive in nature, but rather would be to prevent financial harm to consumers, policyholders and/or the general public. The department works with insurers in the case of a violation to ensure the issue is corrected and consumer protection is preserved. The primary goal is to ensure any prohibited practices are stopped.

20. What resources are available to assist small businesses with compliance of the regulation?

Department staff is available to answer questions and provide assistance as needed.

Ohio | Common Sense Initiative

EXHIBIT 5

Mike DeWine, Governor
Jon Husted, Lt. Governor
Sean McCullough, Director

MEMORANDUM

TO: Loretta Medved, Ohio Department of Insurance

FROM: Joseph Baker, Business Advocate

DATE: October 20, 2021

RE: **CSI Review – Unfair and Deceptive Practices Rules (OAC 3901-1-07, 3901-1-08, and 3901-1-54)**

On behalf of Lt. Governor Jon Husted, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Department as provided for in ORC 107.54.

Analysis

This rule package consists of one no-change and two amended rules proposed by the Ohio Department of Insurance (Department) as a part of the statutory five-year review process. This rule package was submitted to the CSI Office on August 2, 2021, and the public comment period was held open through August 16, 2021. Unless otherwise noted below, this recommendation reflects the version of the proposed rules filed with the CSI Office on August 2, 2021.

The rules in this package establish business practice requirements for insurers in Ohio. OAC 3901-1-07 outlines insurance business practices that are defined as unfair or deceptive. These practices include knowingly misrepresenting pertinent facts or policy provisions to claimants, failing to acknowledge or reply to communications or claim inquiries in a certain timeframe, and not offering fair and reasonable amounts to claimants in accordance with policy limits and provisions when liability is clear, among others. The Department states in the BIA that the rule is amended for uniformity and to correct a spelling error.

OAC 3901-1-08 establishes additional unfair and deceptive practices specifically relating to the

sale of life insurance products to military members and their families. The rule states that soliciting the purchase of a life insurance product using door-to-door marketing, soliciting members as a part of a mass or captive audience, making appointments with service members during normal duty hours, posting unauthorized advertisements, and certain similar activities are defined as unfair business practices if taking place at a military installation. The rule also sets forth activities that are classified as unfair and deceptive practices regardless of location, such as offering anything of value to military personnel to procure their assistance in facilitating the sale of life insurance to another service member, advising service members in certain pay grades to modify income tax withholding to increase income for purposes of purchasing life insurance, and engaging in direct deposit agreements to divert payroll funds for the payment of life insurance premiums in certain circumstances, among others.

Lastly, OAC 3901-1-54 describes minimum standards for investigating property and casualty insurance claims and defines procedures and practices that constitute unfair claims practices. The rule requires insurers to determine within 21 days of receiving proof of a loss whether to approve or deny a claim, or to notify the claimant regarding the reason for needing additional time, to specify the grounds for denying a claim based on the policy documents and prohibits insurers from using settlement practices that result in litigation by offering substantially less than the amounts claimed, among others. The rule also establishes special requirements for resolving automobile claims and fire and extended coverage claims promptly and fairly and authorizes the Superintendent of the Department to recover the cost of investigations and potentially to fine insurers for violations. The rule is amended to correct an errant citation.

During early stakeholder outreach, the Department shared the proposed rules with various interested parties including the Ohio Insurance Institute, the Ohio Land Title Association, the Association of Ohio Life Insurance Companies, the American Council of Life Insurance, the National Association of Insurance and Financial Advisors, the Ohio Association of Health Plans, and the Professional Independent Agents Association, among others. No comments were provided in response to the request for early stakeholder outreach or during the CSI public comment period.

According to the BIA, the business community impacted by the rules includes insurers authorized in all lines of insurance, insurers authorized to sell life insurance as well as those authorized to sell life insurance or annuities to military members, and insurers authorized to sell property and casualty insurance. The adverse impact created by the rules includes potential disciplinary action for entities that engage unfair or deceptive practices or unfair claims practices as defined by the rules. Additionally, the Department notes in the BIA that insurers may be required to report information to the Superintendent in the case of investigation regarding an allegation of unfair and deceptive practices and that the Superintendent may take action including issuing a cease-and-

desist order, revoking a license, and ordering back payments. The Department states that the adverse impact to business is necessary to preserve consumer protection in the industry and to serve as a clear guide for insurers regarding market misconduct and deceptive sales practices.

Recommendations

Based on the information above, the CSI Office has no recommendations on this rule package.

Conclusion

The CSI Office concludes that the Ohio Department of Insurance should proceed in filing the proposed rules with the Joint Committee on Agency Rule Review.

Ohio Department of Insurance

Mike DeWine, Governor
Jon Husted, Lt. Governor

Judith L. French, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

EXHIBIT 6

MEMORANDUM

To: Joseph Baker, Business Advocate

CC: Sean McCullough, Director of the Common Sense Initiative Office

From: Loretta Medved, Policy Analyst

Date: October 22, 2021

Re: Response to CSI Review – Unfair and Deceptive Practices Rules (OAC 3901-1-07, 3901-1-08, and 3901-1-54)

On October 20, 2021, the Ohio Department of Insurance (the Department) received the Recommendation Memorandum (CSI Recommendation) from the Common Sense Initiative Office for rule(s) 3901-1-07 Unfair trade practices, 3901-1-08 Unfair and deceptive military sales practices, and 3901-1-54 Unfair property/casualty claims settlement practices.

The CSI Recommendation stated that the office does not have any recommendations regarding this rule package, and therefore should proceed with a formal filing of the rule package.

At this time, the Department plans to move forward with the filing of this rule package with the Joint Committee on Agency Rule Review.

If you have any questions please contact Loretta Medved at 614-644-0239 or Loretta.Medved@insurance.ohio.gov.

EXHIBIT 7

Rule Summary and Fiscal Analysis
Part A - General Questions

Rule Number: 3901-1-13

Rule Type: Amendment

Rule Title/Tagline: Mortgage guaranty insurance.

Agency Name: Department of Insurance

Division:

Address: 50 W Town Street Suite 300 Columbus OH 43215

Contact: Tina Chubb **Phone:** (614) 728-1044

Email: Tina.Chubb@insurance.ohio.gov

I. Rule Summary

1. **Is this a five year rule review?** Yes

   A. **What is the rule's five year review date?** 11/30/2021

2. **Is this rule the result of recent legislation?** No

3. **What statute is this rule being promulgated under?** 119.03

4. **What statute(s) grant rule writing authority?** 3901.041

5. **What statute(s) does the rule implement or amplify?** 3929.01(A)(24)

6. **What are the reasons for proposing the rule?**

   This rule is being reviewed as a part of the agency five year rule review.

7. **Summarize the rule's content, and if this is an amended rule, also summarize the rule's changes.**

   The purpose of rule 3901-1-13, is to implement division (A)(24) of section 3929.01 of the Revised Code, as it pertains to the writing and servicing of mortgage guaranty insurance as defined in (C)(1) of the rule.

The recommended amendments are technical - updates references to federal programs and offices.

8. **Does the rule incorporate material by reference?** No

9. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

   Not Applicable

10. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

    Not Applicable

II. Fiscal Analysis

11. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

    This will have no impact on revenues or expenditures.

    $0.00

    Not applicable.

12. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

    Not applicable.

13. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

14. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

15. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

    Not applicable.

III. Common Sense Initiative (CSI) Questions

16. **Was this rule filed with the Common Sense Initiative Office?** Yes

17. **Does this rule have an adverse impact on business?** Yes

    A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

       Paragraph (E)(1) states that Mortgage guaranty insurance may be transacted in this state by insurers fulfilling the requirements of paragraph (E)(6) of this rule and holding a certificate of authority for the transaction of such insurance pursuant to Title XXXIX of the Revised Code and shall be written only to insure loans secured by authorized real estate securities as defined in paragraph (C)(2) of this rule.

    B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** No

    C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** Yes

       Companies are required to notify the department when five per cent or more of their net annual premium is received from policies having a loan to value ratio of greater than ninety-five per cent. If a mortgage guaranty insurance company receives more than twenty per cent of their net annual premium from policies written by affiliates, they are required to notify the superintendent.

    D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restrictions (This section only applies to agencies indicated in R.C. 121.95 (A))

18. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

    A. **How many new regulatory restrictions do you propose adding?**

       Not Applicable

    B. **How many existing regulatory restrictions do you propose removing?**

Not Applicable

3901-1-13 **Mortgage guaranty insurance.**

EXHIBIT 8

(A) Purpose

The purpose of this rule is to implement division (A)(24) of section 3929.01 of the Revised Code, as it pertains to the writing and servicing of that kind of insurance known as mortgage guaranty insurance as hereinafter defined.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under section 3901.041 of the Revised Code.

(C) Definitions

The definitions set forth in this rule shall govern the construction of the terms used in this rule:

(1) "Mortgage guaranty insurance" is:

(a) Insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate, provided the improvement on such real estate is a residential building or a condominium unit or buildings designed for occupancy by not more than four families; or

(b) Insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust or other instrument constituting a lien or charge on real estate, providing the improvement on such real estate is a building or buildings designed for occupancy by five or more families or designed to be occupied for industrial or commercial purposes; or

(c) Insurance against financial loss by reason of nonpayment of rent or other sums agreed to be paid under the terms of a written lease for the possession, use or occupancy of real estate, provided the improvement on such real estate is a building or buildings designed to be occupied for industrial or commercial purposes.

(2) "Authorized real estate security" for the purpose of this rule means a note, bond or other evidence of indebtedness, not exceeding one-hundred and three per cent of the lower of the fair value as fixed by appraisal or purchase price of

the real estate, secured by a mortgage, deed of trust, or other instrument which constitutes, or is equivalent to, a first lien or charge on real estate, provided:

(a) Any percentage in excess of one-hundred per cent is used only for closing costs.

(b) The real estate loan secured in such manner is one of a type which:

(i) A bank,

(ii) A building and loan association, federal savings and loan, or a service corporation of either, or

(iii) An insurance company, which is supervised and regulated by a department of the state of Ohio or an agency of the federal government, is authorized to make, or would be authorized to make, disregarding any requirement applicable to such an institution that the amount of the loan not to exceed a certain percentage of the value of the real estate.

(c) The improvement on such real estate is a building or buildings designed for occupancy as specified by paragraphs (C)(1)(a) and (C)(1)(b) of this rule.

(d) The lien on such real estate may be subject to and subordinate to the following:

(i) The lien on any public bond, assessment or tax, when no installment, call or payment of or under such bond, assessment or tax is delinquent.

(ii) Outstanding mineral, oil, water or timber rights, rights-of-way, easements or rights-of-way of support, sewer rights, building restrictions or other restrictions or covenants, conditions or regulations of use, or outstanding leases upon such real property under which rents or profits are reserved to the owner thereof.

(3) "Contingency reserve" means an additional premium reserve established to protect policyholders against the effect of adverse economic cycles.

(D) Capital and surplus

A mortgage guaranty insurance company shall not transact the business of mortgage guaranty insurance in the state of Ohio unless: if a stock insurance company, it has capital and surplus in the aggregate amount of not less than two million five hundred

thousand dollars, which aggregate shall include paid-in capital of not less than one million and contributed surplus of not less than one million or if a mutual insurance company, a minimum surplus of two million five hundred thousand dollars.

(E) Limitations and restrictions on transacting business

(1) Mortgage guaranty insurance may be transacted in this state by insurers fulfilling the requirements of paragraph (E)(6) of this rule and holding a certificate of authority for the transaction of such insurance pursuant to Title XXXIX of the Revised Code and shall be written only to insure loans secured by authorized real estate securities as defined in paragraph (C)(2) of this rule.

(2) Geographic concentration

(a) A mortgage guaranty insurance company shall not insure loans secured by a single risk in excess of ten per cent of the company's aggregate capital, surplus and contingency reserve.

(b) No mortgage guaranty insurance company shall have more than twenty per cent of its total insurance in force in any one ~~standard metropolitan statistical areas ("SMSA")~~ metropolitan statistical area ("MSA") as defined by the United States ~~department of commerce.~~office of management and budget.

(3) Advertising

No mortgage guaranty insurance company or any agent or representative of a mortgage guaranty insurance company shall prepare or distribute or assist in preparing or distributing any brochure, pamphlet, report or any form of advertising to the effect that the real estate investments of any financial institution are "insured investments," unless the brochure, pamphlet, report or advertising clearly states that the loans are insured by mortgage guaranty insurance companies authorized to transact the business of mortgage guaranty insurance in the state of Ohio or are insured by an agency of the federal government, as the case may be.

(4) Investment limitation

A mortgage guaranty insurance company shall not invest in notes or other evidences of indebtedness secured by a mortgage or other lien upon real property. This section shall not apply to obligations secured by real property or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of the good faith settlement of claims under policies of

insurance issued by the mortgage guaranty insurance company, or in the good faith disposition of real property so acquired.

(5) Coverage limitation

(a) A mortgage guaranty insurance company shall limit its coverage, with respect to any one authorized real estate security, net of reinsurance, ceded to a reinsurer unaffiliated with the company or an affiliated reinsurer which does not own, and is not owned by, in whole or in part, the ceding mortgage guaranty insurer, to a maximum of twenty-five per cent of the entire indebtedness to the insured under that authorized real estate security. In lieu thereof, a mortgage guaranty insurance company may elect to pay the entire indebtedness to the insured and acquire title to the authorized real estate security.

(b) The coverage limits set out in paragraph (E)(5)(a) of this rule shall not apply to a mortgage guaranty insurance company that possesses capital and surplus in excess of twenty-five million dollars.

(6) Mortgage guaranty insurance as monoline

(a) A mortgage guaranty insurance company which anywhere transacts any class of insurance other than mortgage guaranty insurance is not eligible to transact mortgage guaranty insurance in the state of Ohio.

(b) A mortgage guaranty insurance company which anywhere transacts the classes of insurance defined in paragraph (C)(1)(b) or (C)(1)(c) of this rule may not transact in the state of Ohio the class of mortgage guaranty insurance defined in paragraph (C)(1)(a) of this rule, provided, however, a mortgage guaranty insurance company which transacts a class of insurance defined in paragraph (C)(1)(a) of this rule may write up to five per cent of its insurance in force on residential property designed for occupancy by five or more families.

(7) Underwriting discrimination

(a) Nothing in this rule shall be construed as limiting the right of any mortgage guaranty insurance company to impose reasonable requirements upon the lender with regard to the terms of any note or bond or other evidence of indebtedness secured by a mortgage or deed of trust, such as requiring a stipulated down payment by the borrower.

(b) No mortgage guaranty insurance company may discriminate in the issuance or extension of mortgage guaranty insurance on the basis of sex, marital

status, race, color, creed, national origin, physical handicap or mental handicap.

(c) No policy of mortgage guaranty insurance, excluding policies of reinsurance, shall be written unless and until the insurer itself or the lender, in compliance with underwriting directives from the insurer and subject to periodic underwriting audits by the insurer, shall have conducted a reasonable and thorough examination of the evidence supporting credit worthiness of the borrower and the appraisal report reflecting market evaluation of the property and shall have determined that prudent underwriting standards have been met.

(8) Policy forms and premium rates filed

(a) All policy forms and endorsements, and rates to be charged and the premium including all modifications of rates and premiums to be paid by the policyholder shall be filed with and subject to the provisions of sections 3937.01 to 3937.18 of the Revised Code. With respect to owner-occupied, single-family dwellings or owner-occupied two family dwellings, the mortgage guaranty insurance policy shall provide that the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.

(b) Every mortgage guaranty insurance company shall adopt, print and make available a schedule of premium charges for mortgage guaranty insurance policies. Premium charges made in conformity with the provisions of this rule shall not be deemed to be of interest or other charges under any other provision of law limiting interest or other charges in connection with mortgage loans. The schedule shall show the entire amount of premium charge for each type of mortgage guaranty insurance policy issued by the insurance company.

(9) Outstanding total liability

(a) A mortgage guaranty insurance company shall not at any time have outstanding a total liability, net of reinsurance, under its aggregate mortgage guaranty insurance policies exceeding twenty-five times its capital, surplus and contingency reserve. In the event that any mortgage guaranty insurance company has outstanding total liability exceeding twenty-five times its capital, surplus and contingency reserve, it shall cease transacting new mortgage guaranty business until such time as its total liability no longer exceeds twenty-five times its capital, surplus and contingency reserve.

(b) The superintendent, in the superintendent's sole discretion, may permit a temporary exception to the requirement set out in paragraph (E)(9)(a) of this rule at the written request of a mortgage guaranty insurer upon a finding that the mortgage guaranty insurer's policyholders position is reasonable in relationship to the mortgage guaranty insurer's aggregate insured risk and adequate to its financial needs. The request must be made in writing at least ninety days in advance of the date that the mortgage guaranty insurer expects to exceed the requirements of paragraph (E)(9)(a) of this rule and shall, at a minimum, address the factors specified in paragraph (E)(9)(c) of this rule, provided, however, that a mortgage guaranty insurance company may submit a request for such exception within ten days after the effective date of this rule as amended and shall be deemed to have complied with the ninety day requirement in paragraph (E)(9)(b) of this rule.

(c) In determining whether a mortgage guaranty insurer's policyholders position is reasonable in relation to the mortgage guaranty insurer's aggregate insured risk and adequate to its financial needs, the superintendent shall consider all of the following:

(i) The size of the mortgage guaranty insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other criteria as deemed appropriate by the superintendent.

(ii) The extent to which the mortgage guaranty insurer's business is diversified across time, geography, credit quality, origination, and distribution channels.

(iii) The nature and extent of the mortgage guaranty insurer's reinsurance program.

(iv) The quality, diversification, and liquidity of the mortgage guaranty insurer's assets and its investment portfolio.

(v) The historical and forecasted trend in the size of the mortgage guaranty insurer's policyholder's position.

(vi) The policyholder's position maintained by other comparable mortgage guaranty insurers in relation to the nature of their respective insured risks.

(vii) The adequacy of the mortgage guaranty insurer's reserves.

(viii) The quality and liquidity of investments in affiliates. The superintendent may treat any such investment as a non-admitted asset for purposes of determining the adequacy of surplus as regards policyholders.

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

(x) An independent actuary's opinion as to the reasonableness and adequacy of the mortgage guaranty insurer's historical and projected policyholder position.

(xi) The capital contributions which have been infused or are available for future infusion into the mortgage guaranty insurer.

(xii) The historical and projected trends in the components of the mortgage guaranty insurer's aggregate insured risk, including, but not limited to, the quality and type of the risks included in the aggregate insured risk.

(d) The superintendent may retain accountants, actuaries, or other experts to assist the superintendent in the review of the mortgage guaranty insurer's request submitted pursuant to paragraph (E)(9)(b) of this rule. The mortgage guaranty insurer shall bear the cost of retaining such experts.

(e) Any waiver shall be for a specified time, not to exceed two years and shall be subject to any terms and conditions imposed by the superintendent, in the superintendent's sole discretion. ~~The superintendent shall not grant a waiver that extends beyond October 1, 2014.~~

(10) High risk underwriting

Any mortgage guaranty insurance company which receives five per cent or more of its net annual premium from policies written to insure loans secured by authorized real estate securities having a greater than ninety-five per cent loan-to-value ratio shall notify the superintendent within thirty days. The superintendent may, if the superintendent finds that further underwriting of loans having a greater than ninety-five per cent loan-to-value ratio would have an adverse impact on the solvency of the company, prohibit the company from further underwriting such loans.

(F) Rebates, commissions, charges and conflict of interest

(1) Rebates, commissions and charges

(a) A mortgage guaranty insurance company shall not pay or cause to be paid either directly or indirectly, to any owner, purchaser, lessor, lessee, mortgagee or prospective mortgagee of the real property which secures the authorized real estate security or which is the fee of an insured lease, or any interest therein, or any person who is acting as an agent, representative, attorney or employee of such owner, purchaser or mortgagee, any commission, or any part of its premium charges or any other consideration as an inducement for or as compensation on any mortgage guaranty insurance business.

(b) In connection with the placement of any mortgage guaranty insurance, a mortgage guaranty insurance company shall not cause or permit any commission, fee, remuneration, or other compensation to be paid to, or received by, any insured lender or lessor; any subsidiary or affiliate of any insured; any officer, director or employee of any insured or any member of their immediate family; any corporation, partnership, trust, trade association in which any insured or any such officer, director, or employee or member of their immediate family has a financial interest; or any designee, trust, nominee, or other agent or representative of any of the foregoing.

(c) No mortgage guaranty insurance company shall make any rebate of any portion of the premium charge shown by the schedule required by paragraph (E)(8)(b) of this rule. No mortgage guaranty insurance company shall quote any rate or premium charge to any person which is different than that currently available to others for the same type of coverage. The amount by which any premium charge is less than that called for by the current schedule of premium charges is an unlawful rebate.

(2) Conflict of interest

(a) If a member of a holding company system, a mortgage guaranty insurance company licensed to transact business in this state shall not knowingly underwrite mortgage guaranty insurance on mortgages originated by the holding company system or an affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly, by the holding company system or any affiliate unless such insurance is underwritten on the same basis, for the same consideration and subject to the same insurability requirements as insurance provided to nonaffiliated lenders.

(i) Any mortgage guaranty insurance company which receives, in the aggregate, twenty per cent of more of its net annual premium from policies written to insure mortgages originated by affiliates in the holding company system shall, concurrent with the filing of its annual statement, notify the superintendent of that fact.

(ii) The superintendent may, if the superintendent finds that further underwriting of policies issued on said loans would have an adverse impact on the solvency of the company, prohibit the mortgage guaranty insurance company for further underwriting such loans.

(b) A mortgage guaranty insurance company, the holding company system of which it is a part or any affiliate shall not pay any commission, remuneration, rebates or engage in activities proscribed in paragraph (F) (1) of this rule.

(G) Reserves

(1) Unearned premium reserves

A mortgage guaranty insurance company shall compute and maintain an unearned premium reserve as required by the superintendent of insurance.

(2) Loss reserve

A mortgage guaranty insurance company shall compute and maintain adequate case basis and other loss reserves which accurately reflect loss frequency and loss severity and shall include components for claims reported and unpaid, and for claims incurred but not reported, including estimated losses on:

(a) Insured loans which have resulted in the conveyance of property which remains unsold;

(b) Insured loans in the process of foreclosure;

(c) Insured loans in default for four months or for any lesser period which is defined as default for such purposes in the policy provisions; and

(d) Insured leases in default for four months or for any lesser period which is defined as default for such purposes in policy provisions.

(3) Contingency reserve

Each mortgage guaranty insurance company shall establish a contingency reserve out of net premiums remaining (gross premiums less premiums returned to policyholders net of reinsurance) after establishment of the unearned premium reserve. The mortgage guaranty insurance company shall contribute to the contingency reserve an amount equal to fifty per cent of such remaining earned premiums. Contributions to the contingency reserve made during each calendar year shall be maintained for a period of one hundred twenty months, except that withdrawals may be made by the company in any year in which the actual incurred losses exceed thirty-five per cent of the corresponding earned premiums, and no such releases shall be made without prior approval by the superintendent of the insurance company's state of domicile. If the coverage provided in this rule exceeds the limitations set forth herein, the superintendent of insurance shall establish a rate formula factor that will produce a contingency reserve adequate for the added risk assumed. The face amount of an insured mortgage shall be computed before any reduction by the mortgage guaranty insurance company's election to limit its coverage to a portion of the entire indebtedness.

(H) Reinsurance

Whenever a mortgage guaranty insurance company obtains reinsurance from an insurance company which is properly licensed to provide such reinsurance or from an appropriate governmental agency, the mortgage guaranty insurer and the reinsurer shall establish and maintain the reserves required in this rule in appropriate proportions in relation to the risk retained by the original insurer and ceded to the assuming reinsurer so that the total reserves established shall not be less than the reserves required by this rule.

(I) Miscellaneous

(1) Whenever the laws of any other jurisdiction in which a mortgage guaranty insurance company subject to the requirement of this rule is also licensed to transact mortgage guaranty insurance require a larger unearned premium reserve or contingency reserve in the aggregate than that set forth herein, the establishment of such larger unearned premium reserve or contingency reserve in the aggregate shall be deemed to be in compliance with this rule.

(2) Unearned premium reserves and contingency reserves shall be computed and maintained on risks insured after the effective date of this rule as required by paragraphs (G)(1) and (G)(3) of this rule. Unearned premium reserves and contingency reserves on risks insured before the effective date of this rule may be computed and maintained as required previously.

(J) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms and provisions shall be and continue in full force and effect.

Effective:

Five Year Review (FYR) Dates: 11/30/2021

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	3901.041
Rule Amplifies:	3929.01(A)(24)
Prior Effective Dates:	06/06/1978, 08/11/1994, 06/01/2001, 10/17/2011, 01/10/2019

EXHIBIT 9

Ohio | Common Sense Initiative

Mike DeWine, Governor | **Jon Husted**, Lt. Governor | **Carrie Kuruc**, Director

Business Impact Analysis

Agency Name: ***Ohio Department of Insurance***
Rule Contact Name: ***Loretta Meedved***
Rule Contact Information: ***loretta.medved@insurance.ohio.gov***
614-644-0239

Regulation/Package Title *(a general description of the rules' substantive content)*:
Mortgage Guaranty Insurance, Ohio mine subsidence insurance underwriting association and fund, Public insurance adjusters, and Misconduct by insurance license applicants and licensees

Rule Number(s): ***3901-1-13, 3901-1-24, 3901-1-48, 3901-5-12***

Date of Submission for CSI Review: ***July 20, 2021***
Public Comment Period End Date: ***August 3, 2021 12:00AM***

Rule Type/Number of Rules:

- ☐ New/ rules
- ☒ Amended/ ***3*** rules (FYR? ***2021***)
- ☒ No Change/ ***1*** rules (FYR? ***2021***)
- ☐ Rescinded/ rules (FYR?)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 requires agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the Agency determined the rule(s) create?

   The rule(s):

   - ☒ a. Requires a license, permit, or any other prior authorization to engage in or operate a line of business.
   - ☒ b. Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.
   - ☒ c. Requires specific expenditures or the report of information as a condition of compliance.
   - ☐ d. Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 3901-1-13: The purpose of this rule is to implement the section of Ohio Revised Code which pertains to the writing and servicing of mortgage guaranty insurance. The rule outlines procedural and structural guidelines such as: policy forms, coverage limitations, advertising, and reserving requirements. Recommended amendments will update references to federal programs and offices.

   Rule 3901-1-24: The public insurance adjuster rule provides the baseline guidance for oversight of public insurance adjuster conduct and common consumer protection concerns including: Public insurance adjuster prohibitions, record-keeping, contract requirements, and insurer restrictions. Reccomended amendments will remove gender references throughout the rule.

   Rule 3901-1-48: This rule implements the plan of operation of the "Ohio Mine Subsidence Insurance Underwriting Association," (OMSIUA), pursuant to Ohio Revised Code. Recommended amendments remove the superintendent of insurance from the board of governors, this reflects changes to the ORC in 2017.

   Rule 3901-5-12: This rule establishes standards of conduct and responsibility that apply to insurance license applicants, licensees, and/or insurance companies. The rule outlines practices that would be deemed unfair and deceptive in the sale of insurance. There are no suggested amendments to this rule.

3. Please list the Ohio statute(s) that authorize the Agency to adopt the rule(s) and the statute(s) that amplify that authority.

   3901-1-13: Section 3901.041 of the Revised Code.

   3901-1-24: Section 3901.041 of the Revised Code.

   3901-1-48: Section 3901.041 of the Revised Code.

   3901-5-12: Sections 3901.041, 3905.14 and 3905.85(D) of the Revised Code.

4. Does the regulation implement a federal requirement? ☐ Yes ☒ No
   Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   ☐ Yes ☒ No
   If yes, please briefly explain the source and substance of the federal requirement.

   Not applicable.

5. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   Not applicable.

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   Rule 3901-1-13: Mortgage Guaranty insurance reduces risk to mortgage lenders and provides opportunities for home purchasers who may not otherwise qualify under traditional lending criteria. This rule establishes the regulatory framework for this type of coverage.

   Rule 3901-1-24: Public insurance adjusters represent policyholders by assisting with interpretation of the insured's policy and negotiates with the insurance company on a claim. The public purpose of the rule is consumer protection, accomplished by setting prohibitions and standards of conduct for public insurance adjusters.

   Rule 3901-1-48: Mine subsidence occurs when the foundation of a structure is compromised due to lateral or vertical ground movement caused by a failure in an abandoned mine. Homes located in areas of Ohio with a presence of abandoned mines are at risk for mine subsidence. Mine subsidence insurance coverage is available to elligible Ohioans as an endorsement to a basic property or homeowners policy. Coverage is mandatory in counties with a high concentration of abandoned mines, and optional in counties where a small concentration of abandoned mines are present. Insurers who write basic property or homeowners policies in the eligible counties are required to become members of the OMSIUA and offer this coverage to all eligible applicants. This rule specifies how OMSIUA will operate.

Rule 3901-5-12: This rule works to protect consumers from being mislead or harmed by prohibiting unfair and deceptive acts on behalf of insurance license applicants, licensees and companies.

7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

   The success of rules 3901-1-13 and 3901-1-48 remains evident in the continuing market and consumer protections in the coverage they establish.

   For rules 3901-1-24 and 3901-5-12, success is measured generally through the absence of complaints, or allegations that lead to a need to investigate or penalize licensed individuals and applicants for misconduct, or for the need to take action against non-licensed individuals.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931? ☐ Yes ☒ No

   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

   Not applicable.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation. *If applicable, please include the date and medium by which the stakeholders were initially contacted.*

   In May 2021, an email requesting comment on the rule was sent to various stakeholders, interested parties, trade associations and companies. Specifically, the department reached out to the Ohio Mine Subsidence Insurance Underwriting Association (OMSIUA), the Ohio Land Title Association, the Ohio Insurance Institute (OII), the Association of Ohio Life Insurance Companies (AOLIC), the American Council of Life Insurance (ACLI), the National Association of Insurance and Financial Advisors (NAIFA), Ohio Association of Health Plans (OAHP) and the Professional Independent Agents Association (PIAA), among others. Additionally, these rules were also posted on the department's web site for review.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

    No comments were received during or after the vetting of this rule packet.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

Rules 3901-1-13, 3901-1-24, and 3901-5-12 were drafted pursuant to the National Association of Insurance Commissioners (NAIC) model regulations which were created and vetted through a committee process that includes research and input from various state regulators and stakeholders. The NAIC maintains subgroups that continually monitor trends and conditions of the industry.

Rule 3901-1-48 was established to govern the OMSIUA in order to guarantee eligible Ohioans would be provided an opportunity for mine subsidence coverage. Research determined the specifc areas of Ohio that are at risk for mine subsidence activity.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

    Rules 3901-1-13 and 3901-1-48: The purpose of these rules is to establish the regulatory framework of mortgage guaranty insurance, and establish the function and governing of the OMSIUA board, alternatives are not appropriate.

    Rules 3901-1-24 and 3901-5-12: The practices outlined in both rules were gathered after reviewing trends in the industry and common areas of consumer complaint, these areas are reviwed by the NAIC regularly and alternatives are not appropriate at this time.

13. Did the Agency specifically consider a performance-based regulation? Please explain. *Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.*

    No. Performance-based rules would not apply as the purpose and scope of these rules are to establish the regulatory framework of mortgage guaranty insurance, to establish the function of the OMSIUA board, and proscribe requirements and list prohibited activities. A defined process provides clarity to the regulated community.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

    The Ohio department of insurance is the sole agency regulating insurance and there are no duplicative rules.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

    All rules included in this packet have remained in effect for many years and are understood by the regulated community. All proposed amendments are technical and will not impact any requirements.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:
    a. Identify the scope of the impacted business community;
    b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and
    c. Quantify the expected adverse impact from the regulation.
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a-c.

Rule 3901-1-13: Mortgage guaranty insurers are impacted by the requirements of this rule. Compliance requirements include maintaining minimum reserves. Additionally, companies are required to notify the department when five per cent or more of their net annual premium is received from policies having a loan to value ratio of greater than ninty-five per cent. If a mortgage guaranty insurance company recieves more than twenty per cent of their net annual premium from policies written by affiliates, they are required to notify the superintendent. Generally this data is readily available based on the internal underwriting and accounting practices of the companies.

Rule 3901-1-24: The impacted business community is primarily licensed public insurance adjusters. The rule's scope focuses on standards of conduct and, therefore, does not impose a direct cost or adverse impact for compliance. Statute requires licensure before acting as a publicinsurance adjuster, which includes a $100 initial application fee and a $50 annual renewal fee.

Rule 3901-1-48: Insurers who write basic property or homeowners policies for family dwellings in the defined eligible counties are required to become members of the OMSIUA and offer mine subsidence coverage to all eligible applicants. Member insurers are required to submit quarterly reports and maintain certain agreements with the OMSIUA. Completing these requirements would take no longer than a few hours a year.

Rule 3901-5-12: This rule impacts insurance license applicants, licensees, and/or companies licensed or authorized to transact the business of insurance. Adverse impact is not imposed as the rule addresses only areas of misconduct. It is the responsibility of the individual and or company to comply with the rule as a matter of every day business practices. In cases where an insurance company has reasonable cause to believe that there has been a violation or is a continuing violation of this rule, and the details thereof which are known, the department shall be notified. The department maintains both the market conduct and agent licensing divisions to address such matters, informing the department may require minimal to moderate communications to determine the extent of any investigation.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The guidelines established in these rules assist in maintaining a stable and competitive industry and collectively provide important consumer protections. The prohibited actions for public insurance adjusters and license applicants are in place to potect consumers from conflicts of interests or other actions that may cause financial harm.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Rule 3901-1-13: The requirements apply equally to any company engaged in the sale of mortgage guaranty products in order to ensure a balanced market.

Rule 3901-1-24: The requirements apply equally to any licensed public insurance adjuster, most of which are individual practitioners or small-business agencies.

Rule 3901-1-48: The rule applies equally to insurers who met the requirements of OMSIUA.

Rule 3901-5-12: The rule establishes straight-forward business standards to serve as crucial consumer protection. Consistent compliance across the industry provides predictability for both the industry and consumers.

19. How will the Agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Paperwork violations and/or first time offender issues would be dealt with on a case-by-case basis to determine whether the violation could have a serious impact on the consumer or the general public. Minor errors would be handled by advising the company and giving them an opportunity to cure the omission or irregularity. For rule 3901-1-24 the superintendent may suspend, revoke, or refuse to renew a public adjusters license for a conduct violation, and any such action would be conducted under a Chapter 119. Administrative hearing process.

20. What resources are available to assist small businesses with compliance of the regulation?

Department staff is available to answer questions and provide assistance as needed.

Ohio | Common Sense Initiative

EXHIBIT 10

Mike DeWine, Governor
Jon Husted, Lt. Governor
Sean McCullough, Director

MEMORANDUM

TO: Loretta Medved, Ohio Department of Insurance

FROM: Joseph Baker, Business Advocate

DATE: September 14, 2021

RE: **CSI Review – Mortgage guaranty insurance, Ohio mine subsidence insurance underwriting association and fund, public insurance adjusters, and misconduct by insurance license applicants and licensees (OAC 3901-1-13, 3901-1-24, 3901-1-48, and 3901-5-12)**

On behalf of Lt. Governor Jon Husted, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Department as provided for in ORC 107.54.

Analysis

This rule package consists of one no change and three amended rules proposed by the Ohio Department of Insurance (Department) as a part of the statutory five-year review process. This rule package was submitted to the CSI Office on July 20, 2021, and the public comment period was held open through August 3, 2021. Unless otherwise noted below, this recommendation reflects the version of the proposed rules filed with the CSI Office on July 20, 2021.

The rules in this package establish regulations related to providing mortgage guaranty insurance, establish standards of conduct and records requirements for public insurance adjusters, implement definitions and regulations related to the Ohio Mine Subsidence Underwriting Association, and establish standards of conduct for insurance license applicants and licensees.

OAC 3901-1-13 sets forth definitions related to mortgage guaranty insurance and requirements for business engaged in providing such insurance. The rule prohibits businesses from selling mortgage

guaranty insurance unless they have capital and surplus of at least $2,500,000, institutes geographic limits on the concentration of insurance in certain regions, limits certain adverting practices, and establishes other regulations related to mortgage guaranty insurance companies. The rule is amended to update terms related to federal offices and to remove a prohibition on the Superintendent of Insurance (Superintendent) granting a waiver after October 1, 2014.

OAC 3901-1-24 establishes regulations related to public insurance adjusters. The rule prohibits any public insurance adjuster or agent from engaging in business related to the repair or remodel of certain insured properties, soliciting a loss during a fire or interfering with fire investigators, offering a portion of the adjuster's fee in an effort to secure a contract, representing himself or herself falsely, acting dishonestly with respect to estimates of loss or damage, or owning any property connected to a loss that the adjuster is reviewing, among others. The rule also establishes records retention requirements, contractual limitations, restrictions on insurers, and allows for the Superintendent to revoke or suspend the license of an adjuster who violates the rules. The rule is amended to remove gender pronouns related to insurance adjusters.

OAC 3901-1-48 implements definitions and regulations related to the Ohio Mine Subsidence Underwriting Association and the Mine Subsidence Insurance Fund. The rule provides that the association and fund shall be administered by a board made up of various designees of state agencies and requires that every policy of mine subsidence insurance may not create liability on the part of the member issuing the policy beyond the net premium of policies paid into the fund. The rule also establishes standards related to applying for coverage, administering and processing claims, underwriting, audits, reporting and statistics, investment of custodial funds, reinsurance, and meeting notices. The Department notes in the BIA that the rule is amended to remove the Superintendent from the board overseeing the Mine Subsidence Underwriting Association and the Mine Subsidence Insurance Fund in connection to a statutory change.

OAC 3901-5-12 establishes standards of conduct related to insurance license applicants and licensees and outlines behavior that may be subject to disciplinary action. For example, the rule prohibits an individual from soliciting insurance when the solicitor knew that the customer is currently covered by substantially duplicative coverage or where the customer would not be entitled to the benefits of coverage due to various reasons. The rule also states that insurance companies may be found to have engaged in unfair or deceptive practices if an employee engages in such conduct and where the company has either tolerated, ratified or encourage the behavior, if it failed to notify the Department when a violation known by the business has occurred, or if it fails to refund premiums or payments when the company's agent has violated a law or rule.

During early stakeholder outreach, the Department notified stakeholders including the Ohio Mine

Subsidence Insurance Underwriting Association, the Ohio Land Title Association, the Ohio Insurance Institute, the Association of Ohio Life Insurance Companies, the American Council of Life Insurance, the National Association of Insurance and Financial Advisors, Ohio Association of Health Plans, and the Professional Independent Agents Association, among others. No comments were provided in response to the request for early stakeholder feedback or during the CSI public comment period.

The business communities impacted by the rules include mortgage guaranty insurers, licensed public insurance adjusters, insurers who write basic property or homeowner policies for family dwellings and who are required to offer mine subsidence coverage to all eligible applicants, and insurance license applicants, licensees, or companies licensed or authorized to transact in insurance. The adverse impacts created by the rules include maintaining minimum reserves, notification requirements, potential disciplinary action related to violating standards of conduct, administrative effort and costs associated with applying for and renewing a public insurance adjuster license ($100 and $50, respectively), submitting quarterly reports to the Ohio Mine Subsidence Insurance Underwriting Association, and notifying the Department when employees or agents engage in misconduct. The Department states in the BIA that the adverse impacts created by the rules are necessary to assist in maintaining a stable and competitive industry and protect consumers from conflicts of interests or other actions that may cause financial harm.

Recommendations

Based on the information above, the CSI Office has no recommendations on this rule package.

Conclusion

The CSI Office concludes that the Ohio Department of Insurance should proceed in filing the proposed rules with the Joint Committee on Agency Rule Review.

Ohio Department of Insurance

Mike DeWine, Governor
Jon Husted, Lt. Governor

Judith L. French, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

EXHIBIT 11

MEMORANDUM

To: Joseph Baker, Business Advocate

CC: Sean McCullough, Director of the Common Sense Initiative Office

From: Loretta Medved, Policy Analyst

Date: September 29, 2021

Re: Response to CSI Review – Mortgage guaranty insurance, Ohio mine subsidence insurance underwriting association and fund, public insurance adjusters, and misconduct by insurance license applicants and licensees (OAC 3901-1-13, 3901-1-24, 3901-1-48, and 3901-5-12)

On September 14, 2021, the Ohio Department of Insurance (the Department) received the Recommendation Memorandum (CSI Recommendation) from the Common Sense Initiative Office for rule(s) 3901-1-13 Mortgage guaranty insurance, 3901-1-24 Public insurance adjusters, 3901-1-48 "Ohio mine subsidence insurance underwriting association" and "mine subsidence insurance fund" plan of operation, and 3901-5-12 Misconduct by insurance license applicants and licensees.

The CSI Recommendation stated that the office does not have any recommendations regarding this rule package, and therefore should proceed with a formal filing of the rule package.

At this time, the Department plans to move forward with the filing of this rule package with the Joint Committee on Agency Rule Review.

If you have any questions please contact Loretta Medved at 614-644-0239 or Loretta.Medved@insurance.ohio.gov.

Rule Summary and Fiscal Analysis
Part A - General Questions

EXHIBIT 12

Rule Number: 3901-1-24

Rule Type: Amendment

Rule Title/Tagline: Public insurance adjusters.

Agency Name: Department of Insurance

Division:

Address: 50 W Town Street Suite 300 Columbus OH 43215

Contact: Tina Chubb **Phone:** (614) 728-1044

Email: Tina.Chubb@insurance.ohio.gov

I. Rule Summary

1. **Is this a five year rule review?** Yes

   A. **What is the rule's five year review date?** 11/30/2021

2. **Is this rule the result of recent legislation?** No

3. **What statute is this rule being promulgated under?** 119.03

4. **What statute(s) grant rule writing authority?** 3901.041

5. **What statute(s) does the rule implement or amplify?** Chapter 3951.

6. **What are the reasons for proposing the rule?**

   This rule is being reviewed as a part of the agency five year rule review.

7. **Summarize the rule's content, and if this is an amended rule, also summarize the rule's changes.**

   The purpose of this rule is to regulate the conduct of public insurance adjusters; the rule also provides authority for the removal of licensure due to violation.

   Recommended amendments remove gender specific language.

8. **Does the rule incorporate material by reference?** No

9. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

   Not Applicable

10. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

    Not Applicable

II. Fiscal Analysis

11. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

    This will have no impact on revenues or expenditures.

    $0.00

    Not applicable.

12. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

    The rule's scope focuses on standards of conduct and does not impose a direct cost or adverse impact for compliance. Statute requires individuals become licensed before acting as a public insurance adjuster, which includes a $100 initial application fee and a $50 annual renewal fee.

13. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

14. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

15. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

    Not applicable.

III. Common Sense Initiative (CSI) Questions

16. **Was this rule filed with the Common Sense Initiative Office?** Yes

17. **Does this rule have an adverse impact on business?** Yes

    A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

       The rule clarifies activities that constitute acting as a public insurance adjuster, for which a license is required.

    B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** Yes

       Per authority granted to the Superintendent in statue: violation of the statute regarding public insurance adjusters, and the prohibited activities in this rule, could result in suspension or revocation of license.

    C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** No

       Paragraph (D) requires that every public insurance adjuster shall keep a full record of transaction as an adjuster for the previous three years and such records shall be open at all times to the inspection of the superintendent of insurance.

    D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restrictions (This section only applies to agencies indicated in R.C. 121.95 (A))

18. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

    A. **How many new regulatory restrictions do you propose adding?**

       Not Applicable

    B. **How many existing regulatory restrictions do you propose removing?**

       Not Applicable

3901-1-24 **Public insurance adjusters.** EXHIBIT 13

(A) Purpose

The purpose of this rule is to safeguard the interest of the public by regulating the conduct of public insurance adjusters.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under Chapter 3951. and section 3901.041 of the Revised Code.

(C) Prohibited activities

No public insurance adjuster or public insurance adjuster agent shall:

(1) Engage in any manner or degree, for compensation of any kind, in the business of repairing, remodeling, or replacing damaged or destroyed property, real or personal, which damage or destruction is covered by a policy of insurance; nor have any direct or indirect interest in, nor receive compensation of any kind from any person, firm, association, partnership, or corporation which is engaged in such business;

(2) Attempt in any manner to solicit a loss during the progress of a fire or while the fire department or any of its representatives are in any manner engaged at the damaged premises; nor in any way interfere with the performance of the duties of an investigator of the state fire marshal's office, an investigator of any fire department, or a law enforcement official of this state or of any political subdivision thereof;

(3) Give or offer to give to an insured or ~~his~~ that person's representative any portion of the adjuster's fee or anticipated settlement of the claim for loss or damage as an inducement to secure a contract for the adjustment of a loss;

(4) Represent ~~himself~~ that public insurance adjuster to be an adjuster for or a representative of any insurance company, a fire investigator, or a person connected with any fire department or law enforcement agency;

(5) Compensate any person to act on ~~his~~ that person's behalf in the solicitation, negotiation, or settlement of a claim unless such person is licensed as a public insurance adjuster or a public insurance adjuster agent;

(6) Make an inventory or estimate of loss or damage other than that which is fair and honest; and

(7) Own or acquire any direct or indirect financial interest in any property, real or personal, which is the subject of a loss adjusted by ~~him~~that public insurance adjuster; nor have any direct or indirect financial interest in the sale of any salvage of any property which is the subject of a loss adjusted by ~~him~~that public insurance adjuster.

(D) Records of adjuster

Every public insurance adjuster shall keep a full record of ~~his transaction~~ that perons's transactions as an adjuster for the previous three years and such records shall be open at all times to the inspection of the superintendent of insurance or ~~his~~ the superintendent's representative. Such records shall show for each loss adjusted by ~~him~~the public insurance adjuster:

(1) The name of the insured;

(2) The date, location, and the public insurance adjuster's estimate of the amount of loss;

(3) The name of the insurer or insurers which issued any policy covering the loss which was the subject of the adjustment;

(4) The amount of coverage, the expiration date, and the number of each policy of insurance covering such loss;

(5) An itemized statement of all recoveries by the insured from all sources with regard to such loss;

(6) The names and addresses of any person or persons soliciting the adjustment on behalf of the public insurance adjuster and the date and time when solicited;

(7) The total compensation received by the public insurance adjuster for the adjustment of the loss;

(8) Copies of any agreements between the public insurance adjuster and the insured; and

(9) Names and addresses of all contractors who performed or contracted to perform work of any kind on the damaged or destroyed property prior to settlement of the claim.

(E) Contract requirements

(1) No public insurance adjuster shall use in ~~his~~ that person's business as a public insurance adjuster a contract whereby an insured engages or employs the public insurance adjuster to perform the functions specified in division (A) of section 3951.01 of the Revised Code until thirty days after the form of such contract has been filed with the superintendent of insurance, unless within such time the superintendent gives the public insurance adjuster written approval for the use of such form. If the superintendent finds within such thirty-day period that the form filed contains any language which is prohibited by any law of this state, including any rule of the superintendent, or that it is inconsistent, ambiguous, misleading, deceptive, or likely to mislead an insured, the superintendent will give written notice of such finding to the public insurance adjuster who filed the form, and the public insurance adjuster shall thereafter not use such form.

(2) Every such contract must conspicuously set out the fee of the public insurance adjuster for the adjustment services to be rendered the insured pursuant to the contract.

(F) Restriction on insurers

(1) No insurer authorized to issue the types of insurance policies set forth in division (B) of section 3951.01 of the Revised Code shall:

(a) Recognize a public insurance adjuster as a party interested in the proceeds of any insurance settlements arising from such policies or negotiate an insurance settlement with a public insurance adjuster representing an insured unless such public insurance adjuster has been duly licensed as a public insurance adjuster by the department of insurance.

(b) Negotiate an insurance settlement with a representative of an insured, other than a licensed public insurance adjuster, unless such representative has been duly appointed as such by a court of law or is one of those persons enumerated in division (E) of section 3951.01 of the Revised Code.

(2) Each insurance company referred to in paragraph (F)(1) of this rule shall keep a record of each insurance loss and/or settlement wherein the insured was represented by a public insurance adjuster. Such record shall include a copy of the public insurance adjuster's certificate of authority.

(G) Suspension or revocation

The superintendent of insurance may suspend, revoke, or refuse to renew the license of a public insurance adjuster or public insurance adjuster agent found to be in violation of this rule. Such suspension, revocation, or refusal to renew shall be in

addition to, not a substitution for, the penalties provided in section 3951.99 of the Revised Code.

(H) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms and provisions shall be and continue in full force and effect.

Effective:

Five Year Review (FYR) Dates: 11/30/2021

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	3901.041
Rule Amplifies:	Chapter 3951.
Prior Effective Dates:	08/01/1972, 11/03/2016

EXHIBIT 14

Ohio | Common Sense Initiative

Mike DeWine, Governor | **Jon Husted**, Lt. Governor | **Carrie Kuruc**, Director

Business Impact Analysis

Agency Name: ***Ohio Department of Insurance***
Rule Contact Name: ***Loretta Meedved***
Rule Contact Information: ***loretta.medved@insurance.ohio.gov***
614-644-0239

Regulation/Package Title *(a general description of the rules' substantive content)*:
Mortgage Guaranty Insurance, Ohio mine subsidence insurance underwriting association and fund, Public insurance adjusters, and Misconduct by insurance license applicants and licensees

Rule Number(s): ***3901-1-13, 3901-1-24, 3901-1-48, 3901-5-12***

Date of Submission for CSI Review: ***July 20, 2021***
Public Comment Period End Date: ***August 3, 2021 12:00AM***

Rule Type/Number of Rules:

- ☐ New/ rules
- ☒ Amended/ ***3*** rules (FYR? ***2021***)
- ☒ No Change/ ***1*** rules (FYR? ***2021***)
- ☐ Rescinded/ rules (FYR?)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 requires agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the Agency determined the rule(s) create?

   The rule(s):

   - ☒ a. Requires a license, permit, or any other prior authorization to engage in or operate a line of business.
   - ☒ b. Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.
   - ☒ c. Requires specific expenditures or the report of information as a condition of compliance.
   - ☐ d. Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 3901-1-13: The purpose of this rule is to implement the section of Ohio Revised Code which pertains to the writing and servicing of mortgage guaranty insurance. The rule outlines procedural and structural guidelines such as: policy forms, coverage limitations, advertising, and reserving requirements. Recommended amendments will update references to federal programs and offices.

   Rule 3901-1-24: The public insurance adjuster rule provides the baseline guidance for oversight of public insurance adjuster conduct and common consumer protection concerns including: Public insurance adjuster prohibitions, record-keeping, contract requirements, and insurer restrictions. Reccomended amendments will remove gender references throughout the rule.

   Rule 3901-1-48: This rule implements the plan of operation of the "Ohio Mine Subsidence Insurance Underwriting Association," (OMSIUA), pursuant to Ohio Revised Code. Recommended amendments remove the superintendent of insurance from the board of governors, this reflects changes to the ORC in 2017.

   Rule 3901-5-12: This rule establishes standards of conduct and responsibility that apply to insurance license applicants, licensees, and/or insurance companies. The rule outlines practices that would be deemed unfair and deceptive in the sale of insurance. There are no suggested amendments to this rule.

3. Please list the Ohio statute(s) that authorize the Agency to adopt the rule(s) and the statute(s) that amplify that authority.

   3901-1-13: Section 3901.041 of the Revised Code.

   3901-1-24: Section 3901.041 of the Revised Code.

   3901-1-48: Section 3901.041 of the Revised Code.

   3901-5-12: Sections 3901.041, 3905.14 and 3905.85(D) of the Revised Code.

4. Does the regulation implement a federal requirement? ☐ Yes ☒ No
   Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   ☐ Yes ☒ No
   If yes, please briefly explain the source and substance of the federal requirement.

   Not applicable.

5. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   Not applicable.

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   Rule 3901-1-13: Mortgage Guaranty insurance reduces risk to mortgage lenders and provides opportunities for home purchasers who may not otherwise qualify under traditional lending criteria. This rule establishes the regulatory framework for this type of coverage.

   Rule 3901-1-24: Public insurance adjusters represent policyholders by assisting with interpretation of the insured's policy and negotiates with the insurance company on a claim. The public purpose of the rule is consumer protection, accomplished by setting prohibitions and standards of conduct for public insurance adjusters.

   Rule 3901-1-48: Mine subsidence occurs when the foundation of a structure is compromised due to lateral or vertical ground movement caused by a failure in an abandoned mine. Homes located in areas of Ohio with a presence of abandoned mines are at risk for mine subsidence. Mine subsidence insurance coverage is available to elligible Ohioans as an endorsement to a basic property or homeowners policy. Coverage is mandatory in counties with a high concentration of abandoned mines, and optional in counties where a small concentration of abandoned mines are present. Insurers who write basic property or homeowners policies in the eligible counties are required to become members of the OMSIUA and offer this coverage to all eligible applicants. This rule specifies how OMSIUA will operate.

Rule 3901-5-12: This rule works to protect consumers from being mislead or harmed by prohibiting unfair and deceptive acts on behalf of insurance license applicants, licensees and companies.

7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

   The success of rules 3901-1-13 and 3901-1-48 remains evident in the continuing market and consumer protections in the coverage they establish.

   For rules 3901-1-24 and 3901-5-12, success is measured generally through the absence of complaints, or allegations that lead to a need to investigate or penalize licensed individuals and applicants for misconduct, or for the need to take action against non-licensed individuals.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931? ☐ Yes ☒ No

   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

   Not applicable.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation. *If applicable, please include the date and medium by which the stakeholders were initially contacted.*

In May 2021, an email requesting comment on the rule was sent to various stakeholders, interested parties, trade associations and companies. Specifically, the department reached out to the Ohio Mine Subsidence Insurance Underwriting Association (OMSIUA), the Ohio Land Title Association, the Ohio Insurance Institute (OII), the Association of Ohio Life Insurance Companies (AOLIC), the American Council of Life Insurance (ACLI), the National Association of Insurance and Financial Advisors (NAIFA), Ohio Association of Health Plans (OAHP) and the Professional Independent Agents Association (PIAA), among others. Additionally, these rules were also posted on the department's web site for review.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

    No comments were received during or after the vetting of this rule packet.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

Rules 3901-1-13, 3901-1-24, and 3901-5-12 were drafted pursuant to the National Association of Insurance Commissioners (NAIC) model regulations which were created and vetted through a committee process that includes research and input from various state regulators and stakeholders. The NAIC maintains subgroups that continually monitor trends and conditions of the industry.

Rule 3901-1-48 was established to govern the OMSIUA in order to guarantee eligible Ohioans would be provided an opportunity for mine subsidence coverage. Research determined the specifc areas of Ohio that are at risk for mine subsidence activity.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

    Rules 3901-1-13 and 3901-1-48: The purpose of these rules is to establish the regulatory framework of mortgage guaranty insurance, and establish the function and governing of the OMSIUA board, alternatives are not appropriate.

    Rules 3901-1-24 and 3901-5-12: The practices outlined in both rules were gathered after reviewing trends in the industry and common areas of consumer complaint, these areas are reviwed by the NAIC regularly and alternatives are not appropriate at this time.

13. Did the Agency specifically consider a performance-based regulation? Please explain. *Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.*

    No. Performance-based rules would not apply as the purpose and scope of these rules are to establish the regulatory framework of mortgage guaranty insurance, to establish the function of the OMSIUA board, and proscribe requirements and list prohibited activities. A defined process provides clarity to the regulated community.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

    The Ohio department of insurance is the sole agency regulating insurance and there are no duplicative rules.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

    All rules included in this packet have remained in effect for many years and are understood by the regulated community. All proposed amendments are technical and will not impact any requirements.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:
    a. Identify the scope of the impacted business community;
    b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and
    c. Quantify the expected adverse impact from the regulation.
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a-c.

Rule 3901-1-13: Mortgage guaranty insurers are impacted by the requirements of this rule. Compliance requirements include maintaining minimum reserves. Additionally, companies are required to notify the department when five per cent or more of their net annual premium is received from policies having a loan to value ratio of greater than ninty-five per cent. If a mortgage guaranty insurance company recieves more than twenty per cent of their net annual premium from policies written by affiliates, they are required to notify the superintendent. Generally this data is readily available based on the internal underwriting and accounting practices of the companies.

Rule 3901-1-24: The impacted business community is primarily licensed public insurance adjusters. The rule's scope focuses on standards of conduct and, therefore, does not impose a direct cost or adverse impact for compliance. Statute requires licensure before acting as a publicinsurance adjuster, which includes a $100 initial application fee and a $50 annual renewal fee.

Rule 3901-1-48: Insurers who write basic property or homeowners policies for family dwellings in the defined eligible counties are required to become members of the OMSIUA and offer mine subsidence coverage to all eligible applicants. Member insurers are required to submit quarterly reports and maintain certain agreements with the OMSIUA. Completing these requirements would take no longer than a few hours a year.

Rule 3901-5-12: This rule impacts insurance license applicants, licensees, and/or companies licensed or authorized to transact the business of insurance. Adverse impact is not imposed as the rule addresses only areas of misconduct. It is the responsibility of the individual and or company to comply with the rule as a matter of every day business practices. In cases where an insurance company has reasonable cause to believe that there has been a violation or is a continuing violation of this rule, and the details thereof which are known, the department shall be notified. The department maintains both the market conduct and agent licensing divisions to address such matters, informing the department may require minimal to moderate communications to determine the extent of any investigation.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The guidelines established in these rules assist in maintaining a stable and competitive industry and collectively provide important consumer protections. The prohibited actions for public insurance adjusters and license applicants are in place to potect consumers from conflicts of interests or other actions that may cause financial harm.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Rule 3901-1-13: The requirements apply equally to any company engaged in the sale of mortgage guaranty products in order to ensure a balanced market.

Rule 3901-1-24: The requirements apply equally to any licensed public insurance adjuster, most of which are individual practitioners or small-business agencies.

Rule 3901-1-48: The rule applies equally to insurers who met the requirements of OMSIUA.

Rule 3901-5-12: The rule establishes straight-forward business standards to serve as crucial consumer protection. Consistent compliance across the industry provides predictability for both the industry and consumers.

19. How will the Agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Paperwork violations and/or first time offender issues would be dealt with on a case-by-case basis to determine whether the violation could have a serious impact on the consumer or the general public. Minor errors would be handled by advising the company and giving them an opportunity to cure the omission or irregularity. For rule 3901-1-24 the superintendent may suspend, revoke, or refuse to renew a public adjusters license for a conduct violation, and any such action would be conducted under a Chapter 119. Administrative hearing process.

20. What resources are available to assist small businesses with compliance of the regulation?

Department staff is available to answer questions and provide assistance as needed.

Ohio | Common Sense Initiative

EXHIBIT 15

Mike DeWine, Governor
Jon Husted, Lt. Governor
Sean McCullough, Director

MEMORANDUM

TO: Loretta Medved, Ohio Department of Insurance

FROM: Joseph Baker, Business Advocate

DATE: September 14, 2021

RE: **CSI Review – Mortgage guaranty insurance, Ohio mine subsidence insurance underwriting association and fund, public insurance adjusters, and misconduct by insurance license applicants and licensees (OAC 3901-1-13, 3901-1-24, 3901-1-48, and 3901-5-12)**

On behalf of Lt. Governor Jon Husted, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Department as provided for in ORC 107.54.

Analysis

This rule package consists of one no change and three amended rules proposed by the Ohio Department of Insurance (Department) as a part of the statutory five-year review process. This rule package was submitted to the CSI Office on July 20, 2021, and the public comment period was held open through August 3, 2021. Unless otherwise noted below, this recommendation reflects the version of the proposed rules filed with the CSI Office on July 20, 2021.

The rules in this package establish regulations related to providing mortgage guaranty insurance, establish standards of conduct and records requirements for public insurance adjusters, implement definitions and regulations related to the Ohio Mine Subsidence Underwriting Association, and establish standards of conduct for insurance license applicants and licensees.

OAC 3901-1-13 sets forth definitions related to mortgage guaranty insurance and requirements for business engaged in providing such insurance. The rule prohibits businesses from selling mortgage

guaranty insurance unless they have capital and surplus of at least $2,500,000, institutes geographic limits on the concentration of insurance in certain regions, limits certain adverting practices, and establishes other regulations related to mortgage guaranty insurance companies. The rule is amended to update terms related to federal offices and to remove a prohibition on the Superintendent of Insurance (Superintendent) granting a waiver after October 1, 2014.

OAC 3901-1-24 establishes regulations related to public insurance adjusters. The rule prohibits any public insurance adjuster or agent from engaging in business related to the repair or remodel of certain insured properties, soliciting a loss during a fire or interfering with fire investigators, offering a portion of the adjuster's fee in an effort to secure a contract, representing himself or herself falsely, acting dishonestly with respect to estimates of loss or damage, or owning any property connected to a loss that the adjuster is reviewing, among others. The rule also establishes records retention requirements, contractual limitations, restrictions on insurers, and allows for the Superintendent to revoke or suspend the license of an adjuster who violates the rules. The rule is amended to remove gender pronouns related to insurance adjusters.

OAC 3901-1-48 implements definitions and regulations related to the Ohio Mine Subsidence Underwriting Association and the Mine Subsidence Insurance Fund. The rule provides that the association and fund shall be administered by a board made up of various designees of state agencies and requires that every policy of mine subsidence insurance may not create liability on the part of the member issuing the policy beyond the net premium of policies paid into the fund. The rule also establishes standards related to applying for coverage, administering and processing claims, underwriting, audits, reporting and statistics, investment of custodial funds, reinsurance, and meeting notices. The Department notes in the BIA that the rule is amended to remove the Superintendent from the board overseeing the Mine Subsidence Underwriting Association and the Mine Subsidence Insurance Fund in connection to a statutory change.

OAC 3901-5-12 establishes standards of conduct related to insurance license applicants and licensees and outlines behavior that may be subject to disciplinary action. For example, the rule prohibits an individual from soliciting insurance when the solicitor knew that the customer is currently covered by substantially duplicative coverage or where the customer would not be entitled to the benefits of coverage due to various reasons. The rule also states that insurance companies may be found to have engaged in unfair or deceptive practices if an employee engages in such conduct and where the company has either tolerated, ratified or encourage the behavior, if it failed to notify the Department when a violation known by the business has occurred, or if it fails to refund premiums or payments when the company's agent has violated a law or rule.

During early stakeholder outreach, the Department notified stakeholders including the Ohio Mine

Subsidence Insurance Underwriting Association, the Ohio Land Title Association, the Ohio Insurance Institute, the Association of Ohio Life Insurance Companies, the American Council of Life Insurance, the National Association of Insurance and Financial Advisors, Ohio Association of Health Plans, and the Professional Independent Agents Association, among others. No comments were provided in response to the request for early stakeholder feedback or during the CSI public comment period.

The business communities impacted by the rules include mortgage guaranty insurers, licensed public insurance adjusters, insurers who write basic property or homeowner policies for family dwellings and who are required to offer mine subsidence coverage to all eligible applicants, and insurance license applicants, licensees, or companies licensed or authorized to transact in insurance. The adverse impacts created by the rules include maintaining minimum reserves, notification requirements, potential disciplinary action related to violating standards of conduct, administrative effort and costs associated with applying for and renewing a public insurance adjuster license ($100 and $50, respectively), submitting quarterly reports to the Ohio Mine Subsidence Insurance Underwriting Association, and notifying the Department when employees or agents engage in misconduct. The Department states in the BIA that the adverse impacts created by the rules are necessary to assist in maintaining a stable and competitive industry and protect consumers from conflicts of interests or other actions that may cause financial harm.

Recommendations

Based on the information above, the CSI Office has no recommendations on this rule package.

Conclusion

The CSI Office concludes that the Ohio Department of Insurance should proceed in filing the proposed rules with the Joint Committee on Agency Rule Review.

Ohio Department of Insurance

Mike DeWine, Governor
Jon Husted, Lt. Governor

Judith L. French, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

EXHIBIT 16

MEMORANDUM

To: Joseph Baker, Business Advocate

CC: Sean McCullough, Director of the Common Sense Initiative Office

From: Loretta Medved, Policy Analyst

Date: September 29, 2021

Re: Response to CSI Review – Mortgage guaranty insurance, Ohio mine subsidence insurance underwriting association and fund, public insurance adjusters, and misconduct by insurance license applicants and licensees (OAC 3901-1-13, 3901-1-24, 3901-1-48, and 3901-5-12)

On September 14, 2021, the Ohio Department of Insurance (the Department) received the Recommendation Memorandum (CSI Recommendation) from the Common Sense Initiative Office for rule(s) 3901-1-13 Mortgage guaranty insurance, 3901-1-24 Public insurance adjusters, 3901-1-48 "Ohio mine subsidence insurance underwriting association" and "mine subsidence insurance fund" plan of operation, and 3901-5-12 Misconduct by insurance license applicants and licensees.

The CSI Recommendation stated that the office does not have any recommendations regarding this rule package, and therefore should proceed with a formal filing of the rule package.

At this time, the Department plans to move forward with the filing of this rule package with the Joint Committee on Agency Rule Review.

If you have any questions please contact Loretta Medved at 614-644-0239 or Loretta.Medved@insurance.ohio.gov.

Rule Summary and Fiscal Analysis
Part A - General Questions

EXHIBIT 17

Rule Number: 3901-1-48

Rule Type: Amendment

Rule Title/Tagline: "Ohio mine subsidence insurance underwriting association" and "mine subsidence insurance fund" plan of operation.

Agency Name: Department of Insurance

Division:

Address: 50 W Town Street Suite 300 Columbus OH 43215

Contact: Tina Chubb **Phone:** (614) 728-1044

Email: Tina.Chubb@insurance.ohio.gov

I. Rule Summary

1. **Is this a five year rule review?** Yes

    A. **What is the rule's five year review date?** 11/30/2021

2. **Is this rule the result of recent legislation?** No

3. **What statute is this rule being promulgated under?** 119.03

4. **What statute(s) grant rule writing authority?** 3901.041

5. **What statute(s) does the rule implement or amplify?** 3929.50 to 3929.53, 3929.55, 3929.56, 3929.58 to 3929.61

6. **What are the reasons for proposing the rule?**

    This rule is being reviewed as a part of the agency five year rule review.

7. **Summarize the rule's content, and if this is an amended rule, also summarize the rule's changes.**

    The purpose of this rule is to implement requirements established in ORC to establish the "Ohio Mine Subsidence Underwriting Association," provide for the transfer of risk

from member insurers to the association, and create the "Mine Subsidence Insurance Fund.

Recommended amendments remove the superintendent from the board of governors, this reflects changes to the ORC in 2017, and grammatical amendments.

8. **Does the rule incorporate material by reference?** No

9. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

   Not Applicable

10. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

    Not Applicable

II. Fiscal Analysis

11. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

    This will have no impact on revenues or expenditures.

    $0.00

    Not applicable.

12. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

    Not applicable.

13. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

14. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

15. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

There is no estimated cost of compliance for this rule.

III. Common Sense Initiative (CSI) Questions

16. **Was this rule filed with the Common Sense Initiative Office?** Yes

17. **Does this rule have an adverse impact on business?** Yes

    A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

       This rule applies only to licensed insurers who write basic property or multi-peril policies for family dwellings in eligible counties of Ohio.

    B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** No

    C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** Yes

       Paragraph (M)(3) requires that members shall file on a quarterly basis with financial reports, a summary report of statistics in a form approved by the board. Such reports shall contain; claim reports, financial reports, quarter and year-to-date policy count by county, and quarter and year-to-date premium written by county.

    D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restrictions (This section only applies to agencies indicated in R.C. 121.95 (A))

18. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

    A. **How many new regulatory restrictions do you propose adding?**

       Not Applicable

    B. **How many existing regulatory restrictions do you propose removing?**

Not Applicable

EXHIBIT 18

3901-1-48 **"Ohio mine subsidence insurance underwriting association" and "mine subsidence insurance fund" plan of operation.**

(A) Purpose

The purpose of this rule is to implement sections 3929.50 to 3929.53 and 3929.55 to 3929.56 and 3929.58 to 3929.61 of the Revised Code which:

(1) Establishes the "Ohio Mine Subsidence Underwriting Association,"

(2) Provides for the transfer of risk from member insurers to the association, and

(3) Creates the "Mine Subsidence Insurance Fund."

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under section 3901.041 of the Revised Code.

(C) Definitions

(1) "Basic property insurance" means insurance against direct loss to property as defined and limited in dwelling fire, homeowners, and farm policies and extended coverage endorsements thereon, and insurance for such types, classes and locations of property against the perils of vandalism, malicious mischief, burglary or theft, as the superintendent of insurance shall designate.

(2) "Board" means the four-member board of governors, empowered by division (C) of section 3929.51 of the Revised Code to govern the "Ohio Mine Subsidence Insurance Underwriting Association" and the "Ohio Mine Subsidence Insurance Fund."

(3) "Homeowners insurance" means insurance on owner-occupied dwellings providing personal multi-peril property and liability coverages, commonly known as "homeowners insurance."

(4) "Farm insurance" means insurance providing property coverage on farm dwelling buildings.

(5) "Dwelling fire insurance" means a policy providing property coverage on residential buildings for the perils of fire and lightning and additional coverages.

(6) "Member" means all insurers authorized to write and engaged in writing within the state, on a direct basis, basic property insurance or any component thereof in multi-peril and policies.

(7) "Mine subsidence" means loss caused by the collapse or lateral or vertical movement of structures resulting from the caving in of underground mines, including coal mines, clay mines, limestone mines, and salt mines. Mine subsidence does not include loss caused by earthquakes, landslide, volcanic eruption, or collapse of strip mines, storm and sewer drains or rapid transit tunnels.

(8) "Mine subsidence coverage" means the limits and type of coverage as defined by the mine subsidence insurance governing board in the coverage form and approved by the superintendent.

(9) "Mine Subsidence Insurance Underwriting Association," hereinafter referred to as "association" means the association of members formed pursuant to section 3929.51 of the Revised Code.

(10) "Mine Subsidence Insurance Fund," hereinafter referred to as "fund," means the fund formed pursuant to section 3929.52 of the Revised Code which is administered by the board for the purpose of making available insurance coverage against mine subsidence. The state treasurer is the custodian of the fund.

(11) "Plan of operation," hereinafter referred to as "plan," means the plan of operation approved by the superintendent for the economical, fair and nondiscriminatory administration of the requirements identified in sections 3929.50 to 3929.53 and 3929.55 to 3929.56 and 3929.58 to 3929.61 of the Revised Code.

(12) "Strip mines" means any surface mine.

(13) "Structure" means any one to four-family dwelling as defined and limited in dwelling fire, homeowners, and farm policies and other structures as described, defined, or limited in the mine subsidence insurance form.

(14) "Superintendent" means the superintendent of insurance of the state of Ohio.

(15) "Treasurer" means the treasurer of the state of Ohio.

(16) "Auditor" means the auditor of the state of Ohio.

(D) Board of governors

(1) The association and fund shall be administered by the board consisting of the director of natural resources or the director's designee, as chairperson, the treasurer of the state or the treasurer of state's designee, ~~the superintendent of insurance or the superintendent's designee,~~ and one representative from member companies. The representative from the member companies shall be an Ohio-domiciled member of the association.

(2) The board shall approve all actions of the association, have the responsibility of administering the association and fund.

(3) The board shall meet as often as is required to perform the duties of administration, and shall meet upon the request of any single member of the board. In no event shall the board meet less than two times per year.

(E) Meeting of members

(1) Members shall elect their authorized representative every three years. The member company representative elected to the board shall be an Ohio-domiciled company.

(2) The members may hold meetings as needed and during any such meeting, a quorum shall consist of a simple majority of members present.

(3) Each member shall be entitled to one vote. Members in the same group of insurers shall be entitled to one vote only.

(F) Liability

Every policy of mine subsidence insurance written hereunder shall provide that such policy does not create any liability on the part of the member issuing such policy, the association, or any organization with which it may contract for administrative or claims services, beyond the net premium on such policies paid into the fund. Such policies shall create no liability beyond the amounts in the fund, on the part of the state of Ohio, the "Ohio Insurance Guaranty Association" and its member companies or any other person or organization.

(G) Notice of availability of mine subsidence insurance

(1) Every insurer that offers basic property and homeowners insurance insuring on a direct basis a structure located in the counties of Athens, Belmont, Carroll, Columbiana, Coshocton, Gallia, Guernsey, Harrison, Hocking, Holmes, Jackson, Jefferson, Lawrence, Mahoning, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Scioto, Stark, Trumbull, Tuscarawas, Vinton and Washington shall include mine subsidence coverage provided by the Ohio mine

subsidence insurance underwriting association in each policy of basic property and homeowners insurance that is delivered, issued for delivery or renewed in any of such counties.

(2) The mine subsidence insurance governing board herein designates Delaware, Erie, Geauga, Lake, Licking, Medina, Ottawa, Portage, Preble, Summit and Wayne counties as counties in which mine subsidence coverage must be offered, on an optional basis, by an insurer.

(a) Every insurer that offers basic property and homeowners insurance insuring on a direct basis to a structure located in any county designated in paragraph (G)(2) of this rule shall offer to include, on an optional basis, mine subsidence coverage provided by the association in each policy of basic property insurance that is delivered, issued for delivery, or renewed in any such designated county.

(b) This offer shall contain language and be in a form approved by the superintendent which includes a description of mine subsidence coverage, a statement that the purchase of the coverage is optional, and the premium charged for the coverage.

(H) Application for coverage

A member insurer who receives a request from a named insured or applicant for mine subsidence shall forward to that named insured or applicant an application for mine subsidence coverage. Such application may be included, at the insurer's option, with the offer described in paragraph (G)(2)(a) of this rule. The form of the application shall be approved by the superintendent.

(I) Administration and claims processing

The board may retain a contractor to provide administrative and claims processing. When a contractor is retained, the board may from time to time review:

(1) The performance of the contractor;

(2) The procedures and standards used by the contractor for administration and claims processing; and

(3) The application of those procedures and standards to applicants for insurance and to claims of insureds.

(J) Underwriting

(1) Mine subsidence coverage will be available on eligible property. Eligible property must be:

(a) A structure as defined in this rule;

(b) Covered by a valid basic property or homeowners insurance policy.

(2) The member may refuse to provide mine subsidence coverage on an otherwise eligible property where:

(a) The structure evidences un-repaired subsidence damage; or

(b) The structure evidences any mine subsidence damage in progress.

(3) The limit of liability for direct loss caused by mine subsidence under this plan of operation shall not exceed an amount equal to the coverage on the dwelling provided by a basic property or homeowners policy, or three hundred thousand dollars, whichever is less, and shall not exceed the amount expressed in the mine subsidence coverage form as approved by the mine subsidence insurance governing board and approved by the superintendent of insurance.

(4) All coverage provided pursuant to this plan of operation is subject to a deductible as expressed in the mine subsidence coverage form as approved by the mine subsidence insurance governing board and approved by the superintendent of insurance, but at no time shall the deductible be less than two hundred fifty dollars, or more than five hundred dollars.

(K) Rates and forms

(1) Rates. The board shall periodically review the premium level and experience data and recommend to the superintendent a rate or schedule of rates sufficient to satisfy:

(a) All foreseeable claims;

(b) Normal cost of operation; and

(c) A reserve for unexpected contingencies.

However, the premium level for mine subsidence coverage in a county designated for optional coverage shall not exceed an annual rate that is greater than twenty dollars. The premium level for mine subsidence coverage in a county as designated in paragraph (G)(1) of this rule shall not exceed an annual rate that is greater than five dollars.

(2) Forms. The policy forms and language shall be approved by the superintendent.

(L) Audits

The auditor shall audit the affairs of the fund in accordance with section 3929.55 of the Revised Code at least once each year. The auditor shall ascertain the expenses incurred in making any such audit and shall certify the amount to the board for payment from the fund.

(M) Reporting and statistics

(1) Claim reports. Members shall, upon receipt of notice of claims from policyholder(s), confirm coverage and provide formal notice of claim to the association.

(2) Financial reports:

(a) The fiscal period shall be the calendar year.

(b) Members reports are required quarterly and shall be due on the forty-fifth day following the close of the quarter.

(c) Members' reports shall be in forms approved by the board and shall include, at minimum:

(i) Gross written premium on a per county basis.

(ii) Premium cancelled/returned on a per county basis.

(iii) Ceding commission withheld (for optional counties only).

(d) Members reports shall be accompanied by the appropriate remittance which shall be full premium collected for mine subsidence coverage in the counties denoted in paragraph (G)(1) of this rule and the net premium (gross premium written, less ceding commission) in the counties denoted in paragraph (G)(2) of this rule less any cancellation/returns. In the event a balance is due to the insurer, that balance shall be carried forward as a credit against future written premiums. An insurer may apply for a refund only if it ceases to issue basic property or homeowner insurance coverage.

(e) Members shall report and pay premium taxes as required.

(f) The association shall review, verify and reconcile members' reports and research, and rectify any inconsistencies.

(g) The association shall remit receipts to the fund, said remittance to be supported by a summary report of premium written, cancelled/non-renewed, net premium written and commission taken.

(3) Statistical reports. Members shall compile and file, on a quarterly basis with the financial reports, a summary report of statistics in a form approved by the board. Such reports shall, at minimum, contain:

(a) Quarter and year-to-date policy count by county and in total;

(b) Quarter and year-to-date premium written by county.

(N) "Mine Subsidence Insurance Fund"

The fund shall receive all revenues, appropriations and investment earnings pursuant to this plan of operation. Premiums collected will be considered program income in accordance with the uniform administrative requirements for grants to state and local governments and be used:

(1) To enable the fund to be self-sustaining, with the fund invested by the treasurer of state under guidelines established by the board;

(2) To provide a reserve for payment of claims for verified claims from all types of mine subsidence, including non-coal mining, post-1977 underground mines and active underground mines;

(O) Investment of custodial funds

With the approval of the board, the treasurer of state may invest any monies in the fund that are in excess of the amounts required to meet the immediate cash needs and operating expenses of the fund. The board shall not provide guidelines for the investment of excess funds that are broader or more liberal than the investment provisions for property casualty insurance companies set forth in Chapter 3925. of the Revised Code.

(P) Reinsurance agreement

(1) Every insurer authorized and engaged in writing on a direct basis any property coverages in the state of Ohio shall execute a reinsurance agreement with the association. The form of the reinsurance agreement shall be in a form approved by the board.

(2) An insurer may request exemption from the requirements of paragraph (P) of this rule by filing the exemption form with the superintendent. The exemption shall be effective after review and approved by the superintendent of insurance.

(3) Any insurer who has received an exemption shall notify the association of any change in any circumstances that would be reason to revoke the exemption.

(Q) Effective date of the plan

This plan of operation shall be effective upon the effective date of this rule.

(R) Amendments

Amendments to the plan may be requested by the board or superintendent of insurance in accordance with the provisions of section 3929.53 of the Revised Code.

(S) Meeting notice

(1) The board and each of its committees and subcommittees shall provide notice of regular, special, and emergency meetings as the same are scheduled by posting the dates, times, locations, and agendas (if applicable) on the board's official web site.

(2) The board maintains a list of individuals who have requested individual notice of each meeting. Individual notice may be given via mail, electronic mail, or facsimile.

(a) Any person who desires individual mail notice of the meetings described in paragraph (S)(1) of this rule shall make the request in writing to the board at its business address. The board may refuse to honor a request for individual mail notice unless the person requesting such notice has first supplied the board with a self-addressed, stamped envelope for the transmission of each requested notice.

(b) Any person who desires individual electronic mail notice of the meetings described in paragraph (S)(1) of this rule shall make a request in writing to the board at its business address. The board shall maintain a list of all persons who have requested individual electronic mail notice in this manner. The board may purge the list of all entries as it deems appropriate provided, however, that the board shall first provide notice to any individual whose contact information will be purged at least thirty days in advance.

(c) Any person who desires individual facsimile mail notice of the meetings described in paragraph (S)(1) of this rule shall make a request in writing to the board at its business address. The board shall maintain a list of all persons who have requested individual facsimile notice in this manner. The board may purge the list of all entries as it deems appropriate provided, however, that the board shall first provide notice to any individual whose contact information will be purged at least thirty days in advance.

(d) The board may, at its sole option, provide for an electronic means of requesting individual electronic mail of facsimile notice of the meetings described in paragraph (S)(1) of this rule.

(3) A representative of the news media may obtain notice of all special or emergency meetings of the council, its committees or its subcommittees by requesting such in writing to the "Ohio Mine Subsidence Insurance Governing Board" at its business address.

(a) The request must provide the name of the person to be contacted, the agency whom the person represents, and shall state whether the person wishes to be notified of regular, special, or emergency meetings, or any combination thereof. Additionally, the request shall specify whether the person wishes to be notified by mail, electronic mail, or facsimile, and shall include the appropriate contact information.

(b) The board shall maintain a list of all news media representatives requesting notice of special meetings. The board may purge the list of all entries as it deems appropriate provided, however, that the board shall first provide notice to an individual whose contact information will be purged at least thirty days in advance.

(c) Notice of special meetings shall be provided to news media representatives at least twenty-four hours prior to the special meeting. Notice of emergency meetings shall be provided to news media representatives by telephone or electronic means as soon as practicable.

(4) Notice given by mail is effective upon mailing. Notice given by telephone is effective upon providing actual notice, leaving a message containing the meeting information with any individual who answers the number provided by the requestor or leaving a recorded message, or, if the board makes three unsuccessful attempts to contact the requestor directly or to leave a voice message. Notice given by electronic means shall be complete upon transmission.

(T) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms and provisions shall be and continue in full force and effect.

Effective:

Five Year Review (FYR) Dates: 11/30/2021

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	3901.041
Rule Amplifies:	3929.50 to 3929.53, 3929.55, 3929.56, 3929.58 to 3929.61
Prior Effective Dates:	07/23/1987, 01/01/1993, 12/28/1995, 07/18/2005, 09/25/2011

EXHIBIT 19

Ohio | Common Sense Initiative

Mike DeWine, Governor | **Jon Husted**, Lt. Governor | **Carrie Kuruc**, Director

Business Impact Analysis

Agency Name: ***Ohio Department of Insurance***
Rule Contact Name: ***Loretta Meedved***
Rule Contact Information: ***loretta.medved@insurance.ohio.gov***
614-644-0239

Regulation/Package Title *(a general description of the rules' substantive content)*:
Mortgage Guaranty Insurance, Ohio mine subsidence insurance underwriting association and fund, Public insurance adjusters, and Misconduct by insurance license applicants and licensees

Rule Number(s): ***3901-1-13, 3901-1-24, 3901-1-48, 3901-5-12***

Date of Submission for CSI Review: ***July 20, 2021***
Public Comment Period End Date: ***August 3, 2021 12:00AM***

Rule Type/Number of Rules:

- ☐ New/ rules
- ☒ Amended/ ***3*** rules (FYR? ***2021***)
- ☒ No Change/ ***1*** rules (FYR? ***2021***)
- ☐ Rescinded/ rules (FYR?)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 requires agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the Agency determined the rule(s) create?

   The rule(s):

   - ☒ a. Requires a license, permit, or any other prior authorization to engage in or operate a line of business.
   - ☒ b. Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.
   - ☒ c. Requires specific expenditures or the report of information as a condition of compliance.
   - ☐ d. Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 3901-1-13: The purpose of this rule is to implement the section of Ohio Revised Code which pertains to the writing and servicing of mortgage guaranty insurance. The rule outlines procedural and structural guidelines such as: policy forms, coverage limitations, advertising, and reserving requirements. Recommended amendments will update references to federal programs and offices.

   Rule 3901-1-24: The public insurance adjuster rule provides the baseline guidance for oversight of public insurance adjuster conduct and common consumer protection concerns including: Public insurance adjuster prohibitions, record-keeping, contract requirements, and insurer restrictions. Reccomended amendments will remove gender references throughout the rule.

   Rule 3901-1-48: This rule implements the plan of operation of the "Ohio Mine Subsidence Insurance Underwriting Association," (OMSIUA), pursuant to Ohio Revised Code. Recommended amendments remove the superintendent of insurance from the board of governors, this reflects changes to the ORC in 2017.

   Rule 3901-5-12: This rule establishes standards of conduct and responsibility that apply to insurance license applicants, licensees, and/or insurance companies. The rule outlines practices that would be deemed unfair and deceptive in the sale of insurance. There are no suggested amendments to this rule.

3. Please list the Ohio statute(s) that authorize the Agency to adopt the rule(s) and the statute(s) that amplify that authority.

   3901-1-13: Section 3901.041 of the Revised Code.

   3901-1-24: Section 3901.041 of the Revised Code.

   3901-1-48: Section 3901.041 of the Revised Code.

   3901-5-12: Sections 3901.041, 3905.14 and 3905.85(D) of the Revised Code.

4. Does the regulation implement a federal requirement? ☐ Yes ☒ No
   Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   ☐ Yes ☒ No
   If yes, please briefly explain the source and substance of the federal requirement.

   Not applicable.

5. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   Not applicable.

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   Rule 3901-1-13: Mortgage Guaranty insurance reduces risk to mortgage lenders and provides opportunities for home purchasers who may not otherwise qualify under traditional lending criteria. This rule establishes the regulatory framework for this type of coverage.

   Rule 3901-1-24: Public insurance adjusters represent policyholders by assisting with interpretation of the insured's policy and negotiates with the insurance company on a claim. The public purpose of the rule is consumer protection, accomplished by setting prohibitions and standards of conduct for public insurance adjusters.

   Rule 3901-1-48: Mine subsidence occurs when the foundation of a structure is compromised due to lateral or vertical ground movement caused by a failure in an abandoned mine. Homes located in areas of Ohio with a presence of abandoned mines are at risk for mine subsidence. Mine subsidence insurance coverage is available to elligible Ohioans as an endorsement to a basic property or homeowners policy. Coverage is mandatory in counties with a high concentration of abandoned mines, and optional in counties where a small concentration of abandoned mines are present. Insurers who write basic property or homeowners policies in the eligible counties are required to become members of the OMSIUA and offer this coverage to all eligible applicants. This rule specifies how OMSIUA will operate.

Rule 3901-5-12: This rule works to protect consumers from being mislead or harmed by prohibiting unfair and deceptive acts on behalf of insurance license applicants, licensees and companies.

7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

   The success of rules 3901-1-13 and 3901-1-48 remains evident in the continuing market and consumer protections in the coverage they establish.

   For rules 3901-1-24 and 3901-5-12, success is measured generally through the absence of complaints, or allegations that lead to a need to investigate or penalize licensed individuals and applicants for misconduct, or for the need to take action against non-licensed individuals.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931? ☐ Yes ☒ No

   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

   Not applicable.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation. *If applicable, please include the date and medium by which the stakeholders were initially contacted.*

In May 2021, an email requesting comment on the rule was sent to various stakeholders, interested parties, trade associations and companies. Specifically, the department reached out to the Ohio Mine Subsidence Insurance Underwriting Association (OMSIUA), the Ohio Land Title Association, the Ohio Insurance Institute (OII), the Association of Ohio Life Insurance Companies (AOLIC), the American Council of Life Insurance (ACLI), the National Association of Insurance and Financial Advisors (NAIFA), Ohio Association of Health Plans (OAHP) and the Professional Independent Agents Association (PIAA), among others. Additionally, these rules were also posted on the department's web site for review.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

    No comments were received during or after the vetting of this rule packet.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

Rules 3901-1-13, 3901-1-24, and 3901-5-12 were drafted pursuant to the National Association of Insurance Commissioners (NAIC) model regulations which were created and vetted through a committee process that includes research and input from various state regulators and stakeholders. The NAIC maintains subgroups that continually monitor trends and conditions of the industry.

Rule 3901-1-48 was established to govern the OMSIUA in order to guarantee eligible Ohioans would be provided an opportunity for mine subsidence coverage. Research determined the specifc areas of Ohio that are at risk for mine subsidence activity.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

    Rules 3901-1-13 and 3901-1-48: The purpose of these rules is to establish the regulatory framework of mortgage guaranty insurance, and establish the function and governing of the OMSIUA board, alternatives are not appropriate.

    Rules 3901-1-24 and 3901-5-12: The practices outlined in both rules were gathered after reviewing trends in the industry and common areas of consumer complaint, these areas are reviwed by the NAIC regularly and alternatives are not appropriate at this time.

13. Did the Agency specifically consider a performance-based regulation? Please explain. *Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.*

    No. Performance-based rules would not apply as the purpose and scope of these rules are to establish the regulatory framework of mortgage guaranty insurance, to establish the function of the OMSIUA board, and proscribe requirements and list prohibited activities. A defined process provides clarity to the regulated community.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

    The Ohio department of insurance is the sole agency regulating insurance and there are no duplicative rules.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

    All rules included in this packet have remained in effect for many years and are understood by the regulated community. All proposed amendments are technical and will not impact any requirements.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:
    a. Identify the scope of the impacted business community;
    b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and
    c. Quantify the expected adverse impact from the regulation.
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a-c.

Rule 3901-1-13: Mortgage guaranty insurers are impacted by the requirements of this rule. Compliance requirements include maintaining minimum reserves. Additionally, companies are required to notify the department when five per cent or more of their net annual premium is received from policies having a loan to value ratio of greater than ninty-five per cent. If a mortgage guaranty insurance company recieves more than twenty per cent of their net annual premium from policies written by affiliates, they are required to notify the superintendent. Generally this data is readily available based on the internal underwriting and accounting practices of the companies.

Rule 3901-1-24: The impacted business community is primarily licensed public insurance adjusters. The rule's scope focuses on standards of conduct and, therefore, does not impose a direct cost or adverse impact for compliance. Statute requires licensure before acting as a publicinsurance adjuster, which includes a $100 initial application fee and a $50 annual renewal fee.

Rule 3901-1-48: Insurers who write basic property or homeowners policies for family dwellings in the defined eligible counties are required to become members of the OMSIUA and offer mine subsidence coverage to all eligible applicants. Member insurers are required to submit quarterly reports and maintain certain agreements with the OMSIUA. Completing these requirements would take no longer than a few hours a year.

Rule 3901-5-12: This rule impacts insurance license applicants, licensees, and/or companies licensed or authorized to transact the business of insurance. Adverse impact is not imposed as the rule addresses only areas of misconduct. It is the responsibility of the individual and or company to comply with the rule as a matter of every day business practices. In cases where an insurance company has reasonable cause to believe that there has been a violation or is a continuing violation of this rule, and the details thereof which are known, the department shall be notified. The department maintains both the market conduct and agent licensing divisions to address such matters, informing the department may require minimal to moderate communications to determine the extent of any investigation.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The guidelines established in these rules assist in maintaining a stable and competitive industry and collectively provide important consumer protections. The prohibited actions for public insurance adjusters and license applicants are in place to potect consumers from conflicts of interests or other actions that may cause financial harm.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Rule 3901-1-13: The requirements apply equally to any company engaged in the sale of mortgage guaranty products in order to ensure a balanced market.

Rule 3901-1-24: The requirements apply equally to any licensed public insurance adjuster, most of which are individual practitioners or small-business agencies.

Rule 3901-1-48: The rule applies equally to insurers who met the requirements of OMSIUA.

Rule 3901-5-12: The rule establishes straight-forward business standards to serve as crucial consumer protection. Consistent compliance across the industry provides predictability for both the industry and consumers.

19. How will the Agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Paperwork violations and/or first time offender issues would be dealt with on a case-by-case basis to determine whether the violation could have a serious impact on the consumer or the general public. Minor errors would be handled by advising the company and giving them an opportunity to cure the omission or irregularity. For rule 3901-1-24 the superintendent may suspend, revoke, or refuse to renew a public adjusters license for a conduct violation, and any such action would be conducted under a Chapter 119. Administrative hearing process.

20. What resources are available to assist small businesses with compliance of the regulation?

Department staff is available to answer questions and provide assistance as needed.

Ohio | Common Sense Initiative

EXHIBIT 20

Mike DeWine, Governor
Jon Husted, Lt. Governor
Sean McCullough, Director

MEMORANDUM

TO: Loretta Medved, Ohio Department of Insurance

FROM: Joseph Baker, Business Advocate

DATE: September 14, 2021

RE: **CSI Review – Mortgage guaranty insurance, Ohio mine subsidence insurance underwriting association and fund, public insurance adjusters, and misconduct by insurance license applicants and licensees (OAC 3901-1-13, 3901-1-24, 3901-1-48, and 3901-5-12)**

On behalf of Lt. Governor Jon Husted, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Department as provided for in ORC 107.54.

Analysis

This rule package consists of one no change and three amended rules proposed by the Ohio Department of Insurance (Department) as a part of the statutory five-year review process. This rule package was submitted to the CSI Office on July 20, 2021, and the public comment period was held open through August 3, 2021. Unless otherwise noted below, this recommendation reflects the version of the proposed rules filed with the CSI Office on July 20, 2021.

The rules in this package establish regulations related to providing mortgage guaranty insurance, establish standards of conduct and records requirements for public insurance adjusters, implement definitions and regulations related to the Ohio Mine Subsidence Underwriting Association, and establish standards of conduct for insurance license applicants and licensees.

OAC 3901-1-13 sets forth definitions related to mortgage guaranty insurance and requirements for business engaged in providing such insurance. The rule prohibits businesses from selling mortgage

guaranty insurance unless they have capital and surplus of at least $2,500,000, institutes geographic limits on the concentration of insurance in certain regions, limits certain adverting practices, and establishes other regulations related to mortgage guaranty insurance companies. The rule is amended to update terms related to federal offices and to remove a prohibition on the Superintendent of Insurance (Superintendent) granting a waiver after October 1, 2014.

OAC 3901-1-24 establishes regulations related to public insurance adjusters. The rule prohibits any public insurance adjuster or agent from engaging in business related to the repair or remodel of certain insured properties, soliciting a loss during a fire or interfering with fire investigators, offering a portion of the adjuster's fee in an effort to secure a contract, representing himself or herself falsely, acting dishonestly with respect to estimates of loss or damage, or owning any property connected to a loss that the adjuster is reviewing, among others. The rule also establishes records retention requirements, contractual limitations, restrictions on insurers, and allows for the Superintendent to revoke or suspend the license of an adjuster who violates the rules. The rule is amended to remove gender pronouns related to insurance adjusters.

OAC 3901-1-48 implements definitions and regulations related to the Ohio Mine Subsidence Underwriting Association and the Mine Subsidence Insurance Fund. The rule provides that the association and fund shall be administered by a board made up of various designees of state agencies and requires that every policy of mine subsidence insurance may not create liability on the part of the member issuing the policy beyond the net premium of policies paid into the fund. The rule also establishes standards related to applying for coverage, administering and processing claims, underwriting, audits, reporting and statistics, investment of custodial funds, reinsurance, and meeting notices. The Department notes in the BIA that the rule is amended to remove the Superintendent from the board overseeing the Mine Subsidence Underwriting Association and the Mine Subsidence Insurance Fund in connection to a statutory change.

OAC 3901-5-12 establishes standards of conduct related to insurance license applicants and licensees and outlines behavior that may be subject to disciplinary action. For example, the rule prohibits an individual from soliciting insurance when the solicitor knew that the customer is currently covered by substantially duplicative coverage or where the customer would not be entitled to the benefits of coverage due to various reasons. The rule also states that insurance companies may be found to have engaged in unfair or deceptive practices if an employee engages in such conduct and where the company has either tolerated, ratified or encourage the behavior, if it failed to notify the Department when a violation known by the business has occurred, or if it fails to refund premiums or payments when the company's agent has violated a law or rule.

During early stakeholder outreach, the Department notified stakeholders including the Ohio Mine

Subsidence Insurance Underwriting Association, the Ohio Land Title Association, the Ohio Insurance Institute, the Association of Ohio Life Insurance Companies, the American Council of Life Insurance, the National Association of Insurance and Financial Advisors, Ohio Association of Health Plans, and the Professional Independent Agents Association, among others. No comments were provided in response to the request for early stakeholder feedback or during the CSI public comment period.

The business communities impacted by the rules include mortgage guaranty insurers, licensed public insurance adjusters, insurers who write basic property or homeowner policies for family dwellings and who are required to offer mine subsidence coverage to all eligible applicants, and insurance license applicants, licensees, or companies licensed or authorized to transact in insurance. The adverse impacts created by the rules include maintaining minimum reserves, notification requirements, potential disciplinary action related to violating standards of conduct, administrative effort and costs associated with applying for and renewing a public insurance adjuster license ($100 and $50, respectively), submitting quarterly reports to the Ohio Mine Subsidence Insurance Underwriting Association, and notifying the Department when employees or agents engage in misconduct. The Department states in the BIA that the adverse impacts created by the rules are necessary to assist in maintaining a stable and competitive industry and protect consumers from conflicts of interests or other actions that may cause financial harm.

Recommendations

Based on the information above, the CSI Office has no recommendations on this rule package.

Conclusion

The CSI Office concludes that the Ohio Department of Insurance should proceed in filing the proposed rules with the Joint Committee on Agency Rule Review.

Ohio Department of Insurance

Mike DeWine, Governor
Jon Husted, Lt. Governor

Judith L. French, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

EXHIBIT 21

MEMORANDUM

To: Joseph Baker, Business Advocate

CC: Sean McCullough, Director of the Common Sense Initiative Office

From: Loretta Medved, Policy Analyst

Date: September 29, 2021

Re: Response to CSI Review – Mortgage guaranty insurance, Ohio mine subsidence insurance underwriting association and fund, public insurance adjusters, and misconduct by insurance license applicants and licensees (OAC 3901-1-13, 3901-1-24, 3901-1-48, and 3901-5-12)

On September 14, 2021, the Ohio Department of Insurance (the Department) received the Recommendation Memorandum (CSI Recommendation) from the Common Sense Initiative Office for rule(s) 3901-1-13 Mortgage guaranty insurance, 3901-1-24 Public insurance adjusters, 3901-1-48 "Ohio mine subsidence insurance underwriting association" and "mine subsidence insurance fund" plan of operation, and 3901-5-12 Misconduct by insurance license applicants and licensees.

The CSI Recommendation stated that the office does not have any recommendations regarding this rule package, and therefore should proceed with a formal filing of the rule package.

At this time, the Department plans to move forward with the filing of this rule package with the Joint Committee on Agency Rule Review.

If you have any questions please contact Loretta Medved at 614-644-0239 or Loretta.Medved@insurance.ohio.gov.

Rule Summary and Fiscal Analysis
Part A - General Questions

EXHIBIT 22

Rule Number: 3901-1-54

Rule Type: Amendment

Rule Title/Tagline: Unfair property/casualty claims settlement practices.

Agency Name: Department of Insurance

Division:

Address: 50 W Town Street Suite 300 Columbus OH 43215

Contact: Tina Chubb **Phone:** (614) 728-1044

Email: Tina.Chubb@insurance.ohio.gov

I. Rule Summary

1. **Is this a five year rule review?** Yes

   A. **What is the rule's five year review date?** 11/30/2021

2. **Is this rule the result of recent legislation?** No

3. **What statute is this rule being promulgated under?** 119.03

4. **What statute(s) grant rule writing authority?** 3901.041

5. **What statute(s) does the rule implement or amplify?** 3901.19 to 3901.26

6. **What are the reasons for proposing the rule?**

   This rule is being reviewed as a part of the agency five year rule review.

7. **Summarize the rule's content, and if this is an amended rule, also summarize the rule's changes.**

   The purpose of this rule is to set forth uniform minimum standards for the investigation and disposition of property and casualty claims arising under insurance contracts or certificates issued to residents of Ohio. It is not intended to cover claims involving workers' compensation, or fidelity, suretyship, and boiler and machinery insurance. The provisions of this rule are intended to define procedures and practices which

constitute unfair claims practices. Nothing in this rule shall be construed to create or imply a private cause of action for violation of this rule.

The recommended amendment will correct a citation in paragraph (C)(9) of the rule.

8. **Does the rule incorporate material by reference?** No

9. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

   Not Applicable

10. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

    Not Applicable

II. Fiscal Analysis

11. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

    This will have no impact on revenues or expenditures.

    $0.00

    Not applicable.

12. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

    Not applicable.

13. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

14. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

15. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

    Not applicable.

III. Common Sense Initiative (CSI) Questions

16. **Was this rule filed with the Common Sense Initiative Office?** Yes

17. **Does this rule have an adverse impact on business?** Yes

    A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

    B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** Yes

    Paragraph (K) states that pursuant to section 3901.22 of the Revised Code and a consent agreement with the insurer, the superintendent may recover the cost of an investigation under this rule and/or a penalty from the insurer.

    C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** Yes

    Paragraph (G)(1) requires that if an insurer reasonably believes, based upon information obtained and documented within the claim file, that a claimant has fraudulently caused or contributed to the loss as represented by a properly executed and documented proof of loss, such information shall be presented to the fraud division of the department within sixty days of receipt of the proof of loss.

    D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restrictions (This section only applies to agencies indicated in R.C. 121.95 (A))

18. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

    A. **How many new regulatory restrictions do you propose adding?**

    Not Applicable

    B. **How many existing regulatory restrictions do you propose removing?**

Not Applicable

EXHIBIT 23

3901-1-54 **Unfair property/casualty claims settlement practices.**

(A) Purpose

The purpose of this rule is to set forth uniform minimum standards for the investigation and disposition of property and casualty claims arising under insurance contracts or certificates issued to residents of Ohio. It is not intended to cover claims involving workers' compensation, or fidelity, suretyship, and boiler and machinery insurance. The provisions of this rule are intended to define procedures and practices which constitute unfair claims practices. Nothing in this rule shall be construed to create or imply a private cause of action for violation of this rule.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under sections 3901.041 and 3901.19 to 3901.26 of the Revised Code.

(C) Definitions

As used in this rule:

(1) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.

(2) "Claim file" means any retrievable electronic file, paper file, combination of both, or any other media.

(3) "Claimant" means a first party claimant, a third party claimant.

(4) "Contract" means any insurance policy or document containing the terms of the agreement wherein one party, the insurer, assumes certain obligations including financial obligations that arise as a result of a loss sustained by another party, the insured, or to any other party that has rights under the agreement.

(5) "Days" means calendar days. However, when the last day of a time limit stated in this rule falls on a Saturday, Sunday, or holiday, the time limit is extended to the next immediate following day that is not a Saturday, Sunday, or holiday.

(6) "Department" means the Ohio department of insurance.

(7) "Documentation" includes, but is not limited to, all communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms pertaining to the claim.

(8) "First party claimant" means any individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract.

(9) "Insurer" shall be defined as set forth in division ~~(E)~~ (F) of section 3901.32 of the Revised Code.

(10) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liability under an insurance contract which is in effect or alleged to be in effect~~.~~

(11) "Like kind and quality part" means a salvage motor vehicle part equal to or better than the replaced part that is acquired from a licensed salvage motor dealer.

(12) "Notification of claim" means any notification, under the terms of an insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.

(13) "Person" shall be defined as set forth in section 3901.19 of the Revised Code.

(14) "Practice" means a type of activity or conduct engaged in by an insurer with such frequency as to constitute a customary procedure or policy routinely followed in the settlement of insurance claims. A single act is not a business practice. However, an act that is malicious, deliberate, conscious and knowing may be the basis for corrective action ordered only by the superintendent without a showing that the conduct is a practice.

(15) "Superintendent" means the superintendent of insurance.

(16) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any other individual, corporation, association, partnership or legal entity.

(17) "Proof of loss" means a document from the claimant that provides sufficient information from which the insurer can determine the existence and the amount of the claim.

(D) File and record documentation

An insurer's claim files are subject to examination by the superintendent of insurance or by the superintendent's duly appointed designees. To aid in such examination:

(1) An insurer shall maintain claim data that is accessible and retrievable for examination. Such data shall include number, line of coverage, date of loss and date of payment or date of denial or date when claim is closed without payment. The data for closed claims shall be kept for no less than three years or until the completion of the next financial examination conducted by the state of domicile, whichever is greater. Data for claims where the claims payment is less than one thousand dollars, or for towing, labor, glass or rental reimbursement may be kept in summary form.

(2) An insurer must be able to reconstruct its activities in regard to any claim, by documentation appropriate for the type and size of the claim. If the claim is closed, the time period for retention is set forth in paragraph (D)(1) of this rule.

(3) If an insurer does not maintain hard copy files, claim files shall be accessible and be capable of duplication to hard copy.

(E) Misrepresentation of policy provisions

(1) An insurer shall fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance contract under which a claim is presented.

(2) No agent shall willfully conceal from first party claimants benefits, coverages or other provisions of any insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(3) No insurer shall deny a claim based on the first party claimant's failure to make available for inspection the property which is the subject of the claim unless there is documentation of breach of the policy provisions in the claim file.

(4) No insurer shall deny a claim based upon the failure of a first party claimant to give written notice of loss within a specified time limit unless the notice is required by a policy condition, or a first party claimant's failure to give written notice after being requested to do so by the insurer is so unreasonable as to constitute a breach of the claimant's duty to cooperate with the insurer.

(5) No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that the payment is final or a release of any claim unless the policy limit has been paid or the first party claimant and the insurer have agreed to a compromise settlement regarding coverage and the amount payable under the insurance contract.

(6) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

(F) Response to acknowledge receipt of pertinent communications

(1) Notification of a claim given to an agent of an insurer shall be notification to the insurer.

(2) An insurer shall acknowledge the receipt of a claim within fifteen days of receiving such notification. An insurer may satisfy this requirement by making payment within this fifteen day period. An insurer may also satisfy this requirement by providing necessary claim forms and complete instructions to the claimant within this fifteen day period.

(3) An insurer shall respond within fifteen days to any communication from a claimant, when that communication suggests a response is appropriate. In the event that a complaint has been filed by a claimant in any court, an insurer is not obligated to respond within this time period and any communication between the claimant and the insurer will be subject to the appropriate rule of procedure for the court in which the lawsuit was filed.

(4) An insurer shall, within twenty-one days of receipt of an inquiry from the department regarding a claim, furnish the department with a reasonable response to the inquiry.

(G) General standards for settlement of claims

(1) An insurer shall within twenty-one days of the receipt of properly executed proof(s) of loss decide whether to accept or deny such claim(s). If more time is needed to investigate the claim than the twenty-one days allow, the insurer shall notify the claimant within the twenty-one day period, and provide an explanation of the need for more time. If an extension of time is needed, the insurer has a continuing obligation to notify the claimant in writing, at least every forty-five days, of the status of the investigation and the continued time for the investigation.

If the form and execution of a proof of loss is material to an insurer, the insurer shall immediately provide the claimant with the specific documents and specific instructions so the claimant can submit the claim. An insurer shall not otherwise deny a claim solely on the basis the proof of loss is not on the insurer's usual form.

If an insurer reasonably believes, based upon information obtained and documented within the claim file, that a claimant has fraudulently caused or contributed to the loss as represented by a properly executed and documented proof of loss, such information shall be presented to the fraud division of the department within sixty days of receipt of the proof of loss. Any person making such report shall be afforded such immunity and the information submitted will be confidential as provided by sections 3901.44 and 3999.31 of the Revised Code.

(2) No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The claim file of the insurer shall contain documentation of the denial in accordance with paragraph (D) of this rule.

(3) Except as otherwise provided by policy provisions, an insurer shall settle first party claims upon request by the insured with no consideration given to whether the responsibility for payment should be assumed by others.

(4) No insurer shall require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract.

(5) Notice shall be given to claimants at least sixty days before the expiration of any statute of limitation or contractual limit, where the insurer has not been advised that the claimant is represented by legal counsel.

(6) An insurer shall tender payment to a first party claimant no later than ten days after acceptance of a claim if the amount of the claim is determined and is not in dispute, unless the settlement involves a structured settlement, action by a probate court, or other extraordinary circumstances as documented in the claim file.

(7) If a claim involves a non-negligent party's property loss and multiple liability insurers, the multiple liability insurers shall adjust the property loss within a reasonable time and pay the non-negligent party's loss in equal shares. After payment, the multiple liability insurers may then pursue available remedies to resolve the question of responsibility for the non-negligent party's loss.

(8) If a claim involves multiple coverages under any policy, no insurer shall withhold payment under any such coverage when the payment is known, the payment is not in dispute, and the payment would extinguish the insurer's liability under that coverage. No insurer shall withhold such payment for the purpose of forcing settlement on all other coverage to effect a single payment.

(9) An insurer must document the application of comparative negligence to any claim settlement. Such information shall be fully disclosed to the claimant upon the claimant's written request. An insurer shall not use pattern settlements as set forth in division (P) of section 3901.21 of the Revised Code.

(10) An insurer shall not use settlement practices that result in compelling first party claimants to litigate by offering substantially less than the amounts claimed compared to the amount ultimately recovered in actions brought by such claimants.

(H) Standards for prompt, fair and equitable settlements of automobile insurance claims

(1) When partial losses will be settled on the basis of a written estimate prepared by or for an insurer, the insurer shall supply the claimant a copy of the estimate upon which the proposed settlement is based. If the claimant subsequently claims that necessary repairs will exceed the written estimate, the insurer shall pay the difference between the written estimate and a higher estimate obtained by the claimant or promptly provide the claimant with the name of at least one repair shop that will make the repairs for the amount of the written estimate. If the insurer provides the name of only one repair shop, it shall ensure that the repairs are performed in a workmanlike manner. The insurer shall maintain documentation of all communications with the claimant pursuant to this paragraph.

(2) If an insurer reduces a claim amount because of betterment, depreciation or comparative negligence, it shall maintain all information pertaining to the reduction in the claim file. Such deductions shall be itemized and specified on the written estimate as to dollar amount and shall be appropriate for the amount of deductions.

(3) An insurer may reduce a claim amount because of betterment deductions only if the deductions reflect a measurable decrease in market value due to the poorer condition of, or prior damage to, the vehicle; or reflect the general overall condition of the vehicle, considering its age, for the wear and tear or rust, and/or missing parts, limited to no more of a deduction than the replacement costs of part or parts.

(4) When partial losses will be settled on the basis of a written estimate prepared by or for an insurer, the estimate must clearly indicate the use of the parts in compliance with section 1345.81 of the Revised Code. When like kind and quality parts are expected to be used in the repair, the estimate shall clearly indicate the location of the licensed salvage dealer where the like kind and quality parts are to be obtained.

(5) An insurer which elects to repair and designates a specific repair shop for automobile repairs shall cause the damaged automobile to be restored to its condition prior to the loss. The insurer shall assess no additional cost against the claimant other than as stated in the policy, and the repairs should be effected within a reasonable period of time.

(6) In settlement of claimants' automobile total losses on the basis of actual cash value or replacement of the automobile with another vehicle of like kind and quality, an insurer which elects to offer a replacement automobile shall:

(a) Provide an automobile by the same manufacturer, of the same or newer year, of similar body style, with similar options and mileage as the claimant's vehicle and in as good or better overall condition than the first party automobile prior to loss;

(b) Ensure that the automobile is available for inspection within a reasonable distance of the claimant's residence;

(c) Pay all applicable taxes, license fees, and other fees incident to transfer of evidence of ownership of the automobile at no cost to claimant other than any deductible provided in the policy; and

(d) Document the offer of the replacement automobile and any rejection of the offer in the claim file.

(7) In settlement of claimants' automobile total losses on the basis of actual cash value or replacement of the automobile with another of like kind and quality, an insurer which elects to offer a cash settlement to claimant shall base the offer upon the actual cost to purchase a comparable automobile less any applicable deductible amount contained in the policy, and/or deduction for betterment as contained in paragraph (H)(2) of this rule. The settlement value may be derived from:

(a) The average cost of two or more comparable automobiles in the local market area if comparable automobiles are or were available to consumers within the last ninety days; or

(b) The average cost of two or more comparable automobiles in areas proximate to the local market area, including the closest in-state or out-of-state major metropolitan areas, that are or were available to consumers within the last ninety days if comparable automobiles are not available pursuant to paragraph (H)(7)(a) of this rule; or

(c) The average of two or more quotations obtained by the insurer from two or more licensed dealers located within the local market area if comparable automobiles are not available pursuant to paragraphs (H)(7)(a) and (H)(7)(b) of this rule; or

(d) The cost as determined from a generally recognized used motor vehicle industry source such as:

(i) An electronic database if the pertinent portions of the valuation documents generated by the database are provided by the insurer to the claimant upon request; or

(ii) A guidebook that is generally available to the general public if the insurer identifies the guidebook used as the basis for the cost to the claimant upon request, and to which appropriate adjustments for condition, mileage and major options are made and documented in the claim file.

(e) Any method or source chosen as specified in paragraph (H)(7)(d) of this rule shall be used consistently over a period of time by the insurer.

(f) If within thirty days of receipt by the claimant of a cash settlement for the total loss of an automobile, the claimant purchases a replacement automobile, the insurer shall reimburse the claimant for the applicable sales taxes incurred on account of the claimant's purchase of the automobile, but not to exceed the amount that would have been payable by the claimant for sales taxes on the purchase of an automobile with a market value equal to the amount of the cash settlement. If the claimant purchases an automobile with a market value less than the amount of the cash settlement, the insurer shall reimburse only the actual amount of the applicable sales taxes on the purchased automobile. If the claimant cannot substantiate such purchase and the payment of such sales taxes by submission to the insurer of appropriate documentation within thirty-three days after receipt of the cash settlement, the insurer shall not be required to reimburse the claimant for such sales taxes. In lieu of reimbursement, the insurer may pay directly the applicable sales taxes to the claimant at the time of the cash settlement.

An insurer that settles a total loss on a cash settlement basis must maintain in the claim file the documentation used to determine the loss. Such information shall be provided to the first party claimant upon request. An insurer shall notify the first party claimant of any rights to renegotiate the

settlement if a comparable vehicle is not available for purchase within thirty-five days of receipt of the settlement.

When an insurer elects to offer a replacement vehicle available to the claimant, the insurer shall provide all the details where such vehicle is available including the vehicle identification number.

(g) An insurer that settles a total loss claim shall provide written notice to the claimant of the right to reimbursement of applicable sales tax as specified in paragraph (H)(7)(f) of this rule. The notice shall be issued to the claimant simultaneously with the conveyance of the settlement check to the claimant. If an insurer elects to pay the applicable sales taxes directly to the claimant at the time of the cash settlement in lieu of reimbursement as provided in paragraph (H)(7)(f) of this rule, the insurer is not required to provide written notice of the claimant's right to sales tax reimbursement.

(8) An insurer shall not require a claimant to travel an unreasonable distance to inspect a replacement automobile, to obtain a repair estimate, or to have the automobile repaired at a specific repair shop.

(9) An insurer shall provide notice to a claimant prior to termination of payment for automobile storage charges. The insurer shall document all actions taken pursuant to this paragraph in accordance with paragraph (D) of this rule.

(10) An insurer shall include the first party claimant's deductible, if any, in subrogation demands. The insurer shall share any subrogation recovery received on a proportionate basis with the first party claimant, unless the first party claimant's deductible has been paid in advance or recovered. The insurer shall not deduct expenses from this amount except that an outside attorney or collection agency retained to collect such recovery may be paid a pro rata share of his expenses for collecting this amount.

(I) Standards for prompt, fair and equitable settlement of claims under fire and extended coverage insurance policies

(1) If a fire and extended coverage insurance policy provides for the adjustment and settlement of first party losses based on replacement cost, the following shall apply:

(a) When a loss requires replacement of an item or part, any consequential physical damages incurred in making such repair or replacement not otherwise excluded by the policy, shall be included in the loss.

(b) When an interior or exterior loss requires replacement of an item and the replaced item does not match the quality, color or size of the item suffering the loss, the insurer shall replace as much of the item as to result in a reasonably comparable appearance.

(c) When an insurer settles a loss that results in the insured paying a portion of the repair or replacement as betterment, the insurer shall maintain documentation of the basis for computing the betterment charge, and the insured's agreement to such charge prior to incurring the expense of the repair or replacement.

(2) If a fire and extended coverage insurance policy provides for the adjustment and settlement of losses on an actual cash value basis, the following shall apply:

(a) The insurer shall determine actual cash value by determining the replacement cost of property at the time of loss, including sales tax, less any depreciation. Upon the insured's request, the insurer shall provide documentation detailing all depreciation deductions.

(b) If the insured's interest is limited because his property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the insurer is not required to comply with paragraph (I)(2)(a) of this rule regarding the determination of actual cash value. However, the insurer shall provide upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

(J) Applicability of rule 3901-1-07 of the Administrative Code

If any provisions of any section of this rule conflicts with any of the provisions contained in rule 3901-1-07 of the Administrative Code, the provisions of this rule will apply.

(K) Imposition of fine

Pursuant to section 3901.22 of the Revised Code and a consent agreement with the insurer, the superintendent may recover the cost of an investigation under this rule and/or a penalty from the insurer.

(L) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision

of this rule, but the remaining paragraphs, terms and provisions shall be and continue in full force and effect.

Effective:

Five Year Review (FYR) Dates: 11/30/2021

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	3901.041
Rule Amplifies:	3901.19 to 3901.26
Prior Effective Dates:	04/05/1990, 09/01/1993, 11/12/2004, 04/05/2007, 11/03/2016

EXHIBIT 24

Ohio | Common Sense Initiative

Mike DeWine, Governor | **Jon Husted**, Lt. Governor | **Sean McCullough**, Director

Business Impact Analysis

Agency Name: ***Ohio Department of Insurance***
Rule Contact Name: ***Loretta Medved***
Rule Contact Information: ***614-644-0239***
loretta.medved@insurance.ohio.gov

Regulation/Package Title *(a general description of the rules' substantive content)*:
Unfair and Deceptive Practices Rules

Rule Number(s): ***3901-1-07, 3901-1-08, 3901-1-54***

Date of Submission for CSI Review: ***August 2, 2021***
Public Comment Period End Date: ***August 16, 2021, 12:00AM***

Rule Type/Number of Rules:

- ☐ New/ rules
- ☒ Amended/ ***2*** rules (FYR? ***2021***)
- ☒ No Change/ ***1*** ***p*** rules (FYR? ***2021***)
- ☐ Rescinded/ rules (FYR?)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 requires agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the Agency determined the rule(s) create?

   The rule(s):

   - ☐ a. Requires a license, permit, or any other prior authorization to engage in or operate a line of business.
   - ☐ b. Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.
   - ☒ c. Requires specific expenditures or the report of information as a condition of compliance.
   - ☐ d. Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 3901-1-07: Enumerates specific practices that would be considered unfair and/or deceptive. The provisions of this rule pertain to all lines of insurance, although they are focused heavily on property and casualty (P&C). The rule enacts settlement standards for patterns and practices of deceptive actions, rather than occurrences on a specific claim. Technical amendments restructure the rule for uniformity with other department rules and correct a spelling error.

   Rule 3901-1-08: By adopting the National Association of Insurance Commissioners' (NAIC) "Military Sales Practices Model Regulation," the rule further defines Ohio's unfair trade practices in the business of insurance to include dishonest and predatory practices involving the sale of certain life insurance products, including annuities, to active military members of the United States Armed Forces and their families. The rule also sets acceptable standards for the sale and solicitation of the defined insurance products and adds special protections for enlisted service members. There are no proposed amendments.

   Rule 3901-1-54: Sets forth uniform minimum standards by adopting NAIC model regulation for the investigation and disposition of P&C claims. The rule defines procedures and practices which constitute unfair claims practice and provides specific settlement standards on an individual claims basis. The proposed technical amendment will correct a ciatation in paragraph (C)(9).

3. Please list the Ohio statute(s) that authorize the Agency to adopt the rule(s) and the statute(s) that amplify that authority.

   Rule 3901-1-07: Sections 3901.041, 3901.20 and 3901.21 of the Revised Code.

   Rule 3901-1-08: Sections 3901.041, 3901.20 and 3901.21 of the Revised Code.

   Rule 3901-1-54: Sections 3901.041 and 3901.19 to 3901.26 of the Revised Code.

4. Does the regulation implement a federal requirement? ☐ Yes ☒ No
   Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   ☐ Yes ☒ No
   If yes, please briefly explain the source and substance of the federal requirement.

   Not applicable.

5. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   Not applicable.

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   Rule 3901-1-07: The Unfair trade practices rule enumerates specific acts, which would be unfair & deceptive to consumers. This is a consumer protection rule and works to prevent insurance companies from developing a pattern of misleading practices.

   Rule 3901-1-08: The public purpose is to protect active duty service members from dishonest and predatory insurance sales practices by identifying certain practices as false, misleading or deceptive.

   Rule 3901-1-54: The rule provides consumer protection by setting clear requirements for insurance companies to follow in settling claim disputes.

7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

   Successful outcomes of both the unfair and deceptive practice statute and these rules are evident in a reduction in instances or allegations of unfair practices occurring within Ohio's insurance market place. Success is measured both through regular financial and market conduct reviews, as well as thorough review and investigation of consumer complaints submitted to the department.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931? ☐ Yes ☒ No

   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

Not applicable.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation. *If applicable, please include the date and medium by which the stakeholders were initially contacted.*

In spring 2021 the department reached out to industry stakeholders including the Ohio Insurance Institute (OII) regarding substantive amendments to rule 3901-1-54. Currently both industry and the department identify sections of rule 3901-1-54 that have the potential to strike a better balance of regulatory application. Conversations are ongoing and were not concluded in time for the filing of the 2021 five year rule review. For the purposes of this filing, only technical amendments are proposed. Stakeholders continue to engage with the department and did not raise any concern over the proposed technical amendments.

Additionally, in June 2021, an email requesting comment on this group of rules was sent to various stakeholders, interested parties, trade associations and companies. Specifically, the department reached out to the Ohio Land Title Association, the Ohio Insurance Institute (OII), the Association of Ohio Life Insurance Companies (AOLIC), the American Council of Life Insurance (ACLI), the National Association of Insurance and Financial Advisors (NAIFA), Ohio Association of Health Plans (OAHP) and the Ohio Insurance Agents Association Inc., among others. Additionally, these rules were also posted on the department's web site for review.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

No comments were received during or after the two week comment period. The department will continue conversations with industry regarding the potential for future substantive amendments.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

The rules are based on statutory prohibitions against unfair and deceptive practices, as well as model rules developed by the National Association of Insurance Commissioners (NAIC). The NAIC model rules are developed through a committee review process that considers market practices, consumer protections and industry and regulator input.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

There were no alternative regulations considered because the rules' purposes are to clarify the statutory prohibitions involved.

13. Did the Agency specifically consider a performance-based regulation? Please explain.
Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

No. Performance-based rules would not apply as the purpose of these rules are to clarify prohibited practices.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

The Ohio Department of Insurance is the sole agency regulating insurance and there are no duplicative rules.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

The rules have been in place and the insurance industry is aware of the prohibitions against unfair and deceptive practices. The regulations are applied consistently through oversight and any market conduct reviews performed. Proposed amendments are technical in nature and will not require any implementation for the regulated community.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:
    a. Identify the scope of the impacted business community;
    b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and
    c. Quantify the expected adverse impact from the regulation.
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a.

Rule 3901-1-07 impacts insurers authorized in all lines of insurance.

Rule 3901-1-08 impacts insurers authorized to sell life insurance and that sell life insurance or annuity products to active military members.

Rule 3901-1-54 impacts insurers authorized to sell property and casualty insurance.

b. -

c. All three rules clarify certain prohibited acts and therefore, no adverse impact for insurers that comply. If, however, an insurer violates the unfair and deceptive practices statute and requirements of any of the rules the insurer may be required to report information to the superintendent for purposes of an investigation. Additionally, the superintendent may issue a cease and desist order and impose other administrative penalties such as license revocation and/or order to pay back payments received as a result of the violation.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Unfair and deceptive practices are clearly prohibited in statute, and are critical to consumer protection. The rules clarify those prohibited practices to both serve as a clear guide for insurers and to facilitate the department's clear ability and authority to protect consumers against market misconduct and deceptive sales practices.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Prohibitions against unfair and deceptive practices are required consistently no matter the size or structure of the company. There are no alternative compliance requirements appropriate or necessary for small companies as the prohibitions do not relate to size of company.

19. How will the Agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Any actions or interventions the department must take under the rules' prohibitions are not punitive in nature, but rather would be to prevent financial harm to consumers, policyholders and/or the general public. The department works with insurers in the case of a violation to ensure the issue is corrected and consumer protection is preserved. The primary goal is to ensure any prohibited practices are stopped.

20. What resources are available to assist small businesses with compliance of the regulation?

Department staff is available to answer questions and provide assistance as needed.

Ohio | Common Sense Initiative

EXHIBIT 25

Mike DeWine, Governor
Jon Husted, Lt. Governor
Sean McCullough, Director

MEMORANDUM

TO: Loretta Medved, Ohio Department of Insurance

FROM: Joseph Baker, Business Advocate

DATE: October 20, 2021

RE: **CSI Review – Unfair and Deceptive Practices Rules (OAC 3901-1-07, 3901-1-08, and 3901-1-54)**

On behalf of Lt. Governor Jon Husted, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Department as provided for in ORC 107.54.

Analysis

This rule package consists of one no-change and two amended rules proposed by the Ohio Department of Insurance (Department) as a part of the statutory five-year review process. This rule package was submitted to the CSI Office on August 2, 2021, and the public comment period was held open through August 16, 2021. Unless otherwise noted below, this recommendation reflects the version of the proposed rules filed with the CSI Office on August 2, 2021.

The rules in this package establish business practice requirements for insurers in Ohio. OAC 3901-1-07 outlines insurance business practices that are defined as unfair or deceptive. These practices include knowingly misrepresenting pertinent facts or policy provisions to claimants, failing to acknowledge or reply to communications or claim inquiries in a certain timeframe, and not offering fair and reasonable amounts to claimants in accordance with policy limits and provisions when liability is clear, among others. The Department states in the BIA that the rule is amended for uniformity and to correct a spelling error.

OAC 3901-1-08 establishes additional unfair and deceptive practices specifically relating to the

sale of life insurance products to military members and their families. The rule states that soliciting the purchase of a life insurance product using door-to-door marketing, soliciting members as a part of a mass or captive audience, making appointments with service members during normal duty hours, posting unauthorized advertisements, and certain similar activities are defined as unfair business practices if taking place at a military installation. The rule also sets forth activities that are classified as unfair and deceptive practices regardless of location, such as offering anything of value to military personnel to procure their assistance in facilitating the sale of life insurance to another service member, advising service members in certain pay grades to modify income tax withholding to increase income for purposes of purchasing life insurance, and engaging in direct deposit agreements to divert payroll funds for the payment of life insurance premiums in certain circumstances, among others.

Lastly, OAC 3901-1-54 describes minimum standards for investigating property and casualty insurance claims and defines procedures and practices that constitute unfair claims practices. The rule requires insurers to determine within 21 days of receiving proof of a loss whether to approve or deny a claim, or to notify the claimant regarding the reason for needing additional time, to specify the grounds for denying a claim based on the policy documents and prohibits insurers from using settlement practices that result in litigation by offering substantially less than the amounts claimed, among others. The rule also establishes special requirements for resolving automobile claims and fire and extended coverage claims promptly and fairly and authorizes the Superintendent of the Department to recover the cost of investigations and potentially to fine insurers for violations. The rule is amended to correct an errant citation.

During early stakeholder outreach, the Department shared the proposed rules with various interested parties including the Ohio Insurance Institute, the Ohio Land Title Association, the Association of Ohio Life Insurance Companies, the American Council of Life Insurance, the National Association of Insurance and Financial Advisors, the Ohio Association of Health Plans, and the Professional Independent Agents Association, among others. No comments were provided in response to the request for early stakeholder outreach or during the CSI public comment period.

According to the BIA, the business community impacted by the rules includes insurers authorized in all lines of insurance, insurers authorized to sell life insurance as well as those authorized to sell life insurance or annuities to military members, and insurers authorized to sell property and casualty insurance. The adverse impact created by the rules includes potential disciplinary action for entities that engage unfair or deceptive practices or unfair claims practices as defined by the rules. Additionally, the Department notes in the BIA that insurers may be required to report information to the Superintendent in the case of investigation regarding an allegation of unfair and deceptive practices and that the Superintendent may take action including issuing a cease-and-

desist order, revoking a license, and ordering back payments. The Department states that the adverse impact to business is necessary to preserve consumer protection in the industry and to serve as a clear guide for insurers regarding market misconduct and deceptive sales practices.

Recommendations

Based on the information above, the CSI Office has no recommendations on this rule package.

Conclusion

The CSI Office concludes that the Ohio Department of Insurance should proceed in filing the proposed rules with the Joint Committee on Agency Rule Review.

Ohio Department of Insurance
Mike DeWine, Governor
Jon Husted, Lt. Governor
Judith L. French, Director
50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

EXHIBIT 26

MEMORANDUM

To: Joseph Baker, Business Advocate

CC: Sean McCullough, Director of the Common Sense Initiative Office

From: Loretta Medved, Policy Analyst

Date: October 22, 2021

Re: Response to CSI Review – Unfair and Deceptive Practices Rules (OAC 3901-1-07, 3901-1-08, and 3901-1-54)

On October 20, 2021, the Ohio Department of Insurance (the Department) received the Recommendation Memorandum (CSI Recommendation) from the Common Sense Initiative Office for rule(s) 3901-1-07 Unfair trade practices, 3901-1-08 Unfair and deceptive military sales practices, and 3901-1-54 Unfair property/casualty claims settlement practices.

The CSI Recommendation stated that the office does not have any recommendations regarding this rule package, and therefore should proceed with a formal filing of the rule package.

At this time, the Department plans to move forward with the filing of this rule package with the Joint Committee on Agency Rule Review.

If you have any questions please contact Loretta Medved at 614-644-0239 or Loretta.Medved@insurance.ohio.gov.

EXHIBIT 27

Rule Summary and Fiscal Analysis
Part A - General Questions

Rule Number: 3901-3-19

Rule Type: Amendment

Rule Title/Tagline: Corporate governance annual disclosure.

Agency Name: Department of Insurance

Division:

Address: 50 W Town Street Suite 300 Columbus OH 43215

Contact: Tina Chubb **Phone:** (614) 728-1044

Email: Tina.Chubb@insurance.ohio.gov

I. Rule Summary

1. **Is this a five year rule review?** Yes

   A. **What is the rule's five year review date?** 11/30/2021

2. **Is this rule the result of recent legislation?** No

3. **What statute is this rule being promulgated under?** 119.03

4. **What statute(s) grant rule writing authority?** 3901.77, 3901.041

5. **What statute(s) does the rule implement or amplify?** 3901.074

6. **What are the reasons for proposing the rule?**

   This rule is being reviewed as a part of the agency five year rule review.

7. **Summarize the rule's content, and if this is an amended rule, also summarize the rule's changes.**

   The purpose of this rule is to establish the procedures for filing, and the required content of, the corporate governance annual disclosure, deemed necessary by the superintendent pursuant to sections 3901.072 to 3901.078 of the Revised Code.

   The proposed amendment will correct a citation in paragraph (B).

8. **Does the rule incorporate material by reference?** No

9. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

   Not Applicable

10. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

    Not Applicable

II. Fiscal Analysis

11. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

    This will have no impact on revenues or expenditures.

    $0.00

    Not applicable.

12. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

    Not applicable.

13. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

14. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

15. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

    Not applicable.

III. Common Sense Initiative (CSI) Questions

16. **Was this rule filed with the Common Sense Initiative Office?** Yes

17. **Does this rule have an adverse impact on business?** Yes

    A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

    B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** No

    C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** Yes

       The purpose of this rule is to establish the procedures for filing, and the required content of, the corporate governance annual disclosure, deemed necessary by the superintendent pursuant to sections 3901.072 to 3901.078 of the Revised Code.

    D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restrictions (This section only applies to agencies indicated in R.C. 121.95 (A))

18. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

    A. **How many new regulatory restrictions do you propose adding?**

       Not Applicable

    B. **How many existing regulatory restrictions do you propose removing?**

       Not Applicable

3901-3-19 **Corporate governance annual disclosure.** EXHIBIT 28

(A) Purpose

The purpose of this rule is to establish the procedures for filing, and the required content of, the corporate governance annual disclosure, deemed necessary by the superintendent pursuant to sections 3901.072 to 3901.078 of the Revised Code.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under sections 3901.041 and ~~3901.078~~ 3901.077 of the Revised Code.

(C) Definitions

(1) "Board" means board of directors of an insurer or an insurance group.

(2) "CGAD" means a corporate governance annual disclosure.

(3) "Insurance Group" has the same meaning as defined in division (B)(2) of section 3901.072 of the Revised Code.

(4) "Insurer" has the same meaning as defined in division (B)(3) of section 3901.072 of the Revised Code.

(5) "NAIC" means the national association of insurance commissioners.

(6) "SEC" means the United States securities and exchange commission.

(7) "Senior Management" means any corporate officer responsible for reporting information to the board at regular intervals or providing this information to shareholders or regulators, and shall include, for example and without limitation, the chief executive officer (CEO), chief financial officer, chief operations officer, chief procurement officer, chief legal officer, chief information officer, chief technology officer, chief revenue officer, chief visionary officer, or any other "C" level executive.

(D) Filing procedure

(1) An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by section 3901.073 of the Revised Code, shall, no later than June first of each calendar year, submit to the superintendent a CGAD that contains the information described in paragraph (E) of this rule.

(2) The CGAD must include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer's or insurance groups board or the appropriate committee thereof.

(3) The insurer or insurance group shall have the discretion regarding the appropriate format for providing the information required by these regulations and is permitted to customize the CGAD to provide the most relevant information necessary to permit the superintendent to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or the insurance group.

(4) For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level, and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

(5) Notwithstanding paragraph (D)(1) of this rule, and as outlined in section 3901.073 of the Revised Code, if the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the most recent financial analysis handbook adopted by the NAIC. In these instances, a copy of the CGAD must also be provided, upon request, to the chief regulatory official of any state in which the insurance group has a domestic insurer.

(6) An insurer or insurance group may comply with this section by referencing other existing documents, such as an own risk and solvency assessment (ORSA) summary report, holding company form B or form F filings, securities and exchange commission proxy statements, foreign regulatory reporting requirements, etc., if the documents provide information that is comparable to the information described in paragraph (E) of this rule. The insurer or insurance group shall clearly reference the location of the relevant information with the

CGAD and attach the referenced document if it is not already filed with the department.

(7) Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD, indicating revisions made, or a copy of the prior year filing with a dated statement indicating that no changes have been made in the information or activities reported in the previous year CGAD.

(E) Contents of corporate governance annual disclosure

(1) The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.

(2) The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following:

(a) The board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs, such as ultimate control level, intermediate holding company, legal entity, etc. The insurer or insurance group shall describe and discuss the rationale for the current board size and structure; and

(b) The duties of the board and each of its significant committees and how they are governed, such as bylaws, charters, informal mandates, etc., as well as how the board's leadership is structured, including a discussion of the roles of chief executive officer and chairman of the board within the organization.

(3) The insurer, or insurance group, shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

(a) How the qualifications, expertise and experience of each board member meet the needs of the insurer or insurance group;

(b) How an appropriate amount of independence is maintained on the board and its significant committees;

(c) The number of meetings held by the board and its significant committees over the past year as well as information on director attendance;

(d) How the insurer or insurance group identifies, nominates and elects members to the board and its committees. The discussion should include, for example:

(i) Whether a nomination committee is in place to identify and select individuals for consideration;

(ii) Whether term limits are placed on directors;

(iii) How the election and re-election processes function; and

(iv) Whether a board diversity policy is in place and if so, how it functions.

(e) The processes in place for the board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance, including any board or committee training programs that have been put in place.

(4) The insurer or insurance group shall describe the policies and practices for directing senior management, including a description of the following factors:

(a) Any process or practices, such as suitability standards, to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

(i) Identification of the specific positions for which suitability standards have been developed and a description of the standards employed; and

(ii) Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate.

(b) The insurer's or insurance group's code of business conduct and ethic, the discussion of which considers, for example:

(i) Compliance with laws, rules, and regulations; and

(ii) Proactive reporting of any illegal or unethical behavior.

(c) The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior

management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the superintendent to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk taking. Elements to be discussed may include, for example:

(i) The board's role in overseeing management compensation programs and practices;

(ii) The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

(iii) How compensation programs are related to both company and individual performance over time;

(iv) Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

(v) Any claw-back provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted; and

(vi) Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.

(d) The insurer's or insurance group's plans for CEO and senior management succession.

(5) The insurer or insurance group shall describe the processes by which the board, its committees and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities including a discussion of:

(a) How oversight and management responsibilities are delegated between the board, its committees, and senior management;

(b) How the board is kept informed of the insurer's strategic plans, the associated risks, and steps that senior management is taking to monitor and manage those risks;

(c) How reporting responsibilities are organized for each critical risk area. The description should allow the superintendent to understand the frequency at which information on each critical risk area is reported to and reviewed by senior management and the board. This description may include, for example, the following critical risk areas of the insurer:

(i) Risk management processes. An insurer, or the insurance group of which the insurer is a member, that files an ORSA summary report with the superintendent pursuant to section 3901.375 of the Revised Code may refer to its ORSA summary report;

(ii) Actuarial function;

(iii) Investment decision-making processes;

(iv) Reinsurance decision-making processes;

(v) Business strategy/finance decision-making processes;

(vi) Compliance function;

(vii) Financial reporting/internal auditing; and

(viii) Market conduct decision-making processes.

(F) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms and provisions shall be and continue in full force and effect.

Effective:

Five Year Review (FYR) Dates: 11/30/2021

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	3901.77, 3901.041
Rule Amplifies:	3901.074
Prior Effective Dates:	04/20/2017

EXHIBIT 29

Ohio | Common Sense Initiative

Mike DeWine, Governor | **Jon Husted**, Lt. Governor | **Sean McCullough**, Director

Business Impact Analysis

Agency Name: ***Ohio Department of Insurance***
Rule Contact Name: ***Loretta Medved***
Rule Contact Information: ***loretta.medved@insurance.ohio.gov***
614-644-0239

Regulation/Package Title *(a general description of the rules' substantive content)*:
Health insurance reserves, Corporate governance annual disclosure, and Annuity nonforfeiture product standards.

Rule Number(s): ***3901-3-13, 3901-3-19, 3901-6-16***

Date of Submission for CSI Review: ***August 2, 2021***
Public Comment Period End Date: ***August 16, 2021 12:00AM***

Rule Type/Number of Rules:

- ☒ New/ ***1*** rules
- ☒ Amended/ ***1*** rules (FYR? ***2021***)
- ☒ No Change/ ***1*** rules (FYR? ***2021***)
- ☒ Rescinded/ ***1*** rules (FYR? ***2021***)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 requires agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the Agency determined the rule(s) create?

   The rule(s):

   - ☐ a. Requires a license, permit, or any other prior authorization to engage in or operate a line of business.
   - ☐ b. Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.
   - ☒ c. Requires specific expenditures or the report of information as a condition of compliance.
   - ☐ d. Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 3901-3-13: The purpose of this rule is to establish the minimum reserve standards for all individual and group health insurance coverages, including single premium credit disability insurance, as required by division (Q) of section 3903.723 of the Revised Code. Minimum reserve requirements establish one standard of maintaining solvency for health insurance companies. The National Association of Insurance Commissioners (NAIC) evaluates market trends and industry standards to develop appropriate minimum benchmarks for companies to maintain. These minimum requirements are then reviewed nationally by both industry stakeholders and regulators, and adopted into a national model. Recommended amendments to this rule will incorporate the latest version of the NAIC model. Updates to the model do not implement new requirements, but rather provide the updated standards for recent plan years, and those moving forward. Due to the amount of proposed amendments the rule will be filed as rescind, and ultimately filed as a new rule.

   Rule 3901-3-19: Corporate governance is the system of rules, practices, and processes by which an insurance company governs itself. Ohio Revised Code sections 3901.072 to 3901.078 requires that insurers submit an annual disclosure to the superintendent, detailing specific information related to individual corporate governance practices. The purpose of this rule is to establish the required content, and procedures for filing the annual disclosure. The proposed amendment to this rule is technical and will correct a citation.

Rule 3901-6-16: The purpose of this rule is to amplify Ohio Revised Code by defining the maturity date used for the purpose of calculating nonforfeiture values for annuity contracts. The rule implements what is commonly referred to as the "70/10 Rule" which limits the duration of an annuity to 10 years or age 70, whichever is greater. There are no proposed amendments to this rule.

3. Please list the Ohio statute(s) that authorize the Agency to adopt the rule(s) and the statute(s) that amplify that authority.

   Rule 3901-3-13: Sections 3901.041 and 3903.723(Q) of the Revised code.

   Rule 3901-3-19: Sections 3901.77 and 3901.041 of the Revised code.

   Rule 3901-6-16: Sections 3901.041 and 3901.21 of the Revised code.

4. Does the regulation implement a federal requirement? ☐ Yes ☒ No
   Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   ☐ Yes ☒ No
   If yes, please briefly explain the source and substance of the federal requirement.

   Not applicable.

5. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   Not applicable.

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   Rule 3901-3-13: Implementing the NAIC model for minimum reserve standards promotes insurer solvency, which is crucial to the protection of the company, consumers, and the overall insurance market.

   Rule 3901-3-19: Corporate governance addresses the allocation and regulation of power and accountabilities within an insurer and avoids undue concentration of authority and power. Also, corporate governance has to be transparent and have appropriate systems, controls, and limits to ensure the given authority and power is used to protect the interests of all of the insurance company's stakeholders.

   Rule 3901-6-16: The purpose for this rule is to provide consumer protection, especially to senior citizens when purchasing annuity products. This regulation is specifically intended to prevent unreasonable surrender charges and provide reasonable access to funds.

7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

Success is determined by reviewing trends in complaints and violations as well as the overall wellbeing of insurers; reviewed during financial and, or market conduct examinations. Success is also evident through an overall understanding of expectations set forth in these rules on behalf of the regulated community.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931? ☐ Yes ☒ No

   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

   Not applicable.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation. *If applicable, please include the date and medium by which the stakeholders were initially contacted.*

   In May 2021, an email requesting comment on this group of rules was sent to various stakeholders, interested parties, trade associations and companies. Specifically, the department reached out to the Ohio Land Title Association, the Ohio Insurance Institute (OII), the Association of Ohio Life Insurance Companies (AOLIC), the American Council of Life Insurance (ACLI), Ohio Association of Health Plans (OAHP) and the Ohio Insurance Agent Association Inc., among others. Additionally, these rules were also posted on the department's web site for review.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

    No comments were received during or after the two week comment period.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

    Rule 3901-3-13: The health insurance reserves NAIC model was established through extensive stakeholder and regulator outreach to determine appropriate standards based on market data and research.

    Rule 3901-3-19: The NAIC developed the model CGAD act and rule, which was created and vetted through a committee process that included research and input from numerous state regulators and industry stakeholders. This was a multi-year project to study and compare existing governance requirements for U.S. insurers to establish best practices, international standards and U.S. regulatory needs.

    Rule 3901-6-16: Representatives from industry and other state insurance departments worked together to develop the basics of this rule for the Interstate Insurance Product

Regulation Commission. Several other states have implemented a similar rule or statute. The department conducted extensive outreach to develop a good fit for Ohio.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

    Rule 3901-3-13: The NAIC works to establish national consistency across state department of insurance jurisdictions. National models establish predictability and in regards to maintaining financial reserve methods, an alternative is not appropriate.

    Rule 3901-3-19: No alternative regulation was considered. The rule was specifically developed to provide detail regarding the requirements of the CGAD. The language of this model regulation was developed in conjunction with the model statute during a collaborative stakeholder process.

    Rule 3901-6-16: The standards established in this rule were reached through extensive outreach and review of other states regulations. An industry standard was established to prevent adverse financial impact on senior citizens.

13. Did the Agency specifically consider a performance-based regulation? Please explain. *Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.*

    Rule 3901-3-13 requires health insurers to follow applicable guidelines in determining a satisfactory minimum reserve.

    Rule 3901-3-19: The corresponding statute, section 3901.074 of the Revised Code requires that the superintendent establish the required content of the CGAD. However, the rule was designed so the insurer has discretion regarding the appropriate format for providing the information. The insurer is permitted to customize the communication to provide the most relevant information necessary to permit the superintendent to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer.

    Rule 3901-6-16 requires that applicable filed products meet a specific standard. This standard ensures consumer protection and a balanced market.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

    The department is the sole regulator for insurance in the state of Ohio and confirmed there are no duplicate regulations.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

All rules included in this package are existing and understood by the regulated community. Updates to rule 3901-3-13 have been known to insurers active with the NAIC since their adoption in 2017. Additionally, the department maintains multiple divisions that are available to assist the regulated community and consumers.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:
    a. Identify the scope of the impacted business community;
    b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and
    c. Quantify the expected adverse impact from the regulation.
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a-c.

Rule 3901-3-13: Health insurers are required to maintain minimum reserves according to standards established in the rule. Amendments to the rule do not necessarily impose additional requirements, however will provide updated methods in determining compliance. These amendments implement the NAIC model, which has been familiar to the industry since 2017. Therefore quantifying the staff time necessary to review such amendments is unknown, but believed to be minimal.

Rule 3901-3-19: Insurers domiciled in Ohio are required to complete and submit a corporate governance annual disclosure (CGAD). Most of the information that is required to be included should already be known to the insurer and relied upon in its ongoing board and business operations. Many insurers currently summarize and describe their corporate governance practices to a number of various stakeholders on a regular basis. In addition, the disclosure requirements allow reference to existing documents and filings and provide guidance for filing changes from the prior year to simplify the reporting process. The time to complete subsequent CGADs should drop significantly as the insurer will only need to update the CGAD with any changes that occurred during the year.

Rule 3901-6-16: Insurance companies which sell applicable annuity products are required to comply with the calculation methods established in the rule. The rule remains in place without substantive amendments and therefore does not impose a quantifiable adverse impact.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Rule 3901-3-13: NAIC models establish national standards for insurers, resulting in consistency and regulatory predictability. Additionally, the rule promotes insurer solvency, which ensures consumer claims may be paid by the insurer.

Rule 3901-3-19: Through the adoption of standards in this area, the department can ensure that sufficient information on governance practices is available to assess the solvency of insurers on an annual basis.

Rule 3901-6-16: The standards established in the rule provide consumer protections for individuals, often senior citizens, whom purchase applicable annuity products.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Rule 3901-3-13: The purpose of this rule is to establish the minimum reserve standards for all individual and group health insurance coverages, the rule provides the standards and applicable tables to follow given the size and needs of each entity.

Rule 3901-3-19: The insurer has discretion regarding the appropriate format for providing the information and is permitted to customize the reporting to provide the most relevant information necessary to permit the department to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer. This includes a recognition by the department that smaller insurers may submit less complex CGADs and may need additional advice and guidance as to the filing requirements.

Rule 3901-6-16: Requirements etsablished in this rule promote consumer protection and establish straight-forward business and product standards, it is crucial that they are complied with consistently across the industry.

19. How will the Agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Paperwork violations and/or first time offender issues would be handled on a case by case basis to determine whether the violation could have a serious impact on the overall financial solvency of the insurer, or impact to consumer. Minor errors would be handled by advising the entity and providing them an opportunity to cure the omission.

20. What resources are available to assist small businesses with compliance of the regulation?

Department staff is available to assist any insurer regardless of size.

Ohio | Common Sense Initiative

EXHIBIT 30

Mike DeWine, Governor
Jon Husted, Lt. Governor
Sean McCullough, Director

MEMORANDUM

TO: Loretta Medved, Ohio Department of Insurance

FROM: Joseph Baker, Business Advocate

DATE: September 29, 2021

RE: **CSI Review – Health insurance reserves, corporate governance annual disclosure, and annuity nonforfeiture product standards (OAC 3901-3-13, 3901-3-19, and 3901-6-16)**

On behalf of Lt. Governor Jon Husted, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Department as provided for in ORC 107.54.

Analysis

This rule package consists of one new, one no-change, one amended, and one rescinded rule proposed by the Ohio Department of Insurance (Department) as a part of the statutory five-year review process. This rule package was submitted to the CSI Office on August 2, 2021, and the public comment period was held open through August 16, 2021. Unless otherwise noted below, this recommendation reflects the version of the proposed rules filed with the CSI Office on August 2, 2021.

The rules in this package establish reserve standards for individual and group health insurance coverages, procedures related to insurers required to file corporate governance disclosures and nonforfeiture product standards for annuities.

New OAC 3901-3-13 establishes minimum reserve standards for individual and group health insurance coverages. The rule requires health insurance providers to maintain claim reserves and outlines accounting and actuarial methods and processes for maintaining such reserves and

calculating potential liabilities. The Department states in the BIA that the rule is amended to adopt the latest standards adopted by the National Association of Insurance Commissioners (NAIC). Due to the extent of changes made to the rule, the Department proposes to rescind current OAC 3901-3-13 and replace the existing rule in its entirety.

OAC 3901-3-19 establishes procedures related to filing an annual corporate governance disclosure. The rule specifies that insurers who are required to file corporate governance disclosure must do so annually no later than June 1st of each year, that the disclosure must include a signature of the chief executive officer or corporate security attesting to the individual's belief that the practices described in the disclosure form have been implemented by the entity, that the insurer be as descriptive as possible in completing the disclosure, and that the disclosure describe the structural framework of the entity, the qualifications, expertise, and experience of board members, the independence of the board and its committees, the number of meetings held by the board, how board members are selected and the duration of terms, and other factors related to leadership structure and authority within the entity. The rule is amended to adopt a technical change.

OAC 3901-6-16 establishes standards for the purpose of calculating nonforfeiture values for annuity contracts. The rule specifies notwithstanding any language in a contract, the nonforfeiture maturity date of an annuity shall be the later of the 10th contract anniversary or the contract anniversary following the annuitant's 70th birthday and establishes other related tests, forfeiture conditions, and adjustments.

During early stakeholder outreach, the Department shared the proposed rules with various interested parties, including the Ohio Insurance Institute, the Ohio Land Title Association, the Association of Ohio Life Insurance Companies, the American Council of Life Insurance, the National Association of Insurance and Financial Advisors, the Ohio Association of Health Plans, and the Ohio Insurance Agent Association, among others and posted the rules on its website. No comments were provided in response to the request for early stakeholder outreach or during the CSI public comment period.

The business community impacted by the rules includes Ohio health insurers, Ohio insurers that are required to complete and submit a corporate governance annual disclosure, and insurance companies that sell applicable annuity products in Ohio. The adverse impacts to business include the costs and expense associated with determining appropriate minimum reserves and maintaining such reserves, the costs of completing and submitting corporate governance disclosures as specified, and costs associated with determining and complying with the calculation methods and nonforfeiture requirements for annuities. The Department states in the BIA that the costs of maintaining minimum reserves is unknown, but that the changes to the rule are familiar to the

industry and additional staff time necessary to comply with the changes is anticipated to be minimal. The Department also notes that the costs of completing corporate governance disclosures decreases significantly after the initial disclosure, as the insurer is only required to update the disclosure with changes that took place in the previous year. The Department states that the adverse impact to health insurers created by the rule promotes insurer solvency and ensures consumer claims are paid, that the adverse impact to insurers created by the corporate governance disclosure requirement enables the Department to assess the solvency of insurers and promote best practices, and that the annuity forfeiture standards that affect insurance companies who sell annuity products are necessary to provide consumer protections for purchasers.

Recommendations

Based on the information above, the CSI Office has no recommendations on this rule package.

Conclusion

The CSI Office concludes that the Ohio Department of Insurance should proceed in filing the proposed rules with the Joint Committee on Agency Rule Review.

Ohio Department of Insurance

Mike DeWine, Governor
Jon Husted, Lt. Governor

Judith L. French, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

EXHIBIT 31

MEMORANDUM

To: Joseph Baker, Business Advocate

CC: Sean McCullough, Director of the Common Sense Initiative Office

From: Loretta Medved, Policy Analyst

Date: September 29, 2021

Re: Response to CSI Review – Health insurance reserves, corporate governance annual disclosure, and annuity nonforfeiture product standards (OAC 3901-3-13, 3901-3-19, and 3901-6-16)

On September 29, 2021, the Ohio Department of Insurance (the Department) received the Recommendation Memorandum (CSI Recommendation) from the Common Sense Initiative Office for rule(s) 3901-3-13 Health insurance reserves, 3901-3-19 Corporate governance annual disclosure, and 3901-6-16 Annuity nonforfeiture product standards.

The CSI Recommendation stated that the office does not have any recommendations regarding this rule package, and therefore should proceed with a formal filing of the rule package.

At this time, the Department plans to move forward with the filing of this rule package with the Joint Committee on Agency Rule Review.

If you have any questions please contact Loretta Medved at 614-644-0239 or Loretta.Medved@insurance.ohio.gov.

EXHIBIT 32

Rule Summary and Fiscal Analysis
Part A - General Questions

Rule Number: 3901-7-04

Rule Type: Amendment

Rule Title/Tagline: Title insurance controlled business arrangements.

Agency Name: Department of Insurance

Division:

Address: 50 W Town Street Suite 300 Columbus OH 43215

Contact: Tina Chubb **Phone:** (614) 728-1044

Email: Tina.Chubb@insurance.ohio.gov

I. Rule Summary

1. **Is this a five year rule review?** Yes

   A. **What is the rule's five year review date?** 11/30/2021

2. **Is this rule the result of recent legislation?** No

3. **What statute is this rule being promulgated under?** 119.03

4. **What statute(s) grant rule writing authority?** 3901.041

5. **What statute(s) does the rule implement or amplify?** 3953.21

6. **What are the reasons for proposing the rule?**

   This rule is being reviewed as a part of the agency five year rule review.

7. **Summarize the rule's content, and if this is an amended rule, also summarize the rule's changes.**

   Rule 3901-7-04 establishes ownership and licensing standards for title insurance agents and agencies in accordance with division (B) of section 3953.21 of the Revised Code, which prohibits certain persons from acting as agents for a title insurance company.

The proposed amendment will correct a citation in the definition of "person".

8. **Does the rule incorporate material by reference?** No

9. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

   Not Applicable

10. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

    Not Applicable

II. Fiscal Analysis

11. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

    This will have no impact on revenues or expenditures.

    $0.00

    Not applicable.

12. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

    This rule outlines prohibitions for specific business arrangements. No substantive amendments are recommended to the rule and therefore no cost of compliance is imposed.

13. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

14. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

15. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

    Not applicable.

III. Common Sense Initiative (CSI) Questions

16. **Was this rule filed with the Common Sense Initiative Office?** Yes

17. **Does this rule have an adverse impact on business?** No

    A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

    B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** No

    C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** No

       The rule states that a business entity may not become licensed or remain licensed where the entity is merely a sham arrangement used as a conduit for inducements or compensation for business payments in violation of section 3953.26 and/or section 3933.01 of the Revised Code. When making a determination, the Superintendent may request information for review.

    D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restrictions (This section only applies to agencies indicated in R.C. 121.95 (A))

18. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

    A. **How many new regulatory restrictions do you propose adding?**

       Not Applicable

    B. **How many existing regulatory restrictions do you propose removing?**

       Not Applicable

EXHIBIT 33

3901-7-04 **Title insurance controlled business arrangements.**

(A) Purpose

The purpose of this rule is to establish ownership and licensing standards for title insurance agents and agencies in accordance with division (B) of section 3953.21 of the Revised Code, which prohibits certain persons from acting as agents for a title insurance company.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under section 3901.041 of the Revised Code.

(C) Definitions

As used in this rule:

(1) "Beneficial ownership" means the effective ownership of any interest in a title insurance agency or the right to control an ownership interest even though legal ownership may be held in another person's name.

(2) "Control," including "controlling", "controlled by", and "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing fifty per cent or more of the voting securities or interests of any other person. Control shall also be presumed to exist between a natural person and an immediate family member. These presumptions may be rebutted by showing that control does not exist in fact. The superintendent of insurance may determine that control exists if the facts support such a determination notwithstanding the absence of a presumption to that effect.

(3) "Immediate family member" includes a person's father, mother, stepfather, stepmother, brother, sister, stepbrother, stepsister, son, daughter, stepson, stepdaughter, grandparent, grandson, granddaughter, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, the spouse of any of the foregoing, and the person's spouse.

(4) "Person" means any natural person or any business entity as defined in division ~~(A)~~ (P) of section 3905.01 of the Revised Code.

(5) "Prohibited person" means a person prohibited from acting as an agent for a title insurance company pursuant to division (B) of section 3953.21 of the Revised Code, and includes builders and developers.

(6) "RESPA" means the Real Estate Settlement Procedures Act, 12 U.S.C. 2601 et seq., as amended, and all rules, regulations and interpretations issued under RESPA, as amended, including but not limited to 24 C.F.R. Part 3500 and the Statement of Policy 1996-2 Regarding Sham Controlled Business Arrangements found at 61 Fed. Reg. 29258 et seq.

(D) No business entity may be licensed as a title insurance agency where one or more prohibited persons control the business entity.

(E) A business entity may not become licensed or remain licensed where the entity is merely a sham arrangement used as a conduit for inducements or compensation for business payments in violation of section 3953.26 and/or section 3933.01 of the Revised Code. In determining whether an entity is a sham arrangement, the superintendent may consider factors similar to those used to determine whether a controlled business arrangement is a sham arrangement under RESPA, including, but not limited to:

(1) Does the new entity have sufficient initial capital and net worth, typical of the industry, to conduct the title insurance business for which it was created or is it undercapitalized to do the work it purports to provide?

(2) Is the new entity staffed with its own employees to perform the services it provides or does the new entity have "loaned" employees of one of the parents?

(3) Does the new entity manage its own business affairs or is the new entity being run by one of the parents?

(4) Does the new entity have an office for business which is separate from any of the parents? If the new entity is located at the same business address as one of the parents, does the new entity pay fair market value rent for the facilities actually furnished?

(5) Is the new entity providing substantial services, i.e., the essential functions of the real estate settlement service, for which it receives a fee?

(6) Does the new entity perform all of the substantial services itself or does it contract out part of the work? If so, how much work is contracted out?

(7) If the new entity contracts out some of its essential functions does it contract services from an independent third party or from a parent or affiliate of a parent?

If the new entity contracts out work to a parent or to an affiliate of a parent, does the new entity provide any functions that are of value to the settlement process?

(8) If the new entity contracts out work to another party, is the party performing any contracted services receiving a payment for the services or facilities that bears a reasonable relationship to the value of the goods or services received?

(9) Is the new entity actively competing in the marketplace for business or does it provide services solely for one or more of the parents?

(F) Where a person has a direct or beneficial ownership interest in a business entity title insurance agent, the only thing of value that can flow from such an arrangement, other than permissible payments for services rendered, is a return on ownership interest.

(1) Under this rule, a return on ownership interest may not include any of the following:

(a) Any payment which has, as a basis of calculation, no apparent business motive other than distinguishing among recipients of payments on the basis of the amount of their actual, estimated or anticipated referrals;

(b) Any payment which varies according to the relative amount of referrals by different recipients of similar payments; or

(c) A payment based on an ownership, partnership or joint venture share which has been adjusted on the basis of previous relative referrals by recipients of similar payments.

(2) In determining whether a payment is a return on an ownership interest or an impermissible payment for the referral of title insurance business, the superintendent may consider factors similar to those used to determine whether a payment is an impermissible payment for a referral under RESPA.

(G) A prohibited person may not serve as a partner, officer, director, or managing member of a title insurance agency, nor may a prohibited person be involved in the day-to-day operations of the title agency.

(H) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms and provisions shall be and continue in full force and effect.

Effective:

Five Year Review (FYR) Dates: 11/30/2021

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	3901.041
Rule Amplifies:	3953.21
Prior Effective Dates:	01/01/2007, 11/03/2016

EXHIBIT 34

Ohio | Common Sense Initiative

Mike DeWine, Governor | **Jon Husted**, Lt. Governor | **Carrie Kuruc**, Director

Business Impact Analysis

Agency Name: ***Ohio Department of Insurance***
Rule Contact Name: ***Loretta Medved***
Rule Contact Information: ***loretta.medved@insurance.ohio.gov***
614-644-0239

Regulation/Package Title *(a general description of the rules' substantive content)*:
Title Insurance Rules

Rule Number(s): ***3901-7-01, 3901-7-02, 3901-7-03, 3901-7-04***

Date of Submission for CSI Review: ***July 14, 2021***
Public Comment Period End Date: ***July 28, 2021 12:00AM***

Rule Type/Number of Rules:

- ☐ New/ rules
- ☒ Amended/ ***1*** rules (FYR? ***2021***)
- ☒ No Change/ ***3*** rules (FYR? ***2021***)
- ☐ Rescinded/ rules (FYR?)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 requires agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the Agency determined the rule(s) create?

   The rule(s):

   - ☐ a. Requires a license, permit, or any other prior authorization to engage in or operate a line of business.
   - ☐ b. Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.
   - ☒ c. Requires specific expenditures or the report of information as a condition of compliance.
   - ☐ d. Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 3901-7-01 establishes criteria for the annual independent review of title insurance agents' escrow, settlement, closing and security deposit depository institutions. There are no suggested amendments to this rule.

   Rule 3901-7-02 sets forth the requirements regarding surety bond and errors and omissions coverage to be maintained by title insurance agents or agencies under conditions specified in section 3953.23 of the Revised Code. There are no suggested amendments to this rule.

   Rule 3901-7-03 sets forth the requirements regarding notice to be provided to mortgagors by title insurance agents concerning title insurance coverage under conditions specified in section 3953.30 of the Revised Code. There are no suggested amendments to this rule.

   Rule 3901-7-04 establishes ownership and licensing standards for title insurance agents in accordance with division ( ) section 3953.21 of the Revised Code, which prohibits certain persons from acting as agents for a title insurance company. A technical amendment is proposed to correct a citation.

3. Please list the Ohio statute(s) that authorize the Agency to adopt the rule(s) and the statute(s) that amplify that authority.

   3901-7-01: Sections 3901.041 and 3953.33 of the Revised Code.

   3901-7-02: Sections 3901.041 and 3953.23 of the Revised Code.

   3901-7-03: Sections 3901.041 and 3953.30 of the Revised Code.

3901-7-04: Section 3901.041 of the Revised Code.

4. Does the regulation implement a federal requirement? ☐ Yes ☒ No
   Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   ☐ Yes ☒ No
   If yes, please briefly explain the source and substance of the federal requirement.

   Not applicable.

5. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   Not applicable .

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   Rule 3901-7-01: The public purpose is to ensure appropriate financial reviews are in place to protect consumers when agents are handling escrow transactions. Statute requires that any title agent handling escrow accounts shall have an independent review made of those escrow accounts, and requires the superintendent to establish a rule setting forth requirements of the independent review and its filing.

   Rule 3901-7-02: The public purpose is protection of consumers in the event of theft, fraud, misappropriation and/or agency errors. Statute requires all title agents to carry errors and omissions coverage, and all title agents handling escrow transactions to obtain surety bonds. Statute also requires the superintendent to establish a rule setting minimum limits, requirements and terms and conditions of coverage.

   Rule 3901-7-03: The public purpose of the rule is to ensure borrowers are provided adequate awareness regarding the lender's title insurance policy and availability of owner's title insurance. Statute requires that when a title insurance agent issues a lender's title insurance policy, and where no owner's title insurance policy has been requested, the agent shall provide notice that makes the borrower aware that the lender's policy does not offer the protection an owner's policy does. The notice shall explain what is covered, as well as what would be covered with an owner's title policy.

   Rule 3901-7-04: The public purpose is to protect consumers against inappropriate and illegal controlled business arrangements within the title insurance industry. Statute prohibits banks, mortgage lenders or brokers and real estate companies from acting as agents for title insurance companies. The rule describes the level of ownership related to a title insurance agent that would constitute control of the title insurance agency business, and thus constitute acting as an agent.

7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

Rule 3901-7-01: Success is measured by full compliance of all impacted title insurance agents providing the necessary independent review filings by the annual deadline.

Rule 3901-7-02: Success is measured, through the license application and renewal review process, by documenting that all title insurance agents handling escrow transactions are affirming they hold the required amounts of bonds and errors and omissions coverage.

Rule 3901-7-03: Success is measured by the absence of complaints or requests to investigate title agents for failure to communicate adequately and provide notice of lender's title policy coverage scope.

Rule 3901-7-04: Success is measured through the license application and renewal process, specifically by ensuring compliance with statutory requirements and prohibitions during license application review.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931? ☐ Yes ☒ No

   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

   Not applicable.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation. *If applicable, please include the date and medium by which the stakeholders were initially contacted.*

   In May 2021, an email requesting comment on the rule was sent to various stakeholders, interested parties, trade associations and companies. Specifically, the department reached out to the Ohio Land Title Association, the Ohio Insurance Institute (OII), the Association of Ohio Life Insurance Companies (AOLIC), the American Council of Life Insurance (ACLI), the National Association of Insurance and Financial Advisors (NAIFA), Ohio Association of Health Plans (OAHP) and the Professional Independent Agents Association (PIAA), among others. Additionally, these rules were also posted on the department's web site for review.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

    No comments were received during or after the vetting of this rule packet.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

Rule 3901-7-01: The rule applies best practice procedures as defined by the American Institute of Certified Public Accountants, and clarifies the types of information and activities related to escrow accounts to have reviewed to meet those standards.

Rule 3901-7-02: Statute requires that surety bond and errors and omissions coverage be regulated by the rule. In setting the coverage limitations, the department considered the market premium costs weighed by the anticipated coverage level needed to protect consumers' funds during property transactions and escrow.

Rule 3901-7-03: Statute requires the notice and what must be included in the notice, and development of this rule did not require additional data or research to develop the rule.

Rule 3901-7-04: The prohibition against certain persons acting as agents is statutory, so no additional data was needed to implement the general requirement of the rule. The rule, however, proscribes what constitutes controlling an agency (business entity agent) and thus acting as an agent. The threshold in rule, 50 or greater ownership, is compatible with a reasonable level of ownership that would indicate controlling ownership. Lower than majority ownership was deemed too restrictive and without merit in terms of assuming control, or acting as an agent.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

Rule 3901-7-01: The rule established the filing form and content for independent reviews that are required by statute. There is no need in this case to consider alternatives.

Rule 3901-7-02: The general requirements of the rule are set in statute. The coverage amounts of the bond and errors and omissions insurance requirements could have allowed for alternate (or higher) minimums. The department is continuing the established minimums as a balance that protects consumers while not placing undue burden in business costs for the title agents.

Rule 3901-7-03: The notices required in the rule are set in statute and there were no alternatives to consider beyond the form and content of the notice provided in the rule. The form established in the rule provides the explanation necessary for the borrower to understand the coverage limitations in a lender's policy and the availability of purchasing owners' coverage.

Rule 3901-7-04: Statute prohibits a person engaged in certain lines of business (e.g., realtors or mortgage lenders) from also serving as licensed title agents. The rule establishes the level of ownership or interest of an agency (business entity agent) which would constitute control of that agency and therefore acting as a licensed agent. Alternatives considered in the past have included discussion of different levels of ownership regarding control of the business.

The department continues to consider that 50 or greater constitutes control of the agency, as is standard across most industries when considering level of control.

13. Did the Agency specifically consider a performance-based regulation? Please explain.
Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

Performance based regulations are not appropriate for these rules as they establish clear guuidelines for the title industry when meeting statuatory obligations. These rules provide guidance for annual review filings, minimum coverage standards, borrower notices and agency ownership prohibitions. The requirements of the rules are conditions of title agent licensure.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

The department is the only agency responsible for regulating title insurance companies and title agents, and there are no duplicate rules.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

Theses rules remain in place, no substantive amendments are recommended and therefore require no implementation of new standard operating procedures. The proposed amendment in rule 3901-7-04 is technical to correct a citation.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:
    a. Identify the scope of the impacted business community;
    b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and
    c. Quantify the expected adverse impact from the regulation.
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a. Impacted business community members for the four title insurance rules are title agents.

b-c.

Rule 3901-7-01: Title agents handling escrow accounts must have an annual independent financial review conducted. The estimated cost for CPA review ranges from $800-$1,000 per review. The review can be submitted electronically when filing with the superintendent, which can be done in less than a half hour.

Rule 3901-7-02: Title insurance agents must maintain errors and omissions insurance with minimum coverage of $250,000. Though insurance cost would vary for each business, it is estimated to be available for $600-$1,500 annual premium. Title agents handling escrow for transactions that involve no title insurance must maintain surety bonds with minimum coverage of $150,000. Though cost varies according to credit and other factors, bonds for this level of coverage are estimated to be available for $2,000-$5,000.

Rule 3901-7-03: hen a lender's title insurance policy is issued for a sale where no owner's policy has been requested, title agents must provide notice regarding availability and cost of owner's title insurance, as well as the difference in scope of owner's and lender's title policies. The staff time cost of compliance would include time to research cost range for owner's policy and administrative time to complete the notice form. It is anticipated each notice could be completed in a hour or less.

Rule 3901-7-04: The rule describes the requirements that must exist in order for a business entity title agent to be eligible for licensure, and does not directly impose cost or impact. The licensure requirement itself occurs in statute and a different rule. This rule provides information and standards for eligibility, specifically relating to statutory prohibition of certain persons in other businesses acting as title agents or having control of title insurance agencies. Implementation occurs consistently and according to current operating practice during the license application and renewal review process.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Consumer protection is the primary reason for all four rules, as well as the need to meet statuatory requirements.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Rule 3901-7-01: hile there are no exemptions from meeting the requirements based on size of the business the rule does include an exemption if there are fewer than an average of five transactions per month where the agent is handling escrow funds.

Rule 3901-7-02: The surety bond and errors and omission insurance coverage requirements are not related to business size and are in place to ensure consumers' risks are protected when title insurance and funds-handling services are provided by the business.

Rule 3901-7-03: The notice requirement when issuing lender's title policies are based on the occurrence or transaction and the same requirement exists regardless of business size.

Rule 3901-7-04: The requirements related to control and ownership of title insurance agencies are consistent regardless of size of the agency.

19. How will the Agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

    As all of the rules regard conditions of title agent licensure and licensure eligibility requirements, the general goal is to work with any individual or business entity to meet the compliance standards in order to be able to continue doing business or become eligible if capable.

20. What resources are available to assist small businesses with compliance of the regulation?

    Department staff is available to answer questions and provide assistance as needed.

Ohio | Common Sense Initiative

EXHIBIT 35

Mike DeWine, Governor
Jon Husted, Lt. Governor

Sean McCullough, Director

MEMORANDUM

TO: Loretta Medved, Ohio Department of Insurance

FROM: Joseph Baker, Business Advocate

DATE: September 14, 2021

RE: **CSI Review – Title Insurance Rules (OAC 3901-7-01, 3901-7-02, 3901-7-03, and 3901-7-04)**

On behalf of Lt. Governor Jon Husted, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Department as provided for in ORC 107.54.

Analysis

This rule package consists of one amended and three no change rules proposed by the Ohio Department of Insurance (Department) as a part of the statutory five-year review process. This rule package was submitted to the CSI Office on July 14, 2021, and the public comment period was held open through July 28, 2021. Unless otherwise noted below, this recommendation reflects the version of the proposed rules filed with the CSI Office on July 14, 2021.

The rules in this package establish standards related to the review and practices of title insurance agents, including financial management and auditing practices, insurance coverage minimums, reporting requirements, notification responsibilities, and ownership interest standards.

OAC 3901-7-01 establishes criteria for an independent review of title insurance agents' escrow, settlement, closing, and security deposit accounts. The rule requires each agent to file an independent review or filing exemption claim annually, outlining various information requested by the Department to demonstrate appropriate management of financial accounts. OAC 3901-7-02 requires title insurance agents and agencies to maintain a surety bond of at least $150,000 to

protect against theft, misappropriation, fraud, or any other failure to disburse settlement, closing, or escrow funds. The rule also requires the maintenance of errors and omissions insurance coverage of at least $250,000 (including $50,000 coverage for any subcontractors that act on behalf of the title insurance company) to report insurance maintained under the rule to the Department during the annual escrow account review conducted per OAC 3801-7-01.

OAC 3901-7-03 requires title insurance agents or agencies that issue a lender's title insurance policy connected to a residential mortgage loan to provide written notice and to maintain a copy of the notice for at least 10 years after the effective date of the lender's title insurance policy. The written notice must inform the property owner that the mortgage lender holds a policy protecting the mortgage lender against potential defects connected to the property title and that the property owner may obtain coverage protecting his or her interests through the purchase of an owner's policy. The rule also prescribes the exact language of the form as an appendix to the rule. The rule is amended to correct a citation.

Lastly, OAC 3901-7-04 establishes ownership and licensing standards for title insurance agents and agencies, including prohibiting certain entities from owning or controlling a title insurance company. Such entities prohibited from acting as title agencies include banks, trust companies, bank and trust companies, lending institutions, mortgage services companies, brokerages, escrow companies, real estate companies, and mortgage guaranty companies, as well as any subsidiaries of or individuals employed by such companies. The rule further identifies criteria for evaluating the legitimacy of a title insurance company, such as whether it has sufficient initial capital to conduct the business, is staffed with its own employees, can provide substantial services, and manages its own business affairs, among others.

During early stakeholder outreach, the Department shared the proposed rules with various interested parties including the Ohio Insurance Institute, the Ohio Land Title Association, the Association of Ohio Life Insurance Companies, the American Council of Life Insurance, the National Association of Insurance and Financial Advisors, the Ohio Association of Health Plans, and the Professional Independent Agents Association, among others. No comments were provided in response to the request for early stakeholder outreach or during the CSI public comment period.

The business community impacted by the rules includes title agents licensed to practice in Ohio. The adverse impacts to business include the costs of an annual independent financial review and the administrative expenses associated with conducting the review and submitting the report to the Department. The Department estimates the cost of the review at approximately $800-$1,000 annually. The adverse impacts also include the cost of maintaining errors and omissions insurance and surety bonds. The Department estimates the cost of errors and omissions coverage ranges

between $600-$1,500 annually, while the cost of surety bonds may range between $2,000-$5,000. The adverse impacts identified by the Department also include the administrative effort necessary to provide notice regarding the availability and cost of owner's title insurance, which the Department estimates will require less than an hour of staff time. Lastly, the adverse impacts to business include the loss of business opportunity associated with the denial of a title agent license application if the applicant is engaged in certain lines of business, which reflects ORC 3953.21(B). The Department states in the BIA that the adverse impacts to business created by these rules are necessary to preserve consumer protection and meet statutory requirements.

Recommendations

Based on the information above, the CSI Office has no recommendations on this rule package.

Conclusion

The CSI Office concludes that the Ohio Department of Insurance should proceed in filing the proposed rules with the Joint Committee on Agency Rule Review.

Ohio Department of Insurance

Mike DeWine, Governor
Jon Husted, Lt. Governor

Judith L. French, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

EXHIBIT 36

MEMORANDUM

To: Joseph Baker, Business Advocate

CC: Sean McCullough, Director of the Common Sense Initiative Office

From: Loretta Medved, Policy Analyst

Date: September 28, 2021

Re: Response to CSI Review – Title Insurance Rules (OAC 3901-7-01, 3901-7-02, 3901-7-03, and 3901-7-04)

On September 14, 2021, the Ohio Department of Insurance (the Department) received the Recommendation Memorandum (CSI Recommendation) from the Common Sense Initiative Office for rule(s) 3901-7-01 Annual review of title insurance agent escrow accounts, 3901-7-02 Title insurance agents maintenance of surety bond and errors and omissions coverage, 3901-7-03 Recognition of 2001 CSO mortality table for use in determining minimum reserve liabilities and nonforfeiture benefits, and 3901-7-04 Permitting the recognition of preferred mortality tables for use in determining minimum reserve liabilities.

The CSI Recommendation stated that the office does not have any recommendations regarding this rule package, and therefore should proceed with a formal filing of the rule package.

At this time, the Department plans to move forward with the filing of this rule package with the Joint Committee on Agency Rule Review.

If you have any questions please contact Loretta Medved at 614-644-0239 or Loretta.Medved@insurance.ohio.gov.

Rule Summary and Fiscal Analysis
Part A - General Questions

EXHIBIT 37

Rule Number: 3901-3-13

Rule Type: Rescission

Rule Title/Tagline: Health insurance reserves.

Agency Name: Department of Insurance

Division:

Address: 50 W Town Street Suite 300 Columbus OH 43215

Contact: Tina Chubb **Phone:** (614) 728-1044

Email: Tina.Chubb@insurance.ohio.gov

I. Rule Summary

1. **Is this a five year rule review?** Yes

   A. **What is the rule's five year review date?** 11/30/2021

2. **Is this rule the result of recent legislation?** No

3. **What statute is this rule being promulgated under?** 119.03

4. **What statute(s) grant rule writing authority?** 3901.041, 3903.723(Q)

5. **What statute(s) does the rule implement or amplify?** 3903.723(Q)

6. **What are the reasons for proposing the rule?**

   This rule is being reviewed as a part of the agency five year rule review.

7. **Summarize the rule's content, and if this is an amended rule, also summarize the rule's changes.**

   The purpose of this rule is to establish the minimum reserve standards for all individual and group health insurance coverages, including single premium credit disability insurance, as required by division (Q) of section 3903.723 of the Revised Code.

Recommended amendments to this rule will incorporate the latest version of the NAIC model. Updates to the model do not implement new requirements, but rather provide the updated standards for recent plan years, and those moving forward. Due to the amount of proposed amendments the rule will be filed as rescind, and ultimately filed as a new rule.

8. **Does the rule incorporate material by reference?** No

9. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

   Not Applicable

10. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

    Not Applicable

II. Fiscal Analysis

11. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

    This will have no impact on revenues or expenditures.

    $0.00

    Not applicable.

12. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

    Not applicable.

13. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

14. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

15. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

Not applicable.

III. Common Sense Initiative (CSI) Questions

16. **Was this rule filed with the Common Sense Initiative Office?** Yes

17. **Does this rule have an adverse impact on business?** No

    A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

    B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** No

    C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** No

    D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restrictions (This section only applies to agencies indicated in R.C. 121.95 (A))

18. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

    A. **How many new regulatory restrictions do you propose adding?**

    Not Applicable

    B. **How many existing regulatory restrictions do you propose removing?**

    Not Applicable

TO BE RESCINDED

EXHIBIT 38

3901-3-13 **Health insurance reserves.**

(A) Purpose

The purpose of this rule is to establish the minimum reserve standards for all individual and group health insurance coverages, including single premium credit disability insurance, as required by division (Q) of section 3903.723 of the Revised Code. All other credit insurance is not subject to this rule.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under section 3901.041 and division (Q) of section 3903.723 of the Revised Code.

(C) Scope

(1) These standards establish a minimum reserve standard for all individual and group health insurance coverages including single premium credit disability insurance. When an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

(2) With respect to any block of contracts, or with respect to an insurer's health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

(3) Such a gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's health business as a whole. In the event inadequacy is found to exist, immediate loss recognition shall be made and the reserves restored to adequacy. Adequate reserves (inclusive of claim, premium and contract reserves, if any) shall be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under these standards.

(4) Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under these standards.

(5) This rule sets forth minimum standards for three categories of health insurance reserves; claim reserves, premium reserves and contract reserves. Adequacy of an insurer's health insurance reserves is to be determined on the basis of all three categories combined. However, these standards emphasize the importance of determining appropriate reserves for each of these categories separately.

(D) Definitions

(1) "Annual claim cost" means the net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a one hundred dollar monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age thirty-five, in a certain occupation might be twelve dollars, while the gross premium for this benefit might be eighteen dollars. The additional six dollars would cover expenses and profit or contingencies.

(2) "Claims accrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for "accrued" benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

(3) "Claims reported" means a claim that has been incurred on or prior to the valuation date and the insurer has been informed of it on or before the valuation date. This claim is considered a reported claim for annual statement purposes.

(4) "Claims unaccrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest), must be established.

(5) "Claims unreported" means a claim that has been incurred on or prior to the valuation date but the insurer has not been informed of it on or before the valuation date. This claim is considered an unreported claim for annual statement purposes.

(6) "Date of disablement" means the earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

(7) "Elimination period" means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

(8) "Gross premium" means the amount of premium charged by the insurer. It includes the net premium (based on claim-cost) for the risk, together with any loading for expenses, profit or contingencies.

(9) "Group insurance" means blanket insurance and franchise insurance and any other forms of group insurance.

(10) "Level premium" means a premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time. Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

(11) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health

maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(12) "Modal premium" means the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus if the annual premium is one hundred dollars and if, instead, monthly premiums of nine dollars are paid then the modal premium is nine dollars.

(13) "Negative reserve" means the terminal reserve where the values of the benefits are decreasing with advancing age or duration such that it results in a negative value, called a negative reserve. Normally the terminal reserve is a positive value.

(14) "Preliminary term reserve method" means the method of valuation where the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

(15) "Present value of amounts not yet due on claims" means the reserve for "claims unaccrued" which may be discounted at interest.

(16) "Rating block" means a grouping of contracts determined by the valuation actuary based on common characteristics filed with the superintendent, such as a policy form or forms having similar benefit designs.

(17) "Reserve" means all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued. An insurer under its contracts promises benefits which result in: claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date, (on these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves); or claims which

are expected to be incurred after the valuation date, (any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.)

(18) "Terminal reserve" means the reserve at the end of the contract year which is equal to the present value of benefits expected to be incurred after the contract year minus the present value of future valuation net premiums.

(19) "Unearned premium reserve" means that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of one hundred twenty dollars was paid on November first, twenty dollars would be earned as of December thirty-first and the remaining one hundred dollars would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

(20) "Valuation net modal premium" means the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

(E) Claim reserves

(1) General

(a) Claim reserves are required for all incurred but unpaid claims on all health insurance policies.

(b) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims.

(c) All such reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

(2) Minimum standards for claim reserves

(a) Disability income

(i) Interest. The maximum interest rate for claim reserves is specified in paragraph (I) of this rule.

(ii) Morbidity. Minimum standards with respect to morbidity are those specified in paragraph (I) of this rule except that, at the option of the insurer:

(a) For individual disability income claims incurred on or after January 1, 2005, assumptions regarding claim termination rates for the period less than two years from the date of disablement may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(b) For group disability income claims incurred on or after January 1, 2005:

(i) Assumptions regarding claim termination rates for the period less than two years from the date of disablement may be based on the insurer's experience, if the experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(ii) Assumptions regarding claim termination rates for the period two or more years but less than five years from the date of disablement may, with the approval of the superintendent, be based on the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for such approval of a plan of modification to the reserve basis must include:

(A) An analysis of the credibility of the experience;

(B) A description of how all of the insurer's experience is proposed to be used in setting reserves;

(C) A description and quantification of the margins to be included;

(D) A summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement;

(E) A copy of the approval of the proposed plan of modification by the superintendent of the state of domicile; and

(F) Any other information deemed necessary by the superintendent.

(c) For disability income claims incurred prior to January 1, 2005 each insurer may elect which of the following to use as the minimum morbidity standard for claim reserves:

(i) The minimum morbidity standard in effect for claim reserves as of the date of the claim was incurred, or

(ii) The standards as defined in paragraphs (E)(2)(a)(ii)(a) and (E)(2)(a)(ii)(b) of this rule, applied to all open claims. Once an insurer elects to calculate reserves for all open claims on the standard defined in paragraphs (E)(2)(a)(ii)(a) and (E)(2)(a)(ii)(b) of this rule, all future valuations must be on that basis.

(iii) Duration of disablement. For contracts with an elimination period, the duration of disablement should be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

(b) All other benefits

(i) Interest. The maximum interest rate for claim reserves is specified in paragraph (I) of this rule.

(ii) Morbidity or other contingency. The reserve should be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(3) Claim reserve methods generally

A generally accepted actuarial reserving method or other reasonable method as approved by the superintendent prior to the statement date based on information and data describing the proposed method, or a combination of methods may be used to estimate all claim liabilities. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, shall be determined in the aggregate.

(F) Premium reserves

(1) General

(a) Unearned premium reserves are required for all contracts, except individual and group single premium credit disability insurance, with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(b) If premiums due and unpaid are carried as an asset, such premiums must be treated as premiums in force, subject to unearned premium reserve determination. .

(c) The gross premiums paid in advance for a period of coverage commencing after the next premium due date which follows the date of valuation may be appropriately discounted to the valuation date and shall be held either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

(2) Minimum standards for unearned premium reserves

(a) The minimum unearned premium reserve with respect to any contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with such premium determined on the basis of:

(i) The valuation net modal premium on the contract reserve basis applying to the contract; or

(ii) The gross modal premium for the contract if no contract reserve applies.

(b) In no event may the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. Such reserve shall never be less than the expected claims for the period beyond the valuation date represented by such unearned premium reserve, to the extent not provided for elsewhere.

(3) Premium reserve methods generally

The insurer may employ suitable approximations and estimates; including, but not limited to groupings, averages and aggregate estimation; in computing premium reserves. Such approximations or estimates should be tested periodically to determine their continuing adequacy and reliability.

(G) Contract reserves

(1) General

(a) Contract reserves are required, unless otherwise specified in paragraph (G)(1)(b) of this rule for:

(i) All individual and group contracts with which level premiums are used; or

(ii) All individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. This evaluation may be applied on a rating block basis if the total premiums for the block were developed to support the total risk assumed and expected expenses for the block each year, and a qualified actuary certifies the premium development. The actuary should state in the certification that premiums for the rating block were developed such that each year's premium was intended to cover that year's costs without any prefunding. If the premium is also intended to recover costs for any prior years, the actuary should also disclose the reasons for and magnitude of such recovery. The values specified in paragraph (G)(1)(a)(ii) of this rule shall be determined on the basis specified in paragraph (G)(2) of this rule.

(b) Contracts not requiring a contract reserve are:

(i) Contracts which cannot be continued after one year from issue; or

(ii) Contracts already in force on the effective date of these standards for which no contract reserve was required under the immediately preceding standards.

(c) The contract reserve is in addition to claim reserves and premium reserves.

(d) The methods and procedures for contract reserves should be consistent with those for claim reserves for any contract, or else appropriate adjustment must be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral must be the same in both determinations.

(e) The contract reserves for single premium credit disability insurance shall never be less than the expected claims for the period beyond the valuation date.

(f) The total contract reserve established shall incorporate provisions for moderately adverse deviations.

(2) Minimum standards for contract reserves

(a) Basis

(i) Morbidity or other contingency. Minimum standards with respect to morbidity are those set forth in paragraph (I) of this rule. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated.

Contracts for which tabular morbidity standards are not specified in paragraph (I) of this rule shall be valued using tables established for reserve purposes by a qualified actuary and acceptable to the superintendent. The morbidity tables shall contain a pattern for incurred claims cost that reflects the underlying morbidity and shall not be constructed for the primary purpose of minimizing reserves.

(a) In determining the morbidity assumptions, the actuary shall use assumptions that represent the best estimate of anticipated future experience, but shall not incorporate any expectation of future morbidity improvement. Morbidity improvement is a change, in the combined effect of claim frequency and the present value of future expected claim payments given that a claim has occurred, from the current morbidity tables or experience that will result in a reduction to reserves. It is not the intent of this provision to restrict the ability of the actuary to reflect the morbidity impact for a specific known event that has occurred and that is able to be evaluated and quantified.

(b) Business in force as of the effective date of paragraph (G)(2)(a)(iii) of this rule may be permitted to retain the original reserve basis which may not meet the provisions of paragraph (G)(2)(a)(i)(a) of this rule, subject to the acceptability of the superintendent.

(ii) Interest. The maximum interest rate is specified in paragraph (I) of this rule.

(iii) Termination rates. Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in paragraph (I) of this rule except as noted in paragraphs (G)(2)(a)(iii)(a), (G)(2)(a)(iii)(b), and (G)(2)(a)(iii)(c) of this rule.

(a) Under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard or for return of premium or other deferred cash benefits, total termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(i) Eighty per cent of the total termination rate used in the calculation of the gross premiums, or

(ii) Eight per cent.

(b) For long-term care individual policies or group certificates issued after December 31, 2003, the contract reserve may be established on a basis of separate:

(i) Mortality (as specified in paragraph (I) of this rule); and

(ii) Terminations other than mortality, where the terminations are not to exceed:

(A) For policy years one through four, the lesser of eighty per cent of the voluntary lapse rate used in the calculation of gross premiums and eight per cent;

(B) For policy years five and later, the lesser of one hundred per cent of the voluntary lapse rate used in the calculation of gross premiums and four per cent.

(c) For long-term care individual policies or group certificates issued on or after January 1, 2011, the contract reserve may be established on a basis of separate:

(i) Mortality (as specified in paragraph (I) of this rule); and

(ii) Terminations other than mortality, where the terminations are not to exceed;

(A) For policy year one, the lesser of eighty per cent of the voluntary lapse rate used in the calculation of gross premiums and six per cent;

(B) For policy year two through four, the lesser of eighty per cent of the voluntary lapse rate used in the calculation of gross premiums and four per cent;

(C) For policy year five and later, the lesser of one hundred per cent of the voluntary lapse rate used in the calculation of gross premiums and two per cent, except for group insurance as defined in section 3923.41 of the Revised Code where the two per cent shall be three per cent.

(d) Where a morbidity standard specified in paragraph (I) of this rule is on an aggregate basis, such morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments must be appropriate to the underwriting and be acceptable to the superintendent.

(b) Reserve method

(i) For insurance except long-term care and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(ii) For long-term care insurance, the minimum reserve is the reserve calculated as follows:

(a) For individual policies and group certificates issued on or before December 31, 1996, reserves calculated on the two-year full preliminary term method;

(b) For individual policies and group certificates issued on or after January 1, 1997, reserves calculated on the one-year full preliminary term method.

(iii) For return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated as follows:

(a) On the one year preliminary term method if such benefits are provided at any time before the twentieth anniversary;

(b) On the two year preliminary term method if such benefits are only provided on or after the twentieth anniversary.

The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions (e.g., projected inflation rates) or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

(c) Negative reserves. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

(d) Nonforfeiture benefits for long-term care insurance. The contract reserve on a policy basis shall not be less than the net single premium for the nonforfeiture benefits at the appropriate policy duration, where the net single premium is computed according to the above specifications.

(3) Alternative valuation methods and assumptions generally

Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above; an insurer may use any reasonable assumptions as to interest rates, termination and mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such contracts, including, but not limited to the following: the net level premium method; the one-year full preliminary term method; prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses; the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms; the computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and the use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

(4) Tests for adequacy and reasonableness of contract reserves

Annually, an appropriate review shall be made of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of paragraph (G)(2) of this rule.

In the event a company has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, insurance department regulations, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

(H) Reinsurance

Increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with these minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

(I) Specific standards for morbidity, interest and mortality

(1) Morbidity

(a) Minimum morbidity standards for valuation of specified individual contract health insurance benefits are as follows:

(i) Disability income benefits due to accident or sickness.

(a) Contract reserves:

Contracts issued on or after January 1, 1965 and prior to January 1, 1992:

The 1964 commissioners disability table (64CDT).

Contracts issued on or after January 1, 1992:

The 1985 commissioners individual disability tables A (85CIDA); or

The 1985 commissioners individual disability tables B (85CIDB).

Contracts issued during 1987 through 1991:

Optional use of either the 1964 Table or the 1985 Tables.

Each insurer shall elect, with respect to all individual contracts issued in any one statement year, whether it will use Tables A or Tables B as the minimum standard. The insurer may, however, elect to use the other tables with respect to any subsequent statement year.

(b) Claim reserves:

(i) For claims incurred on or after January 1, 2004:

The 1985 "Commissioners Individual Disability Table A" (85CIDA) with claim termination rates multiplied by the following adjustment factors:

Duration	Adjustment Factor	Adjusted Termination Rates*
Week 1	0.366	0.04831
2	0.366	0.04172
3	0.366	0.04063
4	0.366	0.04355
5	0.365	0.04088
6	0.365	0.04271
7	0.365	0.04380
8	0.365	0.04344
9	0.370	0.04292
10	0.370	0.04107

11	0.370	0.03848
12	0.370	0.03478
13	0.370	0.03034
Month 4	0.391	0.08758
5	0.371	0.07346
6	0.435	0.07531
7	0.500	0.07245
8	0.564	0.06655
9	0.613	0.05520
10	0.663	0.04705
11	0.712	0.04486
12	0.756	0.04309
13	0.800	0.04080
14	0.844	0.03882
15	0.888	0.03730
16	0.932	0.03448
17	0.976	0.03026
18	1.020	0.02856
19	1.049	0.02518
20	1.078	0.02264
21	1.107	0.02104
22	1.136	0.01932
23	1.165	0.01865

24	1.195	0.01792
Year 3	1.369	0.16839
4	1.204	0.10114
5	1.199	0.07434
6 and later	1.000	**

*The adjusted termination rates derived from the application of the adjustment factors to the "DTS Valuation Table" termination rates shown in exhibits 3a, 3b, 3c, 4, and 5 ("Transactions of the Society of Actuaries" (TSA) XXXVII, pages 457 to 463) is displayed. The adjustment factors for age, elimination period, class, sex, and cause displayed in exhibits 3a, 3b, 3c, and 4 should be applied to the adjusted termination rates shown in this table.

**Applicable "DTS Valuation Table" duration rate from exhibits 3c and 4 (TSA XXXVII, pages 462 to 463).

The 85CIDA table so adjusted for the computation of claim reserves shall be known as 85CIDC (The 1985 "Commissioners Individual Disability Table C").

(ii) For claims incurred prior to January 1, 2004:

Each insurer may elect which of the following to use as the minimum standard for claims incurred prior to January 1, 2004:

(A) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred, or

(B) The standard as defined in paragraph (I)(1)(a)(i)(b)(i) of this rule, applied to all open claims.

(C) Once an insurer elects to calculate reserves for all open claims on the standard defined in paragraph

(I)(1)(a)(i)(b)(i) of this rule, all future valuations must be on that basis.

(ii) Hospital benefits, surgical benefits and maternity benefits (scheduled benefits or fixed time period benefits only).

(a) Contract reserves:

Contracts issued on or after January 1, 1955, and before January 1, 1982:

The 1956 intercompany hospital-surgical tables.

Contracts issued on or after January 1, 1982:

The 1974 medical expense tables, Table A, "Transactions of the Society of Actuaries", Volume XXX, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

(b) Claim reserves:

No specific standard. See paragraph (I)(1)(a)(vi) of this rule.

(iii) Cancer expense benefits (scheduled benefits or fixed time period benefits only.)

(a) Contract reserves:

Contract issued on or after January 1, 1986:

The 1985 NAIC Cancer claim cost tables.

(b) Claim reserves:

No specific standard. See paragraph (I)(1)(a)(vi) of this rule.

(iv) Accidental death benefits.

(a) Contract reserves:

Contracts issued on or after January 1, 1965:

The 1959 accidental death benefits table.

(b) Claim reserves:

Actual amount incurred.

(v) Single premium credit disability.

(a) Contract reserves:

(i) For contracts issued on or after January 1, 2004:

(A) For plans having less than a thirty-day elimination period, the 1985 "Commissioners Individual Disability Table A" (85CIDA) with claim incidence rates increased by twelve per cent.

(B) For plans having a thirty-day and greater elimination period, the 85CIDA for a fourteen-day elimination period with the adjustment in paragraph (I)(1)(a)(v)(a)(i)(A) of this rule.

(ii) For contracts issued prior to January 1, 2004, each insurer may elect either paragraph (I)(1)(a)(v)(a)(ii)(A) or paragraph (I)(1)(a)(v)(a)(ii)(B) of this rule to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in paragraph (I)(1)(a)(v)(a)(i) of this rule, all future valuations must be on that basis.

(A) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the contract was issued, or

(B) The standard as defined in paragraph (I)(1)(a)(v)(a)(i) of this rule, applied to all contracts.

(b) Claim reserves:

Claim reserves are to be determined as provided in paragraph (E)(3) of this rule.

(vi) Other individual contract benefits.

(a) Contract reserves:

For all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(b) Claim reserves:

For all benefits other than disability, claim reserves are to be determined as provided in the standards.

(b) Minimum morbidity standards for valuation of specified group contract health insurance benefits are as follows:

(i) Disability income benefits due to accident or sickness.

(a) Contract reserves:

Contracts issued prior to January 1, 1992:

The same basis, if any, as that employed by the insurer as of January 1, 1992;

Contracts issued on or after January 1, 1992:

The 1987 commissioners group disability income table (87CGDT).

(b) Claim reserves:

For claims incurred on or after January 1, 1992:

The 1987 commissioners group disability income table (87CGDT);

For claims incurred prior to January 1, 1992:

Use of the 87CGDT is optional.

(ii) Single premium credit disability

(a) Contract reserves:

(i) For contracts issued on or after January 1, 2004:

(A) For plans having less than a thirty-day elimination period, the 1985 "Commissioners Individual Disability Table A" (85CIDA) with claim incidence rates increased by twelve per cent.

(B) For plans having a thirty-day and greater elimination period, the 85CIDA for a fourteen-day elimination period with the adjustment in paragraph (I)(1)(b)(ii)(a)(i)(A) of this rule.

(ii) For contracts issued prior to January 1, 2004, each insurer may elect either paragraph (I)(1)(b)(ii)(a)(ii)(A) or paragraph (I)(1)(b)(ii)(a)(ii)(B) of this rule to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in paragraph (I)(1)(b)(ii)(a)(i) of this rule, all future valuations must be on that basis.

(A) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the contract was issued, or

(B) The standard as defined in paragraph (I)(1)(b)(ii)(a)(i) of this rule, applied to all contracts.

(b) Claim reserves:

Claim reserves are to be determined as provided in paragraph (E)(3) of this rule.

(iii) Other group contract benefits.

(a) Contract reserves:

For all other group contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(b) Claim reserves:

For all benefits other than disability, claim reserves are to be determined as provided in the standards.

(2) Interest

(a) For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract.

(b) For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.

(c) For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by one hundred basis points.

(3) Mortality

(a) Except as provided in paragraphs (I)(3)(b) and (I)(3)(c) of this rule, the mortality basis used for all policies except long-term care individual policies and group certificates and for long-term care individual policies or group certificates issued before January 1, 2004 shall be according to a table (but without use of selection factors) permitted by law for the valuation of whole life insurance issued on the same date as the health insurance contract. For long-term care insurance individual policies or group certificates issued on or after January 1, 2004, the mortality basis used shall be the "1983 Group Annuity Mortality Table" without projection. For long-term care insurance individual policies or group certificates issued on or after January 1, 2011, the mortality basis used shall be the "1994 Group Annuity Mortality Static Table."

(b) Other mortality tables adopted by the "NAIC" and promulgated by the superintendent may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the superintendent. The request for such approval must include the proposed mortality table and the reason that the standard specified in paragraph (I)(3)(a) of this rule is inappropriate.

(c) For single premium credit insurance using the 85CIDA table, no separate mortality shall be assumed.

(J) Reserves for waiver of premium

Waiver of premium reserves involve several special considerations. First, the disability valuation tables promulgated by the "NAIC" are based on exposures that include contracts on premium waiver as in-force contracts. Hence, contract reserves

based on these tables are not reserves on active lives but rather reserves on contracts in force. This is true for the 1964 CDT and for both the 1985 CIDA and CIDB tables.

Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

Claim reserves should include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.

Premium reserves should include contracts on premium waiver as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived.

Contract reserves should include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

If an insurer is, instead, valuing reserves on what is truly an active life table, or if a specific valuation table is not being used but the insurer's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, then it may not be necessary to provide specifically for waiver of premium reserves. Any insurer using such a true active life basis should carefully consider, however, whether or not additional liability should be recognized on account of premiums waived during periods of disability or during claim continuation.

(K) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms, and provisions shall continue in full force and effect.

Effective:

Five Year Review (FYR) Dates: 11/30/2021

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	3901.041, 3903.723(Q)
Rule Amplifies:	3903.723(Q)
Prior Effective Dates:	06/01/1996, 12/14/2003, 11/18/2010, 06/10/2017

EXHIBIT 39

Ohio | Common Sense Initiative

Mike DeWine, Governor | **Jon Husted**, Lt. Governor | **Sean McCullough**, Director

Business Impact Analysis

Agency Name: ***Ohio Department of Insurance***
Rule Contact Name: ***Loretta Medved***
Rule Contact Information: ***loretta.medved@insurance.ohio.gov***
614-644-0239

Regulation/Package Title *(a general description of the rules' substantive content)*:
Health insurance reserves, Corporate governance annual disclosure, and Annuity nonforfeiture product standards.

Rule Number(s): ***3901-3-13, 3901-3-19, 3901-6-16***

Date of Submission for CSI Review: ***August 2, 2021***
Public Comment Period End Date: ***August 16, 2021 12:00AM***

Rule Type/Number of Rules:

- ☒ New/ ***1*** rules
- ☒ Amended/ ***1*** rules (FYR? ***2021***)
- ☒ No Change/ ***1*** rules (FYR? ***2021***)
- ☒ Rescinded/ ***1*** rules (FYR? ***2021***)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 requires agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the Agency determined the rule(s) create?

   The rule(s):

   - ☐ a. Requires a license, permit, or any other prior authorization to engage in or operate a line of business.
   - ☐ b. Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.
   - ☒ c. Requires specific expenditures or the report of information as a condition of compliance.
   - ☐ d. Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 3901-3-13: The purpose of this rule is to establish the minimum reserve standards for all individual and group health insurance coverages, including single premium credit disability insurance, as required by division (Q) of section 3903.723 of the Revised Code. Minimum reserve requirements establish one standard of maintaining solvency for health insurance companies. The National Association of Insurance Commissioners (NAIC) evaluates market trends and industry standards to develop appropriate minimum benchmarks for companies to maintain. These minimum requirements are then reviewed nationally by both industry stakeholders and regulators, and adopted into a national model. Recommended amendments to this rule will incorporate the latest version of the NAIC model. Updates to the model do not implement new requirements, but rather provide the updated standards for recent plan years, and those moving forward. Due to the amount of proposed amendments the rule will be filed as rescind, and ultimately filed as a new rule.

   Rule 3901-3-19: Corporate governance is the system of rules, practices, and processes by which an insurance company governs itself. Ohio Revised Code sections 3901.072 to 3901.078 requires that insurers submit an annual disclosure to the superintendent, detailing specific information related to individual corporate governance practices. The purpose of this rule is to establish the required content, and procedures for filing the annual disclosure. The proposed amendment to this rule is technical and will correct a citation.

Rule 3901-6-16: The purpose of this rule is to amplify Ohio Revised Code by defining the maturity date used for the purpose of calculating nonforfeiture values for annuity contracts. The rule implements what is commonly referred to as the "70/10 Rule" which limits the duration of an annuity to 10 years or age 70, whichever is greater. There are no proposed amendments to this rule.

3. Please list the Ohio statute(s) that authorize the Agency to adopt the rule(s) and the statute(s) that amplify that authority.

   Rule 3901-3-13: Sections 3901.041 and 3903.723(Q) of the Revised code.

   Rule 3901-3-19: Sections 3901.77 and 3901.041 of the Revised code.

   Rule 3901-6-16: Sections 3901.041 and 3901.21 of the Revised code.

4. Does the regulation implement a federal requirement? ☐ Yes ☒ No
   Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   ☐ Yes ☒ No
   If yes, please briefly explain the source and substance of the federal requirement.

   Not applicable.

5. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   Not applicable.

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   Rule 3901-3-13: Implementing the NAIC model for minimum reserve standards promotes insurer solvency, which is crucial to the protection of the company, consumers, and the overall insurance market.

   Rule 3901-3-19: Corporate governance addresses the allocation and regulation of power and accountabilities within an insurer and avoids undue concentration of authority and power. Also, corporate governance has to be transparent and have appropriate systems, controls, and limits to ensure the given authority and power is used to protect the interests of all of the insurance company's stakeholders.

   Rule 3901-6-16: The purpose for this rule is to provide consumer protection, especially to senior citizens when purchasing annuity products. This regulation is specifically intended to prevent unreasonable surrender charges and provide reasonable access to funds.

7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

Success is determined by reviewing trends in complaints and violations as well as the overall wellbeing of insurers; reviewed during financial and, or market conduct examinations. Success is also evident through an overall understanding of expectations set forth in these rules on behalf of the regulated community.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931? ☐ Yes ☒ No

   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

   Not applicable.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation. *If applicable, please include the date and medium by which the stakeholders were initially contacted.*

   In May 2021, an email requesting comment on this group of rules was sent to various stakeholders, interested parties, trade associations and companies. Specifically, the department reached out to the Ohio Land Title Association, the Ohio Insurance Institute (OII), the Association of Ohio Life Insurance Companies (AOLIC), the American Council of Life Insurance (ACLI), Ohio Association of Health Plans (OAHP) and the Ohio Insurance Agent Association Inc., among others. Additionally, these rules were also posted on the department's web site for review.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

    No comments were received during or after the two week comment period.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

    Rule 3901-3-13: The health insurance reserves NAIC model was established through extensive stakeholder and regulator outreach to determine appropriate standards based on market data and research.

    Rule 3901-3-19: The NAIC developed the model CGAD act and rule, which was created and vetted through a committee process that included research and input from numerous state regulators and industry stakeholders. This was a multi-year project to study and compare existing governance requirements for U.S. insurers to establish best practices, international standards and U.S. regulatory needs.

    Rule 3901-6-16: Representatives from industry and other state insurance departments worked together to develop the basics of this rule for the Interstate Insurance Product

Regulation Commission. Several other states have implemented a similar rule or statute. The department conducted extensive outreach to develop a good fit for Ohio.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

    Rule 3901-3-13: The NAIC works to establish national consistency across state department of insurance jurisdictions. National models establish predictability and in regards to maintaining financial reserve methods, an alternative is not appropriate.

    Rule 3901-3-19: No alternative regulation was considered. The rule was specifically developed to provide detail regarding the requirements of the CGAD. The language of this model regulation was developed in conjunction with the model statute during a collaborative stakeholder process.

    Rule 3901-6-16: The standards established in this rule were reached through extensive outreach and review of other states regulations. An industry standard was established to prevent adverse financial impact on senior citizens.

13. Did the Agency specifically consider a performance-based regulation? Please explain. *Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.*

    Rule 3901-3-13 requires health insurers to follow applicable guidelines in determining a satisfactory minimum reserve.

    Rule 3901-3-19: The corresponding statute, section 3901.074 of the Revised Code requires that the superintendent establish the required content of the CGAD. However, the rule was designed so the insurer has discretion regarding the appropriate format for providing the information. The insurer is permitted to customize the communication to provide the most relevant information necessary to permit the superintendent to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer.

    Rule 3901-6-16 requires that applicable filed products meet a specific standard. This standard ensures consumer protection and a balanced market.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

    The department is the sole regulator for insurance in the state of Ohio and confirmed there are no duplicate regulations.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

All rules included in this package are existing and understood by the regulated community. Updates to rule 3901-3-13 have been known to insurers active with the NAIC since their adoption in 2017. Additionally, the department maintains multiple divisions that are available to assist the regulated community and consumers.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:
    a. Identify the scope of the impacted business community;
    b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and
    c. Quantify the expected adverse impact from the regulation.
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a-c.

Rule 3901-3-13: Health insurers are required to maintain minimum reserves according to standards established in the rule. Amendments to the rule do not necessarily impose additional requirements, however will provide updated methods in determining compliance. These amendments implement the NAIC model, which has been familiar to the industry since 2017. Therefore quantifying the staff time necessary to review such amendments is unknown, but believed to be minimal.

Rule 3901-3-19: Insurers domiciled in Ohio are required to complete and submit a corporate governance annual disclosure (CGAD). Most of the information that is required to be included should already be known to the insurer and relied upon in its ongoing board and business operations. Many insurers currently summarize and describe their corporate governance practices to a number of various stakeholders on a regular basis. In addition, the disclosure requirements allow reference to existing documents and filings and provide guidance for filing changes from the prior year to simplify the reporting process. The time to complete subsequent CGADs should drop significantly as the insurer will only need to update the CGAD with any changes that occurred during the year.

Rule 3901-6-16: Insurance companies which sell applicable annuity products are required to comply with the calculation methods established in the rule. The rule remains in place without substantive amendments and therefore does not impose a quantifiable adverse impact.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Rule 3901-3-13: NAIC models establish national standards for insurers, resulting in consistency and regulatory predictability. Additionally, the rule promotes insurer solvency, which ensures consumer claims may be paid by the insurer.

Rule 3901-3-19: Through the adoption of standards in this area, the department can ensure that sufficient information on governance practices is available to assess the solvency of insurers on an annual basis.

Rule 3901-6-16: The standards established in the rule provide consumer protections for individuals, often senior citizens, whom purchase applicable annuity products.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Rule 3901-3-13: The purpose of this rule is to establish the minimum reserve standards for all individual and group health insurance coverages, the rule provides the standards and applicable tables to follow given the size and needs of each entity.

Rule 3901-3-19: The insurer has discretion regarding the appropriate format for providing the information and is permitted to customize the reporting to provide the most relevant information necessary to permit the department to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer. This includes a recognition by the department that smaller insurers may submit less complex CGADs and may need additional advice and guidance as to the filing requirements.

Rule 3901-6-16: Requirements etsablished in this rule promote consumer protection and establish straight-forward business and product standards, it is crucial that they are complied with consistently across the industry.

19. How will the Agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Paperwork violations and/or first time offender issues would be handled on a case by case basis to determine whether the violation could have a serious impact on the overall financial solvency of the insurer, or impact to consumer. Minor errors would be handled by advising the entity and providing them an opportunity to cure the omission.

20. What resources are available to assist small businesses with compliance of the regulation?

Department staff is available to assist any insurer regardless of size.

Ohio | Common Sense Initiative

EXHIBIT 40

Mike DeWine, Governor
Jon Husted, Lt. Governor
Sean McCullough, Director

MEMORANDUM

TO: Loretta Medved, Ohio Department of Insurance

FROM: Joseph Baker, Business Advocate

DATE: September 29, 2021

RE: **CSI Review – Health insurance reserves, corporate governance annual disclosure, and annuity nonforfeiture product standards (OAC 3901-3-13, 3901-3-19, and 3901-6-16)**

On behalf of Lt. Governor Jon Husted, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Department as provided for in ORC 107.54.

Analysis

This rule package consists of one new, one no-change, one amended, and one rescinded rule proposed by the Ohio Department of Insurance (Department) as a part of the statutory five-year review process. This rule package was submitted to the CSI Office on August 2, 2021, and the public comment period was held open through August 16, 2021. Unless otherwise noted below, this recommendation reflects the version of the proposed rules filed with the CSI Office on August 2, 2021.

The rules in this package establish reserve standards for individual and group health insurance coverages, procedures related to insurers required to file corporate governance disclosures and nonforfeiture product standards for annuities.

New OAC 3901-3-13 establishes minimum reserve standards for individual and group health insurance coverages. The rule requires health insurance providers to maintain claim reserves and outlines accounting and actuarial methods and processes for maintaining such reserves and

calculating potential liabilities. The Department states in the BIA that the rule is amended to adopt the latest standards adopted by the National Association of Insurance Commissioners (NAIC). Due to the extent of changes made to the rule, the Department proposes to rescind current OAC 3901-3-13 and replace the existing rule in its entirety.

OAC 3901-3-19 establishes procedures related to filing an annual corporate governance disclosure. The rule specifies that insurers who are required to file corporate governance disclosure must do so annually no later than June 1st of each year, that the disclosure must include a signature of the chief executive officer or corporate security attesting to the individual's belief that the practices described in the disclosure form have been implemented by the entity, that the insurer be as descriptive as possible in completing the disclosure, and that the disclosure describe the structural framework of the entity, the qualifications, expertise, and experience of board members, the independence of the board and its committees, the number of meetings held by the board, how board members are selected and the duration of terms, and other factors related to leadership structure and authority within the entity. The rule is amended to adopt a technical change.

OAC 3901-6-16 establishes standards for the purpose of calculating nonforfeiture values for annuity contracts. The rule specifies notwithstanding any language in a contract, the nonforfeiture maturity date of an annuity shall be the later of the 10th contract anniversary or the contract anniversary following the annuitant's 70th birthday and establishes other related tests, forfeiture conditions, and adjustments.

During early stakeholder outreach, the Department shared the proposed rules with various interested parties, including the Ohio Insurance Institute, the Ohio Land Title Association, the Association of Ohio Life Insurance Companies, the American Council of Life Insurance, the National Association of Insurance and Financial Advisors, the Ohio Association of Health Plans, and the Ohio Insurance Agent Association, among others and posted the rules on its website. No comments were provided in response to the request for early stakeholder outreach or during the CSI public comment period.

The business community impacted by the rules includes Ohio health insurers, Ohio insurers that are required to complete and submit a corporate governance annual disclosure, and insurance companies that sell applicable annuity products in Ohio. The adverse impacts to business include the costs and expense associated with determining appropriate minimum reserves and maintaining such reserves, the costs of completing and submitting corporate governance disclosures as specified, and costs associated with determining and complying with the calculation methods and nonforfeiture requirements for annuities. The Department states in the BIA that the costs of maintaining minimum reserves is unknown, but that the changes to the rule are familiar to the

industry and additional staff time necessary to comply with the changes is anticipated to be minimal. The Department also notes that the costs of completing corporate governance disclosures decreases significantly after the initial disclosure, as the insurer is only required to update the disclosure with changes that took place in the previous year. The Department states that the adverse impact to health insurers created by the rule promotes insurer solvency and ensures consumer claims are paid, that the adverse impact to insurers created by the corporate governance disclosure requirement enables the Department to assess the solvency of insurers and promote best practices, and that the annuity forfeiture standards that affect insurance companies who sell annuity products are necessary to provide consumer protections for purchasers.

Recommendations

Based on the information above, the CSI Office has no recommendations on this rule package.

Conclusion

The CSI Office concludes that the Ohio Department of Insurance should proceed in filing the proposed rules with the Joint Committee on Agency Rule Review.

Ohio Department of Insurance

Mike DeWine, Governor
Jon Husted, Lt. Governor

Judith L. French, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

EXHIBIT 41

MEMORANDUM

To: Joseph Baker, Business Advocate

CC: Sean McCullough, Director of the Common Sense Initiative Office

From: Loretta Medved, Policy Analyst

Date: September 29, 2021

Re: Response to CSI Review – Health insurance reserves, corporate governance annual disclosure, and annuity nonforfeiture product standards (OAC 3901-3-13, 3901-3-19, and 3901-6-16)

On September 29, 2021, the Ohio Department of Insurance (the Department) received the Recommendation Memorandum (CSI Recommendation) from the Common Sense Initiative Office for rule(s) 3901-3-13 Health insurance reserves, 3901-3-19 Corporate governance annual disclosure, and 3901-6-16 Annuity nonforfeiture product standards.

The CSI Recommendation stated that the office does not have any recommendations regarding this rule package, and therefore should proceed with a formal filing of the rule package.

At this time, the Department plans to move forward with the filing of this rule package with the Joint Committee on Agency Rule Review.

If you have any questions please contact Loretta Medved at 614-644-0239 or Loretta.Medved@insurance.ohio.gov.

Rule Summary and Fiscal Analysis
Part A - General Questions

EXHIBIT 42

Rule Number: 3901-3-13

Rule Type: New

Rule Title/Tagline: Health insurance reserves.

Agency Name: Department of Insurance

Division:

Address: 50 W Town Street Suite 300 Columbus OH 43215

Contact: Tina Chubb **Phone:** (614) 728-1044

Email: Tina.Chubb@insurance.ohio.gov

I. Rule Summary

1. **Is this a five year rule review?** No

   A. **What is the rule's five year review date?**

2. **Is this rule the result of recent legislation?** No

3. **What statute is this rule being promulgated under?** 119.03

4. **What statute(s) grant rule writing authority?** 3901.041, 3903.723(Q)

5. **What statute(s) does the rule implement or amplify?** 3903.723(Q)

6. **What are the reasons for proposing the rule?**

   This rule is being reviewed as a part of the agency five year rule review.

7. **Summarize the rule's content, and if this is an amended rule, also summarize the rule's changes.**

   The purpose of this rule is to establish the minimum reserve standards for all individual and group health insurance coverages, including single premium credit disability insurance, as required by division (Q) of section 3903.723 of the Revised Code.

Recommended amendments to this rule will incorporate the latest version of the NAIC model. Updates to the model do not implement new requirements, but rather provide the updated standards for recent plan years, and those moving forward. Due to the amount of proposed amendments the rule will be filed as rescind, and ultimately filed as a new rule.

8. **Does the rule incorporate material by reference?** No

9. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

   Not Applicable

10. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

    Not Applicable

II. Fiscal Analysis

11. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

    This will have no impact on revenues or expenditures.

    $0.00

    Not applicable.

12. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

    Not applicable.

13. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

14. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

15. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

Not applicable.

III. Common Sense Initiative (CSI) Questions

16. **Was this rule filed with the Common Sense Initiative Office?** Yes

17. **Does this rule have an adverse impact on business?** No

    A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

    B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** No

    C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** No

    D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restrictions (This section only applies to agencies indicated in R.C. 121.95 (A))

18. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

    A. **How many new regulatory restrictions do you propose adding?**

    Not Applicable

    B. **How many existing regulatory restrictions do you propose removing?**

    Not Applicable

EXHIBIT 43

3901-3-13 **Health insurance reserves.**

(A) Purpose

The purpose of this rule is to establish the minimum reserve standards for all individual and group health insurance coverages, including single premium credit disability insurance. All other credit insurance is not subject to this rule.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under section 3901.041 and division (Q) of section 3903.723 of the Revised Code.

(C) Scope

(1) These standards establish a minimum reserve standard for all individual and group health insurance coverages, including single premium credit disability insurance. When an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

(2) With respect to any block of contracts, or with respect to an insurer's health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

(3) Such a gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's health business as a whole. In the event inadequacy is found to exist, immediate loss recognition shall be made and the reserves restored to adequacy. Adequate reserves (inclusive of claim, premium and contract reserves, if any) shall be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under these standards.

(4) Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under these standards.

(5) This rule sets forth minimum standards for three categories of health insurance reserves: claim reserves, premium reserves and contract reserves. Adequacy of an insurer's health insurance reserves is to be determined on the basis of all three categories combined. However, these standards emphasize the importance of determining appropriate reserves for each of these categories separately.

(D) Definitions

(1) "Annual claim cost" means the net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a one hundred dollar monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age thirty-five, in a certain occupation might be twelve dollars, while the gross premium for this benefit might be eighteen dollars. The additional six dollars would cover expenses and profit or contingencies.

(2) "Claims accrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for "accrued" benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

(3) "Claims reported" means a claim that has been incurred on or prior to the valuation date and the insurer has been informed of it on or before the valuation date. This claim is considered a reported claim for annual statement purposes.

(4) "Claims unaccrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest), must be established.

(5) "Claims unreported" means a claim that has been incurred on or prior to the valuation date but the insurer has not been informed of it on or before

the valuation date. This claim is considered an unreported claim for annual statement purposes.

(6) "Date of disablement" means the earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

(7) "Elimination period" means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

(8) "Gross premium" means the amount of premium charged by the insurer. It includes the net premium (based on claim-cost) for the risk, together with any loading for expenses, profit or contingencies.

(9) "Group insurance" means blanket insurance and franchise insurance and any other forms of group insurance.

(10) "Group long-term disability income insurance" means any group insurance policy or rider advertised, marketed, offered or designed to provide group disability income coverage with a maximum benefit duration longer than two years that is based on a group pricing structure. The term "group long-term disability income insurance" does not include voluntary group disability income insurance coverage that is priced on an individual risk structure and generally sold in the workplace.

(11) "Level premium" means a premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time. Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

(12) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary

diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(13) "Modal premium" means the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus if the annual premium is one hundred dollars and if, instead, monthly premiums of nine dollars are paid then the modal premium is nine dollars.

(14) "Negative reserve" means the terminal reserve where the values of the benefits are decreasing with advancing age or duration such that it results in a negative value, called a negative reserve. Normally the terminal reserve is a positive value.

(15) "Preliminary term reserve method" means the method of valuation where the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

(16) "Present value of amounts not yet due on claims" means the reserve for "claims unaccrued" which may be discounted at interest.

(17) "Rating block" means a grouping of contracts determined by the valuation actuary based on common characteristics filed with the superintendent, such as a policy form or forms having similar benefit designs.

(18) "Reserve" means all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of

coverage, and whether the liability is accrued or unaccrued. An insurer under its contracts promises benefits which result in:

(a) Claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date, (on these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves); or

(b) Claims which are expected to be incurred after the valuation date, (any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.)

(19) "Terminal reserve" means the reserve at the end of the contract year which is equal to the present value of benefits expected to be incurred after the contract year minus the present value of future valuation net premiums.

(20) "Unearned premium reserve" means that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of one hundred twenty dollars was paid on November first, twenty dollars would be earned as of December thirty-first and the remaining one hundred dollars would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

(21) "Valuation manual" means the manual produced by the "National Association of Insurance Commissioners" (NAIC) and updated annually that contains the minimum reserve and related requirements for life, accident and health insurance.

(22) "Valuation net modal premium" means the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

(23) "Worksite franchise disability insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide individual disability coverage that is sold at the worksite through employer-sponsored enrollment and complies with section 3923.11 of the Revised Code. Worksite franchise disability insurance does not include coverage for business overhead expense, disability buyout, or key person policies.

(24) "Worksite individual disability insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide personal disability coverage that is sold to an individual at the worksite, and is not associated with employer-sponsored enrollment. Worksite individual disability insurance does not include business overhead expense, disability buyout, or key person policies.

(E) Claim reserves

(1) General

(a) Claim reserves are required for all incurred but unpaid claims on all health insurance policies. For contracts with an elimination period, the duration of disablement shall be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

(b) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims.

(c) All such reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

(d) For claim reserves on policies that require contract reserves, the claim incurral date is to be considered the "issue date" for determining the table and interest rate to be used for claim reserves.

(e) The maximum interest rate for claim reserves is specified in paragraph (I) of this rule.

(f) With respect to claim reserves for policies issued prior to January 1, 2017, the operative date of the valuation manual, the requirements for claim reserves on claims incurred after that date shall be as described in the valuation manual based on the incurred date of the claim.

(2) Minimum morbidity standards for individual disability income claim reserves

(a) For claims incurred prior to January 1, 2005, each insurer may elect which of the following to use as the minimum morbidity standard for claim reserves:

(i) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred, or

(ii) The standards as defined in paragraph (E)(2)(b) or (E)(2)(c) of this rule, applied to all open claims. Once an insurer elects to calculate reserves for all open claims on the standard defined in either paragraph (E)(2)(b) or (E)(2)(c) of this rule, all future valuations must be on that basis.

(b) For claims incurred on or after January 1, 2005 and prior to the effective date for the company as determined in paragraph (E)(2)(e) of this rule, the minimum standards with respect to morbidity are those specified in paragraph (I) of this rule, except that, at the option of the insurer, assumptions regarding claim termination rates for the period less than two years from the date of disablement may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions and methods designed to place a sound value on the liabilities.

(c) For claims incurred on or after January 1, 2020, the minimum standards are those specified in paragraph (I) of this rule, including (as derived in accordance with actuarial guideline L, as included in the 2019 version of the NAIC accounting practices and procedures manual):

(i) The use of the insurer's own experience; and

(ii) An adjustment to include the insurer's own experience measurement margin; and

(iii) The application of a credibility factor.

(d) In determining the minimum reserves in accordance with paragraph (E)(2)(c) of this rule, the provisions in paragraphs (E)(2)(c)(i) to (E)(2)(c)(iii) of this rule are not required if:

(i) The insurer meets the own experience measurement exemption provided in actuarial guideline L as included in the 2019 version of the NAIC accounting practices and procedures manual; or

(ii) For worksite franchise disability insurance policies with benefit periods of up to two years, at the option of the insurer, disabled life reserves may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions and methods designed to place a sound value on the liabilities.

(e) An insurer may begin to use the minimum reserve standards in paragraph (E)(2)(c) of this rule at a date earlier than the effective date of this rule.

(f) An insurer may apply the new standards in paragraph (E)(2)(c) of this rule to all open claims regardless of incurred date. Once an insurer elects to calculate reserves for all open claims based on paragraph (E)(2)(c) of this rule, all future valuations must be on that basis.

(3) Minimum morbidity standards for group disability income claim reserves

(a) For claims incurred prior to January 1, 2005, each insurer may elect which of the following to use as the minimum morbidity standard for claim reserves:

(i) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred; or

(ii) The standards as defined in paragraph (E)(3)(b) of this rule, applied to all open group long-term disability income insurance claims; or

(iii) The standards as defined in paragraph (E)(3)(c) of this rule, applied to all open group disability income insurance claims.

Once an insurer elects to calculate reserves for all open claims on a more recent standard, then all future valuations must be on that basis.

(b) For group long-term disability income insurance claims incurred on or after January 1, 2005, but before the effective date in paragraph (E)(3)(c) of this rule, and group disability income insurance claims incurred on or after January 1, 2005, that are not group long-term disability income, the minimum standards with respect to morbidity are those specified in paragraph (I) of this rule, except that, at the option of the insurer:

(i) Assumptions regarding claim termination rates for the period less than two years from the date of disablement may be based on the insurer's experience, if the experience is considered credible, or upon other assumptions and methods designed to place a sound value on the liabilities.

(ii) Assumptions regarding claim termination rates for the period two or more years but less than five years from the date of disablement may, with the approval of the superintendent, be based on the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for such approval of a plan of modification to the reserve basis must include:

(A) An analysis of the credibility of the experience;

(B) A description of how all of the insurer's experience is proposed to be used in setting reserves;

(C) A description and quantification of the margins to be included;

(D) A summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement;

(E) A copy of the approval of the proposed plan of modification by the insurance regulatory agency of the insurer's state of domicile; and

(F) Any other information deemed necessary by the superintendent.

(iii) Each insurer may elect which of the following to use as the minimum morbidity standard for group long-term disability income insurance claim reserves:

(A) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred, or

(B) The standards as defined in paragraph (E)(3)(c) of this rule, applied to all open claims.

Once an insurer elects to calculate reserves for all open claims on a more recent standard, then all future valuations must be on that basis.

(c) For group long-term disability income insurance claims incurred on or after January 1, 2020, the minimum standards with respect to morbidity shall be based on the 2012 GLTD termination table in accordance with actuarial guideline XLVII, as included in the 2019 version of the NAIC accounting practices and procedures manual with considerations of:

(i) The use of the insurer's own experience; and

(ii) An adjustment to include the insurer's own experience measurement margin; and

(iii) The application of a credibility factor.

(d) An insurer may begin to use the minimum reserve standards in paragraph (E)(3)(c) of this rule at a date earlier than the effective date of this rule. An insurer may apply the standards in paragraph (E)(3)(c) of this rule to

all open claims incurred prior to the effective date of paragraph (E)(3)(c) of this rule for the insurer. Once an insurer elects to calculate reserves for all open claims based on paragraph (E)(3)(c) of this rule, all future valuations must be on that basis.

(4) Minimum morbidity or other contingency standard for other health insurance claim reserves

The reserve must be based on the insurer's experience, if the experience is considered credible, or upon other assumptions and methods designed to place a sound value on the liabilities.

(5) Claim reserve methods generally

A generally accepted actuarial reserving method or other reasonable method, based on information and data describing the proposed method, or a combination of methods may be used to estimate all claim liabilities if approved by the superintendent prior to the statement date. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, shall be determined in the aggregate.

(F) Premium reserves

(1) General

(a) Unearned premium reserves are required for all contracts, except individual and group single premium credit disability insurance, with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(b) If premiums due and unpaid are carried as an asset, such premiums must be treated as premiums in force, subject to unearned premium reserve determination. The value of unpaid commissions, premium taxes and the cost of collection associated with due and unpaid premiums shall be carried as an offsetting liability.

(c) The gross premiums paid in advance for a period of coverage commencing after the next premium due date which follows the date of valuation may be appropriately discounted to the valuation date and shall be held either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

(2) Minimum standards for unearned premium reserves

(a) The minimum unearned premium reserve with respect to any contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with such premium determined on the basis of:

(i) The valuation net modal premium on the contract reserve basis applying to the contract; or

(ii) The gross modal premium for the contract if no contract reserve applies.

(b) In no event may the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. Such reserve shall never be less than the expected claims for the period beyond the valuation date represented by such unearned premium reserve, to the extent not provided for elsewhere.

(3) Premium reserve methods generally

The insurer may employ suitable approximations and estimates; including, but not limited to groupings, averages and aggregate estimation; in computing premium reserves. Such approximations or estimates should be tested periodically to determine their continuing adequacy and reliability.

(G) Contract reserves

(1) General

(a) Contract reserves are required, unless otherwise specified in paragraph (G)(1)(b) of this rule for:

(i) All individual and group contracts with which level premiums are used; or

(ii) All individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. This evaluation may be applied on a rating block basis if the total premiums for the block were developed to support the total risk assumed and expected expenses for the block each year, and a qualified actuary certifies the premium development. The actuary should state in the certification

that premiums for the rating block were developed such that each year's premium was intended to cover that year's costs without any prefunding. If the premium is also intended to recover costs for any prior years, the actuary should also disclose the reasons for and magnitude of such recovery. The values specified in paragraph (G)(1)(a)(ii) of this rule shall be determined on the basis specified in paragraph (G)(2) of this rule.

(b) Contracts not requiring a contract reserve are:

(i) Contracts which cannot be continued after one year from issue; or

(ii) Contracts already in force on the effective date of this rule for which no contract reserve was required under the immediately preceding standards.

(c) The contract reserve is in addition to claim reserves and premium reserves.

(d) The methods and procedures for contract reserves should be consistent with those for claim reserves for any contract, or else appropriate adjustment must be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral must be the same in both determinations.

(e) The contract reserves for single premium credit disability insurance shall never be less than the expected claims for the period beyond the valuation date.

(f) The total contract reserve established shall incorporate provisions for moderately adverse deviations.

(2) Minimum standards for contract reserves

(a) Basis

(i) Morbidity or other contingency. Minimum standards with respect to morbidity are those set forth in paragraph (I) of this rule. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated.

Contracts for which tabular morbidity standards are not specified in paragraph (I) of this rule shall be valued using tables established

for reserve purposes by a qualified actuary and acceptable to the superintendent. The morbidity tables shall contain a pattern for incurred claims cost that reflects the underlying morbidity and shall not be constructed for the primary purpose of minimizing reserves.

(A) In determining the morbidity assumptions, the actuary shall use assumptions that represent the best estimate of anticipated future experience, but shall not incorporate any expectation of future morbidity improvement. Morbidity improvement is a change, in the combined effect of claim frequency and the present value of future expected claim payments given that a claim has occurred, from the current morbidity tables or experience that will result in a reduction to reserves. It is not the intent of this provision to restrict the ability of the actuary to reflect the morbidity impact for a specific known event that has occurred and that is able to be evaluated and quantified.

(B) Business in force as of the effective date of paragraph (G)(2)(a)(iii)(c) of this rule may be permitted to retain the original reserve basis which may not meet the provisions of paragraph (G)(2)(a)(i)(a) of this rule, subject to the acceptability of the superintendent.

(ii) Interest. The maximum interest rate is specified in paragraph (I) of this rule.

(iii) Termination rates. Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in paragraph (I) of this rule except as noted in paragraphs (G)(2)(a)(iii)(a), (G)(2)(a)(iii)(b), and (G)(2)(a)(iii)(c) of this rule.

(A) Under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard or for return of premium or other deferred cash benefits, total termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(i) Eighty per cent of the total termination rate used in the calculation of the gross premiums, or

(ii) Eight per cent.

(B) For long-term care individual policies or group certificates issued after December 31, 2003, the contract reserve may be established on a basis of separate:

(i) Mortality (as specified in paragraph (I) of this rule); and

(ii) Terminations other than mortality, where the terminations are not to exceed:

(i) For policy years one through four, the lesser of eighty per cent of the voluntary lapse rate used in the calculation of gross premiums and eight per cent;

(ii) For policy years five and later, the lesser of one hundred per cent of the voluntary lapse rate used in the calculation of gross premiums and four per cent.

(C) For long-term care individual policies or group certificates issued on or after January 1, 2011, the contract reserve may be established on a basis of separate:

(i) Mortality (as specified in paragraph (I) of this rule); and

(ii) Terminations other than mortality, where the terminations are not to exceed;

(i) For policy year one, the lesser of eighty per cent of the voluntary lapse rate used in the calculation of gross premiums and six per cent;

(ii) For policy year two through four, the lesser of eighty per cent of the voluntary lapse rate used in the calculation of gross premiums and four per cent;

(iii) For policy year five and later, the lesser of one hundred per cent of the voluntary lapse rate used in the calculation of gross premiums and two per cent, except for group long-term care insurance as defined in section 3923.41 of the Revised Code where the two per cent shall be three per cent.

(D) Where a morbidity standard specified in paragraph (I) of this rule is on an aggregate basis, such morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments must be appropriate to the underwriting and be acceptable to the superintendent.

(b) Reserve method

(i) The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions (e.g., projected inflation rates) or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

(ii) For insurance except long-term care and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(iii) For long-term care insurance, the minimum reserve is the reserve calculated as follows:

(A) For individual policies and group certificates issued on or before December 31, 1996, reserves calculated on the two-year full preliminary term method;

(B) For individual policies and group certificates issued on or after January 1, 1997, reserves calculated on the one-year full preliminary term method.

(iv) For return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated as follows:

(A) On the one year preliminary term method if such benefits are provided at any time before the twentieth anniversary;

(B) On the two year preliminary term method if such benefits are only provided on or after the twentieth anniversary.

(c) Negative reserves. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total

contract reserve with respect to all benefits combined may not be less than zero.

(d) Nonforfeiture benefits for long-term care insurance. The contract reserve on a policy basis shall not be less than the net single premium for the nonforfeiture benefits at the appropriate policy duration, where the net single premium is computed according to the above specifications.

(3) Alternative valuation methods and assumptions generally

Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above; an insurer may use any reasonable assumptions as to interest rates, termination and mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such contracts, including, but not limited to the following: the net level premium method; the one-year full preliminary term method; prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses; the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms; the computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and the use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

(4) Tests for adequacy and reasonableness of contract reserves

Annually, an appropriate review shall be made of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of paragraph (G)(2) of this rule.

In the event a company has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, or is otherwise restricted by law, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

(H) Reinsurance

Increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with these minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

(I) Specific standards for morbidity, interest and mortality

(1) Morbidity

(a) Minimum morbidity standards for valuation of specified individual contract health insurance benefits are as follows:

(i) Disability income insurance benefits due to accident or sickness.

(A) Contract reserves:

(i) Contracts issued on or after January 1, 1965 and prior to January 1, 1992:

The 1964 commissioners disability table (64CDT).

(ii) Contracts issued on or after January 1, 1992 and prior to January 1, 2020:

(i) The 1985 commissioners individual disability tables A (85CIDA); or

(ii) The 1985 commissioners individual disability tables B (85CIDB).

(iii) Contracts issued during 1987 to 1991:

(i) Optional use of either the 1964 table or the 1985 tables; and

(ii) Each insurer shall elect, with respect to all individual contracts issued in any one statement year, whether it will use tables A or tables B as the minimum standard. The insurer may, however, elect to use the other tables with respect to any subsequent statement year.

(iv) Contracts issued on or after January 1, 2020:

(i) The 2013 IDI valuation table with modifiers as described in actuarial guideline L as included in the 2019 version of the NAIC accounting practices and procedures manual; and

(ii) An insurer may begin to use the 2013 IDI valuation table with modifiers at a date earlier than the effective date of this rule.

(v) Once an insurer begins to use the 2013 IDI valuation table the insurer may elect to apply that morbidity standard for all policies issued subject to other valuation tables. This may be done if the following conditions are met:

(i) The insurer must apply the morbidity standard to all in-force policies and incurred claims;

(ii) The insurer elects or has elected to apply the 2013 IDI valuation table to all claims incurred regardless of incurred date;

(iii) The insurer maintains adequate policy records on policies issued prior to 2020 that allow the insurer to apply the 2013 IDI valuation table appropriately; and

(iv) Once an insurer elects to calculate reserves for all in-force policies based on the current morbidity standard, all future valuations must be on that basis.

(B) Claim reserves:

(i) For claims incurred prior to January 1, 2004:

Each insurer may elect which of the following to use as the minimum standard for claims incurred prior to January 1, 2004:

(i) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred; or

(ii) The standard as defined in paragraph (I)(1)(a)(i)(b)(ii) or (I)(1)(a)(i)(b)(iii) of this rule, applied to all open non-worksite claims provided the insurer maintains adequate claim records to allow the insurer to apply the standard defined in paragraph (I)(1)(a)(i)(b)(ii) or (I)(1)(a)(i)(b)(iii) of this rule appropriately; and

(iii) Once an insurer elects to calculate reserves for all open claims on the standard defined in paragraph (I)(1)(a)(i)(b)(ii) or (I)(1)(a)(i)(b)(iii) of this rule, all future valuations must be on that basis. This option, with respect to paragraph (I)(1)(a)(i)(b)(iii) of this rule, may be selected only if the insurer maintains adequate claim records for all claims incurred to use the 2013 IDI valuation table appropriately.

(ii) For claims incurred on or after January 1, 2004 and prior to January 1, 2020:

The 1985 commissioners individual disability table A (85CIDA) with claim termination rates multiplied by the following adjustment factors:

Duration	Adjustment Factor	Adjusted Termination Rates*
Week 1	0.366	0.04831
2	0.366	0.04172
3	0.366	0.04063

4	0.366	0.04355
5	0.365	0.04088
6	0.365	0.04271
7	0.365	0.04380
8	0.365	0.04344
9	0.370	0.04292
10	0.370	0.04107
11	0.370	0.03848
12	0.370	0.03478
13	0.370	0.03034
Month 4	0.391	0.08758
5	0.371	0.07346
6	0.435	0.07531
7	0.500	0.07245
8	0.564	0.06655
9	0.613	0.05520
10	0.663	0.04705
11	0.712	0.04486
12	0.756	0.04309
13	0.800	0.04080
14	0.844	0.03882
15	0.888	0.03730
16	0.932	0.03448

17	0.976	0.03026
18	1.020	0.02856
19	1.049	0.02518
20	1.078	0.02264
21	1.107	0.02104
22	1.136	0.01932
23	1.165	0.01865
24	1.195	0.01792
Year 3	1.369	0.16839
4	1.204	0.10114
5	1.199	0.07434
6 and later	1.000	**

*The adjusted termination rates derived from the application of the adjustment factors to the DTS valuation table termination rates shown in exhibits 3a, 3b, 3c, 4, and 5 (transactions of the society of actuaries (TSA) XXXVII, pages 457 to 463) is displayed. The adjustment factors for age, elimination period, class, sex, and cause displayed in exhibits 3a, 3b, 3c, and 4 should be applied to the adjusted termination rates shown in this table.

**Applicable DTS valuation table duration rate from exhibits 3c and 4 (TSA XXXVII, pages 462 to 463).

The 85CIDA table so adjusted for the computation of claim reserves shall be known as 85CIDC (the 1985 commissioners individual disability table C).

(iii) For claims incurred on or after January 1, 2020, the 2013 IDI valuation table with modifiers and adjustments for company experience as prescribed in actuarial

guideline L, as included in the 2019 version of the NAIC accounting practices and procedures manual, except for worksite disability insurance policies with benefit periods of twenty-four months or less.

For worksite franchise disability insurance policies with benefit periods of twenty-four months or less, claim reserves may be calculated using claim run-out analysis or claim triangles, or other methods that place a sound value on the reserves that are appropriate for the business and risks involved.

(ii) Hospital benefits, surgical benefits and maternity benefits (scheduled benefits or fixed time period benefits only).

(A) Contract reserves:

(i) Contracts issued on or after January 1, 1955, and prior to January 1, 1982:

The 1956 intercompany hospital-surgical tables.

(ii) Contracts issued on or after January 1, 1982:

The 1974 medical expense tables, table A, TSA XXX, page 63. Refer to the paper (in the same volume, page 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in table A: development of the 1974 medical expense benefits, Houghton and Wolf.

(B) Claim reserves:

Standards are based on paragraphs (E)(4) and (E)(5) of this rule.

(iii) Cancer expense benefits:

(A) Contract reserves:

(i) Contract issued on or after January 1, 1986 and prior to January 1, 2019:

The 1985 NAIC cancer claim cost tables (1985 CCCT).

(ii) Contracts issued on or after January 1, 2019:

(i) For first occurrence and hospitalization benefits:

The 2016 NAIC cancer claim cost valuation tables (2016 CCCVT);

(ii) For all other benefits:

Assumptions based on company experience, relevant industry experience, and actuarial judgement. Such assumptions should be appropriate for valuation which considers a margin for adverse experience.

(B) Claim reserves:

No specific standard. See paragraph (I)(1)(a)(vi) of this rule.

(iv) Accidental death benefits.

(A) Contract reserves:

Contracts issued on or after January 1, 1965:

The 1959 accidental death benefits table.

(B) Claim reserves:

Actual amount incurred.

(v) Single premium credit disability.

(A) Contract reserves:

(i) For contracts issued prior to January 1, 2004, each insurer may elect either paragraph (I)(1)(a)(v)(a)(i)(A) or (I)(1)(a)(v)(a)(i)(B) of this rule to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in paragraph

(I)(1)(a)(v)(a)(i) of this rule, all future valuations must be on that basis.

(i) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the contract was issued; or

(ii) The standard as defined in paragraph (I)(1)(a)(v)(a)(ii) of this rule, applied to all contracts.

(ii) For contracts issued on or after January 1, 2004:

(i) For plans having less than a thirty day elimination period, the 1985 commissioners individual disability table A (85CIDA) with claim incidence rates increased by twelve per cent.

(ii) For plans having a thirty day and greater elimination period, the 85CIDA for a fourteen day elimination period with claim incidence rates increased by twelve per cent.

(B) Claim reserves:

Claim reserves are to be determined as provided in (paragraphs (E)(4) and (E)(5) of this rule.

(vi) Other individual contract benefits.

(A) Contract reserves:

For all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(B) Claim reserves:

For all benefits other than disability income insurance, claim reserves are to be determined as provided in the standards.

(b) Minimum morbidity standards for valuation of specified group contract health insurance benefits are as follows:

(i) Disability income insurance benefits due to accident or sickness, where this rule references this paragraph (I)(1)(b)(i) of this rule, paragraphs (I)(1)(b)(i)(a) and (I)(1)(b)(i)(b) of this rule apply; otherwise actuarial guideline XLVII, as included in the 2019 version of the NAIC accounting practices and procedures manual.

(A) Contract reserves:

(i) Contracts issued prior to January 1, 1992:

The same basis, if any, as that employed by the insurer as of January 1, 1992.

(ii) Contracts issued on or after January 1, 1992:

The 1987 commissioners group disability income table (87CGDT).

(B) Claim reserves:

(i) For claims incurred on or after January 1, 1992:

The 1987 commissioners group disability income table (87CGDT).

(ii) For claims incurred prior to January 1, 1992:

Use of the 87CGDT is optional.

(ii) Single premium credit disability

(A) Contract reserves:

(i) For contracts issued prior to January 1, 2004, each insurer may elect either paragraph (I)(1)(b)(ii)(a)(i)(A) or (I)(1)(b)(ii)(a)(i)(B) of this rule to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in paragraph

(I)(1)(b)(ii)(a)(ii) of this rule, all future valuations must be on that basis.

(i) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the contract was issued; or

(ii) The standard as defined in paragraph (I)(1)(b)(ii)(a)(ii) of this rule, applied to all contracts.

(ii) For contracts issued on or after January 1, 2004:

(i) For plans having less than a thirty day elimination period, the 1985 commissioners individual disability table A (85CIDA) with claim incidence rates increased by twelve per cent.

(ii) For plans having a thirty day and greater elimination period, the 85CIDA for a fourteen day elimination period with the adjustment in paragraph (I)(1)(b)(ii)(a)(i)(A) of this rule.

(B) Claim reserves:

Claim reserves are to be determined as provided in paragraphs (E)(4) and (E)(5) of this rule.

(iii) Other group contract benefits.

(A) Contract reserves:

For all other group contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(B) Claim reserves:

For all benefits other than disability income insurance, claim reserves are to be determined as provided in the standards.

(2) Interest

(a) For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract.

(b) For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.

(c) For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by one hundred basis points.

(3) Mortality

(a) Except as provided in paragraphs (I)(3)(b) and (I)(3)(c) of this rule, the mortality basis used for all policies, except long-term care individual policies and group certificates and for long-term care individual policies or group certificates issued prior to January 1, 2004 shall be according to a table (but without use of selection factors) permitted by law for the valuation of whole life insurance issued on the same date as the health insurance contract. For long-term care insurance individual policies or group certificates issued on or after January 1, 2004, the mortality basis used shall be the 1983 group annuity mortality table without projection. For long-term care insurance individual policies or group certificates issued on or after January 1, 2011, the mortality basis used shall be the 1994 group annuity mortality static table.

(b) Other mortality tables adopted by the NAIC and promulgated by the superintendent may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the superintendent. The request for such approval must include the proposed mortality table and the reason that the standard specified in paragraph (I)(3)(a) of this rule is inappropriate.

(c) For single premium credit insurance using the 85CIDA table, no separate mortality shall be assumed.

(J) Reserves for waiver of premium

(1) Waiver of premium reserves involve several special considerations. First, the disability valuation tables promulgated by the NAIC are based on exposures

that include contracts on premium waiver as in-force contracts. Hence, contract reserves based on these tables are not reserves on active lives but rather reserves on contracts in force. This is true for the 1964 CDT and for both the 1985 CIDA and CIDB tables.

(2) Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

(a) Claim reserves should include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived;

(b) Premium reserves should include contracts on premium waiver as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived; and

(c) Contract reserves should include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

(3) If an insurer is, instead, valuing reserves on what is truly an active life table, or if a specific valuation table is not being used but the insurer's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, then it may not be necessary to provide specifically for waiver of premium reserves. Any insurer using such a true active life basis should carefully consider, however, whether or not additional liability should be recognized on account of premiums waived during periods of disability or during claim continuation.

(K) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms, and provisions shall continue in full force and effect.

Replaces: 3901-3-13

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	3901.041, 3903.723(Q)
Rule Amplifies:	3903.723(Q)
Prior Effective Dates:	06/01/1996, 12/14/2003, 11/18/2010, 06/10/2017

EXHIBIT 44

Ohio | Common Sense Initiative

Mike DeWine, Governor | **Jon Husted**, Lt. Governor | **Sean McCullough**, Director

Business Impact Analysis

Agency Name: ***Ohio Department of Insurance***
Rule Contact Name: ***Loretta Medved***
Rule Contact Information: ***loretta.medved@insurance.ohio.gov***
614-644-0239

Regulation/Package Title *(a general description of the rules' substantive content)*:
Health insurance reserves, Corporate governance annual disclosure, and Annuity nonforfeiture product standards.

Rule Number(s): ***3901-3-13, 3901-3-19, 3901-6-16***

Date of Submission for CSI Review: ***August 2, 2021***
Public Comment Period End Date: ***August 16, 2021 12:00AM***

Rule Type/Number of Rules:

- ☒ New/ ***1*** rules
- ☒ Amended/ ***1*** rules (FYR? ***2021***)
- ☒ No Change/ ***1*** rules (FYR? ***2021***)
- ☒ Rescinded/ ***1*** rules (FYR? ***2021***)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 requires agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the Agency determined the rule(s) create?

   The rule(s):

   - ☐ a. Requires a license, permit, or any other prior authorization to engage in or operate a line of business.
   - ☐ b. Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.
   - ☒ c. Requires specific expenditures or the report of information as a condition of compliance.
   - ☐ d. Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 3901-3-13: The purpose of this rule is to establish the minimum reserve standards for all individual and group health insurance coverages, including single premium credit disability insurance, as required by division (Q) of section 3903.723 of the Revised Code. Minimum reserve requirements establish one standard of maintaining solvency for health insurance companies. The National Association of Insurance Commissioners (NAIC) evaluates market trends and industry standards to develop appropriate minimum benchmarks for companies to maintain. These minimum requirements are then reviewed nationally by both industry stakeholders and regulators, and adopted into a national model. Recommended amendments to this rule will incorporate the latest version of the NAIC model. Updates to the model do not implement new requirements, but rather provide the updated standards for recent plan years, and those moving forward. Due to the amount of proposed amendments the rule will be filed as rescind, and ultimately filed as a new rule.

   Rule 3901-3-19: Corporate governance is the system of rules, practices, and processes by which an insurance company governs itself. Ohio Revised Code sections 3901.072 to 3901.078 requires that insurers submit an annual disclosure to the superintendent, detailing specific information related to individual corporate governance practices. The purpose of this rule is to establish the required content, and procedures for filing the annual disclosure. The proposed amendment to this rule is technical and will correct a citation.

Rule 3901-6-16: The purpose of this rule is to amplify Ohio Revised Code by defining the maturity date used for the purpose of calculating nonforfeiture values for annuity contracts. The rule implements what is commonly referred to as the "70/10 Rule" which limits the duration of an annuity to 10 years or age 70, whichever is greater. There are no proposed amendments to this rule.

3. Please list the Ohio statute(s) that authorize the Agency to adopt the rule(s) and the statute(s) that amplify that authority.

   Rule 3901-3-13: Sections 3901.041 and 3903.723(Q) of the Revised code.

   Rule 3901-3-19: Sections 3901.77 and 3901.041 of the Revised code.

   Rule 3901-6-16: Sections 3901.041 and 3901.21 of the Revised code.

4. Does the regulation implement a federal requirement? ☐ Yes ☒ No
   Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   ☐ Yes ☒ No
   If yes, please briefly explain the source and substance of the federal requirement.

   Not applicable.

5. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   Not applicable.

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   Rule 3901-3-13: Implementing the NAIC model for minimum reserve standards promotes insurer solvency, which is crucial to the protection of the company, consumers, and the overall insurance market.

   Rule 3901-3-19: Corporate governance addresses the allocation and regulation of power and accountabilities within an insurer and avoids undue concentration of authority and power. Also, corporate governance has to be transparent and have appropriate systems, controls, and limits to ensure the given authority and power is used to protect the interests of all of the insurance company's stakeholders.

   Rule 3901-6-16: The purpose for this rule is to provide consumer protection, especially to senior citizens when purchasing annuity products. This regulation is specifically intended to prevent unreasonable surrender charges and provide reasonable access to funds.

7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

Success is determined by reviewing trends in complaints and violations as well as the overall wellbeing of insurers; reviewed during financial and, or market conduct examinations. Success is also evident through an overall understanding of expectations set forth in these rules on behalf of the regulated community.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931? ☐ Yes ☒ No

   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

   Not applicable.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation. *If applicable, please include the date and medium by which the stakeholders were initially contacted.*

   In May 2021, an email requesting comment on this group of rules was sent to various stakeholders, interested parties, trade associations and companies. Specifically, the department reached out to the Ohio Land Title Association, the Ohio Insurance Institute (OII), the Association of Ohio Life Insurance Companies (AOLIC), the American Council of Life Insurance (ACLI), Ohio Association of Health Plans (OAHP) and the Ohio Insurance Agent Association Inc., among others. Additionally, these rules were also posted on the department's web site for review.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

    No comments were received during or after the two week comment period.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

    Rule 3901-3-13: The health insurance reserves NAIC model was established through extensive stakeholder and regulator outreach to determine appropriate standards based on market data and research.

    Rule 3901-3-19: The NAIC developed the model CGAD act and rule, which was created and vetted through a committee process that included research and input from numerous state regulators and industry stakeholders. This was a multi-year project to study and compare existing governance requirements for U.S. insurers to establish best practices, international standards and U.S. regulatory needs.

    Rule 3901-6-16: Representatives from industry and other state insurance departments worked together to develop the basics of this rule for the Interstate Insurance Product

Regulation Commission. Several other states have implemented a similar rule or statute. The department conducted extensive outreach to develop a good fit for Ohio.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

    Rule 3901-3-13: The NAIC works to establish national consistency across state department of insurance jurisdictions. National models establish predictability and in regards to maintaining financial reserve methods, an alternative is not appropriate.

    Rule 3901-3-19: No alternative regulation was considered. The rule was specifically developed to provide detail regarding the requirements of the CGAD. The language of this model regulation was developed in conjunction with the model statute during a collaborative stakeholder process.

    Rule 3901-6-16: The standards established in this rule were reached through extensive outreach and review of other states regulations. An industry standard was established to prevent adverse financial impact on senior citizens.

13. Did the Agency specifically consider a performance-based regulation? Please explain. *Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.*

    Rule 3901-3-13 requires health insurers to follow applicable guidelines in determining a satisfactory minimum reserve.

    Rule 3901-3-19: The corresponding statute, section 3901.074 of the Revised Code requires that the superintendent establish the required content of the CGAD. However, the rule was designed so the insurer has discretion regarding the appropriate format for providing the information. The insurer is permitted to customize the communication to provide the most relevant information necessary to permit the superintendent to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer.

    Rule 3901-6-16 requires that applicable filed products meet a specific standard. This standard ensures consumer protection and a balanced market.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

    The department is the sole regulator for insurance in the state of Ohio and confirmed there are no duplicate regulations.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

All rules included in this package are existing and understood by the regulated community. Updates to rule 3901-3-13 have been known to insurers active with the NAIC since their adoption in 2017. Additionally, the department maintains multiple divisions that are available to assist the regulated community and consumers.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:
    a. Identify the scope of the impacted business community;
    b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and
    c. Quantify the expected adverse impact from the regulation.
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a-c.

Rule 3901-3-13: Health insurers are required to maintain minimum reserves according to standards established in the rule. Amendments to the rule do not necessarily impose additional requirements, however will provide updated methods in determining compliance. These amendments implement the NAIC model, which has been familiar to the industry since 2017. Therefore quantifying the staff time necessary to review such amendments is unknown, but believed to be minimal.

Rule 3901-3-19: Insurers domiciled in Ohio are required to complete and submit a corporate governance annual disclosure (CGAD). Most of the information that is required to be included should already be known to the insurer and relied upon in its ongoing board and business operations. Many insurers currently summarize and describe their corporate governance practices to a number of various stakeholders on a regular basis. In addition, the disclosure requirements allow reference to existing documents and filings and provide guidance for filing changes from the prior year to simplify the reporting process. The time to complete subsequent CGADs should drop significantly as the insurer will only need to update the CGAD with any changes that occurred during the year.

Rule 3901-6-16: Insurance companies which sell applicable annuity products are required to comply with the calculation methods established in the rule. The rule remains in place without substantive amendments and therefore does not impose a quantifiable adverse impact.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Rule 3901-3-13: NAIC models establish national standards for insurers, resulting in consistency and regulatory predictability. Additionally, the rule promotes insurer solvency, which ensures consumer claims may be paid by the insurer.

Rule 3901-3-19: Through the adoption of standards in this area, the department can ensure that sufficient information on governance practices is available to assess the solvency of insurers on an annual basis.

Rule 3901-6-16: The standards established in the rule provide consumer protections for individuals, often senior citizens, whom purchase applicable annuity products.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Rule 3901-3-13: The purpose of this rule is to establish the minimum reserve standards for all individual and group health insurance coverages, the rule provides the standards and applicable tables to follow given the size and needs of each entity.

Rule 3901-3-19: The insurer has discretion regarding the appropriate format for providing the information and is permitted to customize the reporting to provide the most relevant information necessary to permit the department to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer. This includes a recognition by the department that smaller insurers may submit less complex CGADs and may need additional advice and guidance as to the filing requirements.

Rule 3901-6-16: Requirements etsablished in this rule promote consumer protection and establish straight-forward business and product standards, it is crucial that they are complied with consistently across the industry.

19. How will the Agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Paperwork violations and/or first time offender issues would be handled on a case by case basis to determine whether the violation could have a serious impact on the overall financial solvency of the insurer, or impact to consumer. Minor errors would be handled by advising the entity and providing them an opportunity to cure the omission.

20. What resources are available to assist small businesses with compliance of the regulation?

Department staff is available to assist any insurer regardless of size.

Ohio | Common Sense Initiative

EXHIBIT 45

Mike DeWine, Governor
Jon Husted, Lt. Governor
Sean McCullough, Director

MEMORANDUM

TO: Loretta Medved, Ohio Department of Insurance

FROM: Joseph Baker, Business Advocate

DATE: September 29, 2021

RE: **CSI Review – Health insurance reserves, corporate governance annual disclosure, and annuity nonforfeiture product standards (OAC 3901-3-13, 3901-3-19, and 3901-6-16)**

On behalf of Lt. Governor Jon Husted, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Department as provided for in ORC 107.54.

Analysis

This rule package consists of one new, one no-change, one amended, and one rescinded rule proposed by the Ohio Department of Insurance (Department) as a part of the statutory five-year review process. This rule package was submitted to the CSI Office on August 2, 2021, and the public comment period was held open through August 16, 2021. Unless otherwise noted below, this recommendation reflects the version of the proposed rules filed with the CSI Office on August 2, 2021.

The rules in this package establish reserve standards for individual and group health insurance coverages, procedures related to insurers required to file corporate governance disclosures and nonforfeiture product standards for annuities.

New OAC 3901-3-13 establishes minimum reserve standards for individual and group health insurance coverages. The rule requires health insurance providers to maintain claim reserves and outlines accounting and actuarial methods and processes for maintaining such reserves and

calculating potential liabilities. The Department states in the BIA that the rule is amended to adopt the latest standards adopted by the National Association of Insurance Commissioners (NAIC). Due to the extent of changes made to the rule, the Department proposes to rescind current OAC 3901-3-13 and replace the existing rule in its entirety.

OAC 3901-3-19 establishes procedures related to filing an annual corporate governance disclosure. The rule specifies that insurers who are required to file corporate governance disclosure must do so annually no later than June 1st of each year, that the disclosure must include a signature of the chief executive officer or corporate security attesting to the individual's belief that the practices described in the disclosure form have been implemented by the entity, that the insurer be as descriptive as possible in completing the disclosure, and that the disclosure describe the structural framework of the entity, the qualifications, expertise, and experience of board members, the independence of the board and its committees, the number of meetings held by the board, how board members are selected and the duration of terms, and other factors related to leadership structure and authority within the entity. The rule is amended to adopt a technical change.

OAC 3901-6-16 establishes standards for the purpose of calculating nonforfeiture values for annuity contracts. The rule specifies notwithstanding any language in a contract, the nonforfeiture maturity date of an annuity shall be the later of the 10th contract anniversary or the contract anniversary following the annuitant's 70th birthday and establishes other related tests, forfeiture conditions, and adjustments.

During early stakeholder outreach, the Department shared the proposed rules with various interested parties, including the Ohio Insurance Institute, the Ohio Land Title Association, the Association of Ohio Life Insurance Companies, the American Council of Life Insurance, the National Association of Insurance and Financial Advisors, the Ohio Association of Health Plans, and the Ohio Insurance Agent Association, among others and posted the rules on its website. No comments were provided in response to the request for early stakeholder outreach or during the CSI public comment period.

The business community impacted by the rules includes Ohio health insurers, Ohio insurers that are required to complete and submit a corporate governance annual disclosure, and insurance companies that sell applicable annuity products in Ohio. The adverse impacts to business include the costs and expense associated with determining appropriate minimum reserves and maintaining such reserves, the costs of completing and submitting corporate governance disclosures as specified, and costs associated with determining and complying with the calculation methods and nonforfeiture requirements for annuities. The Department states in the BIA that the costs of maintaining minimum reserves is unknown, but that the changes to the rule are familiar to the

industry and additional staff time necessary to comply with the changes is anticipated to be minimal. The Department also notes that the costs of completing corporate governance disclosures decreases significantly after the initial disclosure, as the insurer is only required to update the disclosure with changes that took place in the previous year. The Department states that the adverse impact to health insurers created by the rule promotes insurer solvency and ensures consumer claims are paid, that the adverse impact to insurers created by the corporate governance disclosure requirement enables the Department to assess the solvency of insurers and promote best practices, and that the annuity forfeiture standards that affect insurance companies who sell annuity products are necessary to provide consumer protections for purchasers.

Recommendations

Based on the information above, the CSI Office has no recommendations on this rule package.

Conclusion

The CSI Office concludes that the Ohio Department of Insurance should proceed in filing the proposed rules with the Joint Committee on Agency Rule Review.

Ohio Department of Insurance

Mike DeWine, Governor
Jon Husted, Lt. Governor

Judith L. French, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

EXHIBIT 46

MEMORANDUM

To: Joseph Baker, Business Advocate

CC: Sean McCullough, Director of the Common Sense Initiative Office

From: Loretta Medved, Policy Analyst

Date: September 29, 2021

Re: Response to CSI Review – Health insurance reserves, corporate governance annual disclosure, and annuity nonforfeiture product standards (OAC 3901-3-13, 3901-3-19, and 3901-6-16)

On September 29, 2021, the Ohio Department of Insurance (the Department) received the Recommendation Memorandum (CSI Recommendation) from the Common Sense Initiative Office for rule(s) 3901-3-13 Health insurance reserves, 3901-3-19 Corporate governance annual disclosure, and 3901-6-16 Annuity nonforfeiture product standards.

The CSI Recommendation stated that the office does not have any recommendations regarding this rule package, and therefore should proceed with a formal filing of the rule package.

At this time, the Department plans to move forward with the filing of this rule package with the Joint Committee on Agency Rule Review.

If you have any questions please contact Loretta Medved at 614-644-0239 or Loretta.Medved@insurance.ohio.gov.

EXHIBIT 47

Behrendt, Jennifer

From: Chubb, Tina
Sent: Thursday, July 15, 2021 8:13 AM
To: Medved, Loretta; Craig, Meredith; Haughawout, Carrie
Cc: Behrendt, Jennifer; Chase, Elizabeth; Marcum-Welch, Coty
Subject: FW: Rule Review

Good Morning - E-Comment

On 7/14/21, 6:37 PM, "Ronald Morrow Jr" <rdmorrowjr@gmail.com> wrote:

I have reviewed those Rule Titles and don't have any questions.
Ronald D Morrow Jr

Sent from my iPad