Draft Pending Adoption

Draft: 3/30/21

Market Information Systems (D) Task Force
Virtual Meeting (*in lieu of meeting at the 2021 Spring National Meeting*)
March 22, 2021

The Market Information Systems (D) Task Force met March 22, 2021. The following Task Force members participated: Mike Kreidler, Chair (WA); Chlora Lindley-Myers, Vice Chair (MO); Evan G. Daniels represented by Maria Ailor (AZ); Ricardo Lara represented by Pam O'Connell (CA); Michael Conway represented by Damion Hughes (CO); Andrew M. Mais represented by Kurt Swan (CT); Trinidad Navarro represented by Frank Pyle (DE); Dana Popish Severinghaus represented by Erica Weyhenmeyer (IL); Vickie Schmidt represented by Tate Flott (KS); James J. Donelon represented by Jeff Zewe (LA); Troy Downing represented by Jeannie Keller (MT); Marlene Caride represented by Ralph Boeckman (NJ); Barbara D. Richardson represented by Nick Stosic (NV); Judith L. French represented by Rodney Beetch (OH); Glen Mulready represented by Landon Hubbart (OK); Doug Slape represented by Rachel Cloyd (TX); Michael S. Pieciak represented by Isabelle Turpin Keiser (VT); and James A. Dodrill represented by Jeannie Tincher (WV). Also participating was: Brent Kabler (MO).

1. Adopted its Nov. 17, 2020, Minutes

Director Lindley-Myers made a motion, seconded by Mr. Flott, to adopt the Task Force's Nov. 17, 2020 minutes (*see NAIC Proceedings – Fall 2020, Market Information Systems (D) Task Force*). The motion passed unanimously.

2. Discussed the Task Force's 2021 Charges

Commissioner Kreidler said the Task Force's 2021 charges remain consistent with its charges from last year. He said the Task Force will continue to ensure that the market information systems (MIS) support the strategic goals set by the Market Regulation and Consumer Affairs (D) Committee. The Task Force will do this by analyzing the quality of the data reported into the MIS, making recommendations for improving data quality, and providing guidance on the appropriate use of the MIS and data.

Commissioner Kreidler said the Task Force has one Working Group, the Market Information Systems Research and Development (D) Working Group, reporting to the Task Force. It is chaired by Mr. Kabler. Commissioner Kreidler said the Task Force relies on the members of the Working Group to review and prioritize the Uniform System Enhancement Requests (USER) forms, which are sent to the Working Group by interested state insurance regulators to request changes to the MIS. He said the Working Group is also responsible for the yearly MIS metrics report, which measures the timeliness, accuracy and completeness of data reported into the MIS.

Commissioner Kreidler said the Task Force is moving the charge to "develop recommendations for the incorporation of artificial intelligence (AI) abilities in the MIS for use in market analysis" to the Working Group. He said the charge is moving to the Working Group for two reasons. First, the Working Group has members with expertise in this field. Second, the Working Group meets more frequently and can devote more time to the charge. Commissioner Kreidler said the Task Force will still be responsible for the final product, and the Working Group will undertake this charge in open meetings.

3. Adopted the Report of the Market Information Systems Research and Development (D) Working Group

Mr. Kabler said the Working Group met March 19, 2021, and Dec. 2, 2020. During these meetings the Working Group reviewed and adopted the MIS metric report and recommendations for metric updates and methods to improve metric result reporting and data quality.

Mr. Kabler said the Working Group also reviewed a new process for prioritizing USER forms. Ginny Ewing (NAIC) noted that the new process moves from a waterfall process to the lean, agile process used by NAIC Information Services. She said it is more transparent regarding what is in the backlog.

Mr. Kabler said the Working Group also adopted proposed changes to the Regulatory Information Retrieval System (RIRS) coding structure. He said the proposal was reviewed with representatives of the Financial Analysis Solvency Tools (E) Working Group and the state producer licensing directors. He noted that modifications were made to the proposal based on their feedback. He said the proposal was also reviewed with the state back-office system vendors, who made a recommendation to create a user's guide providing guidance for how the new codes should be used. He noted that based on the current available information, the vendors do not anticipate an additional cost to implement the necessary system changes to support the proposal.

Mr. Kabler said the RIRS coding change and re-structure has been the most ambitious project of the Market Information Systems Research and Development (D) Working Group. He has been working on it even before the Working Group was formed.

Mr. Kabler said the Working Group also considered the charge to "develop recommendations for the incorporation of artificial intelligence (AI) abilities in the MIS for use in market analysis." He said he has some concerns because the term "artificial intelligence" is nebulous and defined in different, often contradictory, ways. He said the Working Group's first task will be to develop a working definition for AI. He encouraged interested parties and interested state insurance regulators to participate in the discussions. He also said the Working Group was concerned that there is not enough market data to make AI feasible for market analysis. However, he noted that the Working Group is approaching the charge with an open mind and willingness to learn.

Birny Birnbaum (Center for Economic Justice—CEJ) asked why the proposed RIRS coding changes did not include all lines of business that are included in the financial annual statement. As an example, he noted that there were no line of business codes for lender-placed insurance. He noted that the definition of each proposed RIRS line of business states that it corresponds to the financial annual statement, so it would be expected that all financial lines of business should be included. Mr. Kabler said if additional lines of business are needed, he would not be averse to adding them. He said they may not have been included because there was not much market conduct concern in the missing lines of business.

Mr. Birnbaum asked for clarification of the meaning of the "Origin of Action" code statuses "keep" and "delete." Mr. Kabler said codes with a code status of "delete" would be removed from the RIRS as an option.

Mr. Birnbaum said there were many codes in the "Reasons for Action" that were mutually exclusive; yet, the RIRS will allow multiple reasons per action. He asked if that would compromise the integrity of the data. Mr. Kabler said the nature of regulatory actions is that they often have multiple concerns and reasons. He said an examination is a single record within the RIRS, and the system must be able to capture all the reasons for a regulatory action.

Commissioner Kreidler said when adopting the Working Group's report, the Task Force will also be adopting the changes to the USER form process, but it will not be adopting the proposed RIRS changes. He said the proposed RIRS change will be posted on the Task Force web page, and they will be considered for adoption at the Summer National Meeting.

Director Lindley-Myers made a motion, seconded by Mr. Flott, to adopt the Market Information Systems Research and Development (D) Working Group report. The motion passed unanimously.

4. Adopted the MIS Data Analysis Metrics and Recommendations

Commissioner Kreidler said review of the market data analysis metrics and recommendations began at the 2020 Fall National Meeting, but the report was not ready for adoption. He said the report is attached to the materials, and it is ready for adoption.

Director Lindley-Myers made a motion, seconded by Mr. Flott, to adopt the MIS data analysis and recommendations. The motion passed unanimously.

5. Heard a Report on Outstanding USER Forms

Ms. Ewing said the following USER forms are in development or complete:

- USER Form 10051 is a request to implement the Market Actions Tracking Systems (MATS) Web Service in State Based Systems (SBS). Ms. Ewing said this project is in progress. She said prototype and design decisions are being made.

- USER Form 10053 is a request to review RIRS codes to clarify definitions for consistent usage and make recommendations for revisions. Ms. Ewing said the coding changes were shared with financial and producer licensing regulators, and their input has been incorporated. She said the Working Group adopted the RIRS changes.

- USER Form 10080 is the request to update the RIRS to display data retention policies and terminology related to action dates. She said much of this request is complete, but the RIRS subject matter experts (SMEs) are reviewing

the data dictionary and considering the issue of the "earliest action date" being misleading in the Regulatory Systems Participating State Report.

- USER Form 10082 is the request to add a Complaints Database System (CDS) subject code for "pandemic" and a coverage code for "business interruption." She said while completing this request, it was discovered that subject codes are not displayed. She said a USER form will be created to correct this issue.

Ms. Ailor said USER Form 10069B was to add codes for pet insurance and lender-placed insurance. She said the pet insurance codes were implemented but not the lender-placed insurance codes. Ms. Ewing said the codes were supposed to have all been completed. She will check on the status and have them implemented.

Having no further business, the Market Information Systems (D) Task Force adjourned.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

MARKET INFORMATION SYSTEMS RESEARCH AND DEVELOPMENT (D) WORKING GROUP
July 21, 2021 / July 15, 2021 / June 16, 2021

Summary Report

The Market Information Systems Research and Development (D) Working Group met July 21, July 15, and June 16, 2021.

1. During the July 21 meeting, the Working Group:
   a. Heard a presentation from Birny Birnbaum (Center for Economic Justice—CEJ) on how artificial intelligence (AI) could be used in market analysis. He encouraged the Working Group to adopt a long-term perspective and develop a multi-year plan to explore AI techniques that might be beneficial to market analysis. He also indicated that state insurance regulators have to date failed to acquire granular transactional data that could be leveraged by AI methods to provide a much more robust surveillance system to reduce consumer harm to the extent possible.
   b. Discussed next steps to address the Working Group's charge to develop recommendations for the incorporation of AI abilities in NAIC Market Information Systems (MIS) for use in market analysis. An MIS AI subject matter expert (SME) group of interested state insurance regulators has been formed to research and draft recommendations.

2. During the July 15 and June 16 meetings in regulator-to-regulator sessions, pursuant to paragraph 3 (specific companies, entities, or individuals) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings, the Working Group:
   a. Heard a presentation regarding AI methods being explored by NAIC staff and state insurance regulators to predict which insurers are likely to experience financial stress, including insolvency. A consultant was retained in January to develop both AI, as well as more traditional statistical techniques, to construct predictive models of insolvency risk. NAIC staff believe the methods show promise and could significantly advance financial risk surveillance. Among AI and statistical models explored were decision tree analysis, generalized linear models, and logistic regression.
   b. Reviewed the first Uniform System Enhancement Request (USER) form submitted through the updated process. USER form 10083 requests adding complaint subject code to iSite+ and Consumer Information Search (CIS) reports. The Working Group approved the request, which has been added to the development backlog.
   c. Reviewed comments received regarding the Regulatory Information Retrieval System (RIRS) code restructuring proposal. Comments were submitted by California and the CEJ. The Working Group questioned the value of the subjective nature of the CEJ suggestions; however, it did not strongly oppose them. The Working Group requested clarification on California's comments.
   d. Reviewed the status of the MIS data analysis metric recommendations for metric updates and methods to improve metric result reporting and data quality. Of the 17 action items, two are complete, eight are in progress, and seven are in backlog awaiting staff availability.

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Regulatory Information Retrieval System (RIRS)
Proposed Coding Structure Changes

Overview

Outlined below are the Market Information Systems Research and Development (D) Working Group proposed revisions to the Regulatory Information Retrieval System (RIRS) coding structure. These revisions address the serious deficiencies of the current coding structure. They are designed to render greater coherency to the data structure and make the system more compatible with other market information systems.

In brief, this proposal consists of:

1) New Record Type field to distinguish routine administrative actions from actions that are a result of an infraction or financial impairment. This distinction is important for market analysis purposes.
2) New Modification Indicator field to link related RIRS records. Some RIRS records represent a termination, modification, or extension of a previous RIRS record. This new field can be used to eliminate duplicate records when counting unique actions.
3) New Line of Business field to reflect infractions that arise out of activity specific to a line of business.
4) Significant Revisions to the Origin of Action, Reason for Action, and Disposition for Action codes to provide a more logical overall data structure.

Record Type (New)

Code	Code Name	Definition	Code Status	Notes
XXX	Financial Impairment	Action was taken by the state regulatory authority with respect to the financial condition of an insurer or other regulated entity.	New	
XXX	Violation	Action was taken regarding a violation of statute or regulation. Excludes routine or administrative actions that do not involve such a violation.	New	
XXX	Administrative Action Only (no violation)	A formal action taken by the state regulatory authority in which no violation of statute or regulation has occurred related to the action. Could include such actions as rate filing review or transfer from a state's wind pool.	New	
XXX	Other	Any formal action that is not adequately described by any of the above three record types.	New	

Modification Indicator (New)

Code	Code Name	Definition	Code Status	Notes
Y	Yes	Action is a Modification to Existing RIRS Record	New	If Yes, provide previous RIRS identifier in new field
N	No	Action is Not a Modification to Existing RIRS Record	New	

Line of Business (New)

Code	Code Name	Definition	Code Status	Notes
XXX	Accident and Health - Group	Corresponds to financial annual statement	New	

Code	Code Name	Definition	Code Status	Notes
XXX	Accident and Health - Individual	Corresponds to financial annual statement	New	
XXX	Annuity – Group	Corresponds to financial annual statement	New	
XXX	Annuity – Individual	Corresponds to financial annual statement	New	
XXX	Auto – Commercial	Corresponds to financial annual statement	New	
XXX	Auto – Private Passenger	Corresponds to financial annual statement	New	
XXX	Bail Bonds	Corresponds to financial annual statement	New	
XXX	Commercial Liability	Corresponds to financial annual statement	New	
XXX	Commercial Property	Corresponds to financial annual statement	New	
XXX	Credit	Corresponds to financial annual statement	New	
XXX	Fidelity and Surety	Corresponds to financial annual statement	New	
XXX	Homeowner	Corresponds to financial annual statement	New	
XXX	Life - Group	Corresponds to financial annual statement	New	
XXX	Life - Individual	Corresponds to financial annual statement	New	
XXX	Long Term Care	Corresponds to financial annual statement	New	
XXX	Medical Malpractice	Corresponds to financial annual statement	New	
XXX	Medicare Supplement	Corresponds to financial annual statement	New	
XXX	Title	Corresponds to financial annual statement	New	
XXX	Workers Compensation	Corresponds to financial annual statement	New	
XXX	None	Corresponds to financial annual statement	New	
XXX	Other	Corresponds to financial annual statement	New	

Origin of Action (Revised)

The Origin of Action field is meant to provide information about the origin (source) of the regulatory action. The code(s) used should be reflective of the source of information or activity that resulted in the regulatory action. Information about the reason (allegations) and/or disposition (outcome) of the action should be reported in those respective fields. (max 4)

Code	Code Name	Definition	Code Status	Notes
1002	FINRA	Reporting by a state insurance department of an action taken by FINRA associated with a domicile or resident entity or individual subject to the jurisdiction of said state insurance department.	Keep	
1003	Market Analysis	Action resulting from market analysis, including but not limited to actions resulting from Baseline, Level 1, or Level 2 market analysis reviews.	Keep	
1005	Complaint Investigation	Action resulting from an investigation of one or more complaints against the entity or individual.	Keep	
1007	Field Investigation	Action resulting from a regulatory investigation and verification of circumstances through direct communication with an entity or individual. These investigations often involve on-site work and would include investigations completed by those in fraud and/or investigation units of the department.	Keep	
1008	Public Inquiry	Concern resulting from close examination of a matter to determine information or truth provided by an outside party (other than the Insurance Department, insurer, or producer).	Delete	Used by 12 states, 17 times. Proposed alternative: (1055) "Third Party Information"
1010	Routine Dept. Action	Action resulting from recurring insurance departmental activity not triggered by a	Keep	May also consider Code 1020

Code	Code Name	Definition	Code Status	Notes
		regulatory issue contemplated in other origin codes. Examples of actions included in this code include, but are not limited to, instances where the entity fails to file a report timely.		
1013	Financial	Action resulting from activity associated with or related to financial aspects of the entity, including, but not be limited to, actions taken as result of financial filings (e.g., Risk Based Capital (RBC) filings), financially hazardous conditions, suspensions, rehabilitation, liquidations, mergers, domestications, etc.	Keep	
1015	Information/Action by Other State(s)	Action resulting from information or an action taken against the Entity or individual by another state's Department of Insurance or other state agency.	Code Name Change	Previous Code Name "Other States Action"
1016	Annual Statement Filing	Action resulting from the review of an insurers financial annual statement or market conduct annual statement.	Code Name Change	Previous Code Name "Annual Statement"
1018	Information/Referral from Another State Agency	Action resulting from information or referral from another state agency within the entering state.	Keep	
1020	Insurer Report	Action taken as the result of any type of report filed with the Department of Insurance not explicitly contemplated by another origin code. This would include, but not be limited to Statistical Filings and other state mandated filings.	Keep	May also consider Code 1010
1023	Statistical Filing	Action resulting from litigation or other legal proceeding. This would include, but not be limited to, actions resulting from class actions lawsuits and other legal proceedings.	Delete	Used by 10 states, 59 times. Proposed alternative: (1020) "Insurer Report"
1025	Legal	Action resulting from litigation or other legal proceeding. This would include, but not be limited to, actions resulting from class actions lawsuits and other legal proceedings.	Keep	
1030	Market Conduct Exam	Action resulting from a market conduct examination, including but not limited actions resulting from targeted, comprehensive, or desk examinations.	Keep	
1035	Financial Exam	Action resulting from a financial examination of a regulated entity, including but not limited to actions taken because of routine examinations and premium tax audits.	Keep	
1040	Workers Comp Exam	Concern resulting from examination of a workers compensation insurer's business practices and operations in order to determine its compliance with state insurance laws and regulations.	Delete	Used by 3 states, 7 times. Proposed alternatives: (1030) "Market Conduct Exam", (1035) "Financial Exam", or both
1045	Combined Exam	Concern resulting from a combined Financial and Market Conduct Examination.	Delete	Used by 7 states, 43 times. Proposed alternative: (1030) "Market Conduct Exam" and (1035) "Financial Exam"
1050	Bankruptcy Notices	Concern resulting from a notice that an insurer or producer has filed for legal insolvency, indicating that the insurer is unable to meet financial obligations to customers and stockholders, or that a producer or agency has financial issues that may impact compliance with state insurance laws and regulations.	Delete	Used by 5 states, 6 times. Proposed alternative: (1025) "Legal"

Code	Code Name	Definition	Code Status	Notes
1055	Third Party Information	Action resulting from information obtained from an outside source that is not explicitly contemplated by another origin code. This would include, but not be limited to actions resulting from information contained in media coverage and other sources of public information.	Keep	
1060	Licensing / Company Administration	Action resulting from a regulated entity's licensing status. This would include but not be limited to actions resulting from the submission of applications by the regulatory entity, failure of the entity to provide information in response to an application.	Code Name Change	Previous Code Name "Licensing Administration"
1063	Background Check	Action resulting from the review of a background check of a producer or employee of a regulated entity. This would include but not be limited to actions stemming from a review of criminal, financial, or disciplinary events regardless of the source that are not explicitly contemplated by another origin code.	Keep	
1065	Other*	Action taken that was prompted by information, an activity or event not contemplated by another origin code.	Code Name Change	Previous Code Name "Other if checked you must enter description, up to 100 characters"
XXXX	Form/Rate/Rule Filing	Action taken as a result of a review/analysis of a regulated entity's policy form, rate, and/or rule filing. This would include a review/analysis of underwriting guidelines where such filings are required to be made.	New	
XXXX	Information/Referral from Federal Agency	Action resulting from information or referral from a Federal agency.	New	
XXXX	Market Conduct Initiative	Action resulting from a market conduct initiative along the continuum of regulatory responses, including but not limited actions resulting from interrogatories, targeted information gathering (i.e. surveys, data calls, etc.), and policy & procedure reviews.	New	
XXXX	Multi-state Regulatory Action/Settlement	Action resulting from a multi-state regulatory action and/or settlement of a regulated entity. This would include, but not be limited to, actions resulting from a multi-state examination, settlement or other coordinated activity along the continuum or regulatory responses.	New	
XXXX	Prior Dept. Action	An action taken as the direct result of a prior action taken against the entity or individual. This would include but not be limited to failure to comply with a previous order, lifting of prior orders, suspensions, or restrictions.	New	
XXXX	Self-reported Information	Action taken as the result of information voluntarily reported by the entity or individual.	New	

*If checked, you must enter a description of up to 100 characters.

Reason for Action (Revised)

The Reason for Action field is meant to provide information about the reason (allegations) for the regulatory action. The code(s) used should be reflective of allegations associated with the action (i.e. the nature of the violation found). Information about the origin (source) and/or disposition (outcome) of the action should be reported in those respective fields. (max 20)

Claims

Code	Code Name	Definition	Code Status	Notes
2015	Claim Handling	Finding of cause resulting from the process of dealing with demands for payment of contract/policy benefits by the insured or the insured's beneficiary or representative.	Delete	Proposed alternative: use new, more specific code(s) related to claim handling issues
XXXX	Claim Denials Due to Improper Rescission	Improper rescission of a policy subsequent to the presentation of a claim.	New	
XXXX	Failure to Pay Mandated Coverages	Improper denial or reduction of coverages that are mandated by statute or regulation.	New	
XXXX	Failure to Provide Appropriate Claims Materials or Other Reasonable Assistance	Failure to provide required claim forms, notifications of coverage, coinsurance, deductibles, or other items necessary to properly process a claim.	New	
XXXX	Failure to Resolve Timely / Prompt Pay	Failure to resolve and if appropriate pay claims within statutory timeframes. This would include failure to comply with 'prompt pay' statutes and/or regulations.	New	
XXXX	Files Not Adequately Documented	Inadequate documentation of claims and/or retention of claims records.	New	
XXXX	Improperly Compelling Claimant to Litigate	Delay or inadequate settlement offer made after claim liability has become reasonably clear, thus compelling a claimant to litigate.	New	
XXXX	Inadequate Explanations of Claims Denied / Closed Without Payment	Deficient correspondence with a claimant or policyholder regarding the reasons for a claim denial, including failure to explain the policy basis for a denial and appeal rights or other related issue in violation of statute or regulation.	New	
XXXX	Inadequate Loss Valuation Practices / Procedures	Improper damage estimates, total loss valuations or other claim valuation procedures and practices.	New	
XXXX	Inadequate / Untimely Investigation	Inadequate or untimely investigation to determine available coverage or liability.	New	
XXXX	Inappropriate Subrogation Practices / Procedures	Inappropriate recoupment of a loss from a liable third party, improper distribution of such a recoupment, and/or other inadequate subrogation practice and/or procedure.	New	
XXXX	Initial Contact Not Timely / Not Made	Failure to make initial contact or failure to make initial contact with an insured or claimant within timeframes established by statute and/or regulation.	New	
XXXX	Misrepresentation of Coverage	Available coverage was not adequately communicated to a policyholder or claimant.	New	
XXXX	Other Claims Handling Issue*	Any other claims handling issue not described by any other reason code and/or combination of reason codes.	New	
XXXX	Other Improper Claims Settlement Practice*	All other improper claim handling procedures or practices not described by any other reason code and/or combination of reason codes.	New	
XXXX	Other Improper Denial of Claim*	All claim denial violations not included in an above category not described by any other reason code and/or combination of reason codes.	New	

Complaint Handling

Code	Code Name	Definition	Code Status	Notes
XXXX	Failure to Maintain Complaint	Improper documentation of consumer	New	

Code	Code Name	Definition	Code Status	Notes
	Log	complaints, both those received directly from a consumer and via insurance departments.		
XXXX	Failure to Provide Adequate Response / Resolution to Complaints	Failure to address issues that rose in a complaint and take appropriate remedial actions, as necessary.	New	
XXXX	Failure to Timely Respond / Manage Complaints	Failure to respond to consumer complaints within required time frames. This would include but not be limited to the failure to respond to the insurance department and/or the complainant.	New	
XXXX	Other Complaint Handling Issue*	Other deficiency in complaint handling practices and/or procedures (including the failure to have complaint handling procedures.) not described by any other reason code and/or combination of reason codes.	New	

Escrow/Settlement, Closing or Security Deposit Funds

Code	Code Name	Definition	Code Status	Notes
XXXX	Funds Submitted for Collection / Deposited in Non-qualified Institution	Failure to collect and deposit funds in an appropriate institution, such as an institution insured by the FDIC.	New	
XXXX	Inappropriate Disbursement Procedures / Practices	Failure to disburse funds in conformity with all applicable statutes and regulations. This would include, but not be limited to escrow funds that are applied in a way that is not in accordance with statutes and/or regulations regarding the handling of funds, escrow shortages, failure to provide good funds, or Improper or Inadequate Escrow Accounting Procedures or Controls.	New	
XXXX	Inappropriate Interest Paid	Failure to pay appropriate interest in accordance with statute or regulation.	New	
XXXX	Other Escrow / Settlement, Closing or Security Deposit Funds Issue*	Any other issue not described by any other reason code and/or combination of reason codes.	New	

Marketing & Sales

Code	Code Name	Definition	Code Status	Notes
2010	Marketing & Sales	Finding of cause resulting from an entity's activities involving the marketing, advertising and sales of products that are regulated by the Department of Insurance.	Delete	Proposed alternative: use new, more specific code(s) related to marketing and sales
2012	Unsuitable / Inappropriate Replacement	Failure to comply with mandated replacement and/or suitability statutes and/or regulations.	Code Name Change	Previous Code Name "Life Insurance Replacement Violation" Typically related to life insurance or annuities
2014	Misrepresentation of Insurance Produce / Policy	Deceptive representations regarding the nature of an insurance product.	Keep	
2025	Misleading Advertising	Use of advertising that does not comply with applicable state statutes and/or regulations, including but not limited to false and/or misleading advertising.	Code Name Change	Previous Code Name "Advertising"
2045	Rebating	Improperly providing monetary inducements to purchase coverage.	Keep	

Code	Code Name	Definition	Code Status	Notes
2111	Inappropriate Sales or Solicitation to a Military Service Member	Inappropriate sales and/or solicitation of insurance products to military service member, including but not limited to violations of the Military Sales Practices Model Regulation or similar state statute and/or regulation.	Keep	
2112	Inappropriate Sales or Solicitation on a Military Installation**	Inappropriate sales or solicitation of insurance products on a military installation, including but not limited to violations of the Military Sales Practices Model Regulation or similar state statute and/or regulation.	Keep	
XXXX	Disclosure / Outline of Coverage Inadequate / Not Timely / Not Provided	Inadequate procedures to provide full disclosure or appropriate outline of coverage to consumers in connection with the sale of an insurance product.	New	
XXXX	Failure to Provide Adequate Producer Training, Education, Compliance Oversight	Training materials and communications with producers fail to comply with statute or regulation.	New	
XXXX	Illustrations Inadequate / Not Timely / Not Provided	Sales materials and exhibits fail to contain all required information, disclaimers, or are otherwise misleading.	New	
XXXX	Other Marketing & Sales Issue*	Any of marketing and sales violation not described by any other reason code and/or combination of reason codes.	New	
XXXX	Other Unfair Marketing & Sales Practice*	Any other unfair marketing and sales practice not described by any other reason code and/or combination of reason codes.	New	

Operations & Management

Code	Code Name	Definition	Code Status	Notes
2028	TPA Violation	Finding of cause resulting from non-compliance with a state's Third Party Administrator (TPA) laws and regulations.	Delete	Proposed alternative: (XXXX) "Failure to Adequately Supervise MGAs, TPAs, or Other 3rd Party Contractor"
2039	Failure to Maintain Adequate Books & Records	Records are incomplete, inaccessible, inconsistent, or disordered, or fail to conform to state record retention laws.	Code Name Change	Previous Code Name "Failure to Maintain Books & Records"
2065	Notice of Financial Impairment from Another State	Notification from another state of financial impairment.	Keep	
2070	Financial Impairment	Finding of cause resulting from an insurer having insufficient assets, capital, policyholder surplus, or reserves to meet financial obligations to customers and stockholders and is therefore ineligible to transact insurance business in the state.	Keep	
2072	Cure of Financial Impairment	Used when *Financial Impairment* was reported, where an insurer was found to be ineligible to transact insurance business, has remedied the problem; is now considered solvent and eligible to transact insurance business.	Keep	
2080	Dissolution	Finding of cause resulting from notification that a producer firm or insurer has been dissolved, disbanded, or liquidated as a corporation.	Keep	
2100	No Certificate of Authority	Finding of cause resulting from an insurer engaging in the business of insurance in a state without authorization from the Department of Insurance.	Keep	

Code	Code Name	Definition	Code Status	Notes
2101	Exceeded Certificate of Authority	Engaging in activities not contemplated within the scope of authority of an existing certificate of authority. This could include, but not be limited to, writing lines of business not covered by the existing certificate of authority and/or exceeding geographical boundaries associated with the existing certificate of authority.	Code Name Change	Previous Code Name "Certification Violation"
2102	Unauthorized Insurance Business	Finding of cause resulting from an entity engaging in actions that are regulated as the business of insurance without authorization from the Department of Insurance in the state.	Delete	Proposed alternative: (2100) "No Certificate of Authority" and/or (2101) "Exceeded Certificate of Authority"
XXXX	Failure to Adequately Supervise MGAs, TPAs, or Other 3rd Party Contractor	Failure to exercise an appropriate level of oversight of third parties that assume a business function and act on behalf of an insurer. Example: An MGA that is not operating in accordance with statutes and/or regulations regarding the supervisory responsibility for the local and field operations of an insurer.	New	
XXXX	Inadequate Appeals Practices / Procedures	Improper or inadequate procedures to appeal unsatisfactory claim outcomes. Examples: First-level appeals are reviewed by a qualified medical practitioner. Second-level review processes conform to applicable statute and/or regulation.	New	
XXXX	Inadequate External / Independent Review Practices / Procedures	Failure to provide appropriate cost-free access to an independent external body to review medical determinations in relations to the terms of a policy or applicable statute and/or regulation.	New	
XXXX	Inadequate Grievance Practices / Procedures	Failure to adhere to policy provisions regarding the handling of complaints or appeals by consumers or health care providers.	New	
XXXX	Inadequate Internal / External Audit Practices / Procedures	Company failed to implement proper surveillance procedures to ensure the absence of significant structural or systemic problems with core functions.	New	
XXXX	Inadequate Network	Failure to provide timely and local access to healthcare providers in accordance with policy provisions or state and/or federal requirements. Example: A health plan network that is not in accordance with requirements mandated by statute and/or regulation related to a network adequacy.	New	
XXXX	Inadequate Provider Credentialing / Monitoring	Failure to ensure that contracted providers are properly licensed and practicing within the scope of their license and at the contracted location.	New	
XXXX	Inadequate Safeguards for Security of Data & Information	Failure to adequately preserve the privacy of confidential or sensitive information. This would include but not be limited to, improper disclosure within a regulated entity, failure of procedures to maintain the integrity of company information stored in electronic or other media, failure to provide appropriate privacy disclosures to consumers, or to notify consumers of security breaches. Example: Failure to maintain adequate	New	

Code	Code Name	Definition	Code Status	Notes
		information controls, data backup and recovery systems, or to restrict access to sensitive information.		
XXXX	Inadequate Utilization Review Practices / Procedures	Improper procedures or practices associated with monitoring the use, delivery, or efficiency of medical services by insureds.	New	
XXXX	Quality Assurance Violation	Inappropriate or inadequate procedures or practices associated with conducting quality assessments and improving health outcomes, including adequately communicating such procedures to health care providers.	New	
XXXX	Other Operations & Management Issue*	Any other management and operations issue not described by any other reason code and/or combination of reason codes.	New	

Policyholder Service

Code	Code Name	Definition	Code Status	Notes
2020	Policyholder Service	Finding of cause resulting from a company's service to owners of insurance policies, including complaints, customer service, claims or any other service.	Delete	Proposed alternative: use new, more specific code(s) related to policyholder service
XXXX	COBRA Non-compliance	Improper documentation of eligibility for group health insurance coverage.	New	
XXXX	HIPPA Non-compliance	Improper handling of private electronic claims records or other patient information.	New	
XXXX	Improper Processing of Free Looks	Failure to remit a full refund if a policy is returned with required timeframes; or to adhere to any other free-look provisions prescribed by the policy or by statute or regulation.	New	
XXXX	Improper Processing of Nonforfeitures	Failure to secure a policyholder's interest in a policy in the event the policy lapses, in accordance with policy provisions or statute and/or regulation.	New	
XXXX	Improper Processing of Reinstatements	Differential treatment of similarly situated individuals with respect to reinstatement rights provided under the policy or as required by state law or regulation.	New	
XXXX	Premium / Billing Notices Inadequate / Not Timely / Not Provided	Failure to provide billing notices and/or notify consumers of premiums due within timeframes established by statute and/or regulation. This would include instances where billing notices are inadequate and/or did not contain information required by statutes and/or regulations.	New	
XXXX	Other Required Notification / Correspondence Inadequate / Not Timely / Not Provided	Failure to make any other required notification and/or made the notification in a timely manner. This would include instances where notices are inadequate and/or did not contain information required by statutes and/or regulations.	New	
XXXX	Reasonable Attempts to Locate Policyholder Not Made	No reasonable attempt was made to locate policyholders or beneficiaries.	New	
XXXX	Other Policy Holder Service Issue*	Any other policyholder service issue not described by any other reason code and/or combination of reason codes, including but not limited to a failure to provide notification of changes in customer service telephone numbers or locations, failure to promptly answer telephone calls or electronic inquiries, or failure	New	

Code	Code Name	Definition	Code Status	Notes
		to clearly identify the name of the underwriter on correspondence.		

Producer Licensing

Code	Code Name	Definition	Code Status	Notes
2026	Premium Finance Act Violation	Finding of cause resulting from non-compliance with the premium finance act, including but not limited to licensing, record-keeping, policy notices and contractual charges.	Delete	Used by 4 states, 5 times. Proposed alternative: use appropriate "other" code
2027	Surplus Lines Violation	A producer committed a violation of statutes and/or regulations related to surplus lines business.	Keep	
2030	Failure to Meet Continuing Education Requirements	A producer failed to meet the mandatory continuing education requirements. This would also include instances where the producer failed to maintain one or more qualifications to hold a license.	Keep	
2032	Continuing Education Requirements Met	A producer deficient in respects to meeting mandated continuing education requirements is now compliant. This would also include instances where the failure to maintain a qualification required to hold a license has been rectified.	Keep	
2037	Failure to Notify Department of Address Change	A producer failed to notify the department of a change in address in accordance with statutes and/or regulations. This would include instances where the producer failed to notify the department in a timely manner.	Keep	
2042	Failure to Pay Child Support / Student Loans	A producer license was denied, suspended, or revoked due to the producer failing to pay child support and/or student loans.	Code Name Change	Previous Code Name "Failure to Pay Child Support"
2055	Producer / Adjuster / Other Not Properly Licensed	A producer is not properly licensed to transact business for a given line of insurance; or adjuster not properly licensed according to statute or regulation.	Code Name Change	Previous Code Name "No License"
2056	Demonstrated Lack of Fitness or Trustworthiness	Action taken on a producer license due to a demonstrated lack of fitness and/or trustworthiness. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2058	Misstatement on Application	Action taken on a producer license due to a misstatement on the application. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2059	Failure to Make Required Disclosure on Application	Action taken on a producer license due to the failure to make a required disclosure on the application. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Code Name Change	Previous Code Name "Failure to Make Required Disclosure on application"
2060	Producer / Adjuster / Other Not Properly Appointed	A producer or adjuster is not properly appointed to an insurer as required by statute or regulation.	Code Name Change	Previous Code Name "Not Appointed"
2061	Selling for Unlicensed Insurer	A producer solicited on behalf of an unlicensed insurer.	Keep	
2062	Allowed Business from Agent Not Appointed / Licensed	Finding of cause resulting from an insurer accepting policy applications from producers at a time when they were not licensed or under appointment with that insurer as required by the	Delete	Proposed alternative: (2055) "Producer / Adjuster / Other Not Properly Licensed" and/or (2060)

Code	Code Name	Definition	Code Status	Notes
		state's laws and the company's requirements.		"Producer / Adjuster / Other Not Properly Appointed"
2063	Employed Unlicensed Individuals	Finding of cause resulting from employees of a producer or insurer conducting the business of insurance without required authorization or license from the Department of Insurance.	Delete	Proposed alternative: (2055) "Producer / Adjuster / Other Not Properly Licensed"
2064	Paid Commission to Un-appointed Agents	Finding of cause resulting from an insurer or producer providing payment or sharing of commissions to producers who are not appointed with the issuing insurer.	Delete	Proposed alternative: (2060) "Producer / Adjuster / Other Not Properly Appointed"
2097	Bail Bond Forfeiture Judgment	Action taken on a producer license was due to a bail bond forfeiture judgment. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2075	Failure to Report Other State Action	Action was taken on a producer license due to the failure to report an action taken by another state. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2104	Failure to Remit Premiums to Insurer	A producer failed to remit premiums to an insurer.	Keep	
2105	Misappropriation of Premium	A producer misappropriated premium.	Keep	
2106	Forgery / Fraud	A producer committed forgery and/or fraud. This would include, but not be limited to, forgery of an insurance application, providing false evidence insurance, misrepresentation to insurer to obtain policy benefits and/or commission, and other acts of dishonest or fraud. Example: Misrepresentation to insurer to obtain a life insurance policy with the intent to sell interests in the proceeds.	Code Name Change	Previous Code Name "Forgery"
2107	Criminal Record / History	Action taken on a producer license due a criminal record and/or history. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2108	Criminal Proceedings	Action taken on a producer license due to criminal proceedings. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
XXXX	Producer / Adjuster Not Properly Terminated	Failure to adhere to all statutes and regulations regarding the termination of a producer, such as notification requirements to both the producer and the relevant regulation bodies.	New	
XXXX	Other Producer / Adjuster Licensing Issue*	Any other violation with respect to licensure and appointment of producers or adjusters not described by any other reason code and/or combination of reason codes.	New	
XXXX	Failure to Account for Premium Funds	Failure to maintain records showing the deposit, handling, and proper remittance premium funds.	New	
XXXX	Failure to Maintain Separate Fiduciary Account	Failure to create a fiduciary account for the deposit and remittance of premiums separate from agency operating funds.	New	
XXXX	Commingling of Premiums with Personal Funds	Failure to keep premium funds separate from personal funds.	New	
XXXX	Other Fiduciary/Accounting Violation*	A fiduciary violation not included in an above category, not described by any other reason code, or combination of reason codes	New.	

Underwriting & Rating

Code	Code Name	Definition	Code Status	Notes
2005	Underwriting	Finding of cause resulting from the process of selecting, classifying, and rejecting risks in order to assign appropriate rates to insureds.	Delete	Proposed alternative: use new, more specific code(s) related to underwriting
2050	Rate Violation	Finding of cause resulting from use of premium rates not filed with the Department of Insurance, or not aligned with rates that have been filed, or use of inadequate procedures to determine premium rates.	Delete	Proposed alternative: use new, more specific code(s) related to rating violations
XXXX	Inadequate or Excessive Rate	Rates are either excessive or inadequate in relation to expected exposure presented by the risk and/or expected losses, as defined by statute and/or regulation.	New	
XXXX	Incorrect Application of Rate	Actual rates charged deviate from the insurer's established rates or rating plan. This would include, but not be limited to, instances where rates charged are not in accordance with state mandates, filed, do not adhere to filings, and/or improper documentation of modifications exists. Example: Inconsistent application of scheduled rating plan across eligible risks.	New	
XXXX	Rates Not Filed / Approved	The use of rates that have not been filed or approved by the state insurance department as required by statute or regulation.	New	
XXXX	Rates Unfairly Discriminatory	Like risks are charged different rates in a way not justified by expected loss costs.	New	
XXXX	Use of Prohibited Rating Factors	Use of factors for rating prohibited by statute or regulation.	New	
XXXX	Other Rating Issue*	Any improper rating practice not described by any other reason code and/or combination of reason codes.	New	
2053	Forms Not Filed &/or Approved	The use of insurance forms that have not been properly filed or approved by the appropriate regulatory authority.	Code Name Change	Previous Code Name "Use of Unapproved Forms"
XXXX	Improper Question on Application	Insurance application contains improper questions or otherwise not in accordance with applicate statutes and/or regulations.	New	
XXXX	Mandated Coverages / Offerings Not Provided	Failure to provide coverage for benefits required by statute or regulation. This would include, but not be limited to, using forms that do not comply with statutes and/or regulations regarding mandated and/or required coverages.	New	
XXXX	Other Forms Issue*	Any other form violation not described by any other reason code and/or combination of reason codes.	New	
2003	Cancellation / Non- Renewal Notice Inadequate / Not Timely / Not Provided	Notice of the termination of coverage was not issued, was not issued within timeframes prescribed by statute or policy provisions. This would include instances where notices are inadequate and/or did not contain information required by statutes and/or regulations.	Code Name Change	Previous Code Name "Failure to Send Required Cancellation / Non-Renewal Notice"
XXXX	Mandatory Disclosures / Notifications Inadequate / Not Timely / Not Provided	Improper issuance of disclosures or notifications, in violation of policy provisions, statute, or regulation. This would include notices of mandated coverage, disclosure of preexisting	New	

Code	Code Name	Definition	Code Status	Notes
		condition exclusions, or disclosure that credit insurance is optional and not a condition for loan approval. It does not include cancellation or nonrenewal notices, which have a separate code.		
XXXX	Unfairly Discriminatory Underwriting Practices / Procedures	Underwriting practices that treat like risks differently and violate statutes and/or regulations regarding the fair treatment of risks.	New	
XXXX	Other Cancellation / Nonrenewal / Recession Issue*	Any other improper termination of coverage not described by any other reason code and/or combination of reason codes. Example: Rescissions made for non-material misrepresentations.	New	
XXXX	Declination Notice – Inadequate / Not Timely / Not Provided	Failure to issue notify an applicant or failure to timely notify an applicant that coverage is rejected as required by statute and/or regulation. This would include instance where notices where inadequate and/or did not contain information required by statutes and/or regulations.	New	
XXXX	Other Declination Issue*	Other inappropriate declination not described by any other reason code and/or combination of reason codes. Example: Failure to adhere to internal underwriting guidelines.	New	
XXXX	Other Underwriting Issue*	Any other violation related to the determination of eligibility for coverage, not described by any other reason code and/or combination of reason codes.	New	

Miscellaneous

Code	Code	Definition	Code Status	Notes
2007	Market Conduct Examination	Finding of cause resulting from examination of the business practices and operations of an entity in order to determine its compliance with state insurance laws and regulations.	Delete	Describes origin of action Proposed alternative: (1030) "Market Conduct Exam" Origin of Action code and select the appropriate Reason Code(s) that apply to underlying reason for the action.
2074	Other States Action	Finding of cause resulting from another state's Department of Insurance activity about an issue which also affects the entering state.	Delete	Describes origin of action Proposed alternative: (1015) "Other States Action" Origin of Action code and select the appropriate Reason Code(s) that apply to underlying reason for the action.
2029	Unfair Insurance Practices Act Violation	Finding of cause resulting from unfair methods of competition or deceptive acts being used, from this Act or the Unfair Trade Practices Act as applied to the business of insurance.	Delete	Proposed alternative: use new, more specific code(s) related to unfair insurance practices
2035	Failure to Cooperate with Examination / Investigation / Inquiry	Other failure to cooperate with an examination or investigation. This would include, but not be limited to, failure to respond to appropriate	Code Name Change	Previous Code Name "Failure to Respond"

Code	Code	Definition	Code Status	Notes
		requests for information and/or providing inaccurate or misleading information.		If the issue is late or incomplete response, then use 2036.
2036	Late or Incomplete Response	Failure to respond timely and/or failure to provide a complete response in response to a request for information. This would include, but not be limited to failure to submit timely and complete mandated filings such as statistical reports and annual reports.	Keep	
2038	Failure to Comply with Previous Order	Failure to comply with an order pertaining to corrective action, as determined by a follow-up examination, investigation, or other means.	Keep	
2040	Failure to Timely File	Failure to make a filing in a timely manner.	Keep	
2085	Failure to Pay Tax	Failure to pay tax.	Keep	
2087	Failure to Pay Fees	Failure to pay fees.	Keep	
2090	Failure to Pay Fine	Failure to pay fine.	Keep	
2095	Failure to Pay Assessment	Failure to pay an assessment.	Keep	
2103	Fiduciary Violation	Finding of cause resulting from producers violating positions of trust in relation to insurers and policyholders.	Delete	Proposed alternative: use new, more specific code(s) related to fiduciary violations
2110	Reconsideration	The Department of Insurance has re-evaluated a Regulatory Action because of new information received or because the entity has corrected the cause of action.	Keep	
2115	Other Miscellaneous*	Any other reason not described by any other reason code and/or combination of reason codes.	Code Name Change	Previous Code Name "Other* (enter up to 100 char)"

*If checked, you must enter a description of up to 100 characters.

**If code (2112) is checked, please enter the name of the Military Base in the '(xxxx) Other Marketing & Sales Issue*' box.

Disposition for Action (Revised)

The Disposition field is meant to provide information about the disposition (outcome) of the regulatory action. The code(s) used should be reflective of the outcome of the action. In other words what happened as a result of the action. Information about the reason (allegations) and/or origin (source) of the action should be reported in those respective fields. (max 4)

Code	Code Name	Definition	Code Status	Notes
3001	License, Denied	The entity or individual applied for a new license or attempted to renew a license and it was denied	Keep	
3003	License, Suspended	The entity or individual's license was suspended. The entity or individual is temporarily prohibited from engaging in the business of insurance.	Keep	
3004	License, Cancelled	The entity or individual's license was cancelled.	Keep	
3006	License, Revoked	The entity or individual's license was revoked; The entity or individual is prohibited from engaging in the business of insurance.	Keep	
3009	License, Probation	The entity or individual's license is subject to a probationary period during which the entity or individual is obligated to comply with certain standards and/or conditions specified by the issuing authority or the license can be	Keep	

Code	Code Name	Definition	Code Status	Notes
		cancelled, revoked or suspended.		
3010	License, Conditional	The entity or individual's license is issued on a conditional basis under which the entity or individual must meet certain standards and/or conditions specified by the issuing authority before an unrestricted license can be issued. Failure to meet the conditions may result in license being cancelled, revoked, or suspended by the issuing authority.	Keep	
3011	License, Supervision	The entity or individual's license is under supervision of the issuing authority and the entity or individual is subject to a formal supervisory plan regarding a hazardous financial condition or non-compliant business practice. Failure to comply with the supervisory plan may result in the license being cancelled, revoked, or suspended by the issuing authority.	Keep	
3012	License, Reinstatement	The license of an entity or individual was reinstated.	Keep	
3013	License, Granted	A license was granted to an entity or individual as a result of an administrative process regarding a prior action to deny, cancel or revoke a license.	Keep	
3014	License, Surrendered	The entity or individual's license was ordered to surrender the license.	Keep	
3015	License, Voluntarily Surrendered	The entity or individual's license was voluntarily surrendered by the entity or individual. This disposition is typically associated with situations where the entity or individual agreed to voluntarily surrender the license in lieu of the issuing authority pursuing additional administrative action.	Keep	
3016	License, Other*	Any other disposition related to an entity or individual license not described by any other disposition code or combination of codes.	Keep	
3021	Certificate of Authority, Denied	The entity's application for a certificate of authority or an expansion of an existing certificate of authority was denied by the issuing authority.	Keep	
3023	Certificate of Authority, Suspended	The regulated entity's certificate of authority was suspended for a specific time period. During this time period, the entity is prohibited from engaging in the business of insurance in the affected jurisdiction.	Keep	
3025	Certificate of Authority, Suspension Extended	The suspension of regulated entity's certificate of authority was extended beyond the initial suspension period. The temporary prohibition from engaging in the business of insurance in the affected jurisdiction is continued.	Keep	
3026	Certificate of Authority, Revoked	The regulated entity's certificate of authority was revoked. The entity prohibited from engaging in the business of insurance in the affected jurisdiction.	Keep	
3028	Certificate of Authority, Expired	The entity failed to take the appropriate action to renew or continue its certificate of authority.	Keep	
3029	Certificate of Authority, Probation	The regulated entity's certification of authority is subject to a probationary period during which the entity is obligated to comply with	Keep	

Code	Code Name	Definition	Code Status	Notes
		certain standards and/or conditions specified by the issuing authority or the certificate of authority can be cancelled, revoked or suspended.		
3031	Certificate of Authority, Reinstated	The regulated entity's certificate of authority was reinstated.	Keep	
3034	Certificate of Authority, Surrendered	The entity surrendered its certificate of authority.	Keep	
3036	Certificate of Authority, Other*	Any other disposition related to a certificate of authority not described by any other disposition code or combination of codes.	Keep	
3042	Cease and Desist from Violations	The entity was ordered to cease and desist from engaging in specific activities that are not compliant with insurance statutes, rules, and/or regulations of the issuing jurisdiction.	Keep	
3043	Cease and Desist from all Insurance Activity	The entity or individual was ordered to cease and desist from engaging in the business of insurance.	Keep	
3044	Remedial Measures Ordered	The entity or individual was ordered to take specific action in order to remediate a situation which caused harm to one or more persons as a result of one or more acts taken by the entity or individual.	Keep	
3045	Consent Order	The entity or individual entered into a voluntary agreement in order to resolve the issue regulatory issue that is the subject of the action.	Keep	
3046	Stipulated Agreement/Order from a commissioner	The entity or individual entered into a stipulated agreement which was approved via a formal process (i.e. approved by an administrative law judge or hearing examiner) in order to resolve the issue regulatory issue that is the subject of the action.	Keep	
3047	Previous Order Vacated / Stayed / Set Aside	A previous order under which the entity or individual was subject has been set aside, nullified, cancelled, or rescinded. Or an order that postpones or suspends a previous order.	Code Name Change	Previous Code Name "Previous Order Vacated"
3048	Ordered to Provide Requested Information	The entity or individual has been ordered to produce information requested by the jurisdiction under its statutory authority.	Keep	
3049	Stayed Order	The Department of Insurance stops a previously issued order from being put into effect.	Delete	Used by 3 states, 10 times. Proposed alternative: (3047) "Previous Order Vacated / Stayed / Set Aside"
3051	Final Agency Order	The final agency order was issued against the entity or individual.	Keep	
3052	Ordered to Comply with Specific Statute or Regulation	The entity or individual was ordered comply with a specific insurance statute, rule, and/or regulation.	Keep	
3055	Reprimanded / Censured	The entity or individual was formally reprimanded or censured.	Code Name Change	Previous Code Name "Reprimanded"
3060	Hearing Waiver	The entity or individual waived their right to a hearing.	Keep	
3065	Show Cause	An order directing the entity or individual to appear before the reporting jurisdiction to explain why they took or failed to act or why the reporting jurisdiction should or should not grant some relief.	Keep	

Code	Code Name	Definition	Code Status	Notes
3070	Re-exam	The Department of Insurance orders a follow-up examination of an entity to ensure compliance with state laws and regulations.	Delete	Used by 4 states, 11 times. Proposed alternative: (3105) "Other"
3075	Rescission of	The Department of Insurance retracts a previous action or order. An additional Disposition code must be selected to identify what was rescinded. If Other is selected, text explanation must be entered into the Other action disposition field.	Keep	
3076	Involuntary Forfeiture	The Department of Insurance requires the surrender of the authority of an individual or firm to engage in the business of insurance in the state because of a crime, offense, or breach of contract.	Delete	Used by 0 states, 0 times. Proposed alternatives: (3102) "Monetary Penalty" or (3103) "Aggregated Monetary Penalty"
3078	Restitution	The entity or individual was ordered to pay restitution in order to compensate one or more persons or entities harmed by actions of the regulated or unauthorized entity or individual.	Keep	
3079	Suspended from Writing New Business; Renewals Ok	The entity is prohibited from writing new business. However, it is still permitted to service current policyholders.	Keep	
3080	Supervision	The financial condition of the entity was placed under supervision and being closely monitored by the jurisdiction.	Keep	
3085	Rehabilitation	The entity was found to be financially impaired or insolvent. Action is being taken to restore the impaired or insolvent entity to sound financial standing.	Keep	
3090	Liquidation	The entity was found to be insolvent and unable to become viable. Action is being taken to liquidate the entity.	Keep	
3095	Conservatorship	The entity and its financial condition are being evaluated to determine whether the policyholders and creditors will be best served by liquidation, rehabilitation, or returning the entity to private management.	Keep	
3097	Hearing	A hearing was brought about as are result of the action against the entity or individual.	Keep	
3100	Receivership	The entity was placed into receivership by jurisdiction in which the entity is legally domiciled.	Keep	
3101	Ancillary Receivership	The entity was placed into receivership by a jurisdiction other than the jurisdiction in which the entity is legally domiciled.	Keep	
3102	Monetary Penalty	Monetary fine or penalty imposed on a single entity or individual in a single action for one or more violations of insurance statutes, rules, and/or regulations.	Keep	
3103	Aggregate Monetary Penalty	Monetary fine or penalty imposed on one or more entities or individuals in a single action for one or more violations of insurance statutes, rules, and/or regulations.	Keep	
3104	Settlement	The Department of Insurance negotiates an agreement with an entity without legal action or litigation being undertaken.	Keep	
3105	Other*	Any other disposition not described by any other disposition code or combination of codes.	Keep	

* If checked, you must enter a description of up to 100 characters.

Center for Economic Justice – May 1, 2021

I also wanted to offer a comment on the proposed revisions to the RIRS Coding Structure. The data include a section for Origin for Action with the instruction that up to 4 sources of information or activity that resulted in the regulatory action. I suggest that instead of a Y/N data entry, the permissible data entries be 1, 2, 3 or 4 to indicate the relative importance of the source of information in prompting the regulatory action. This would enable better analysis of the most important sources of information for different types of regulatory actions. With this type of entry, the limit to sources can be increased from 4. And this would then represent a data set amendable to an AI-type analysis. I'd suggest the same numeric ordering entry approach for reason for action.

I'm unclear about the entry instructions for the Disposition for Action. The instruction state that up to 4 entries are permitted. my first question is whether multiple entries are possible or whether each action is mutually exclusive of all others. If the answer is that for the same regulatory action multiple actions are possible, then, again, I'd suggest a numerical entry approach, but starting with 1 as the first action, 2 as the second action and so on. Instead of the numerical hierarchy representing the hierarchy of importance as with Origin of Action and Reason for Action, the numerical hierarchy here would be oldest to newest.

From: Kinney, Holly <Holly.Kinney@insurance.ca.gov>
Sent: Wednesday, June 16, 2021 3:47:53 PM
To: Helder, Randy <RHelder@naic.org>
Cc: Berkstresser, Carrie <Carrie.Berkstresser@insurance.ca.gov>; Ferguson, Charlene <Charlene.Ferguson@insurance.ca.gov>; Campbell, Teresa <Teresa.Campbell@insurance.ca.gov>; canaic@naic.org <canaic@naic.org>
Subject: RE: NAIC NOTICE: MISTF - RIRS Coding Change Proposal Exposure and Comments

Good afternoon Randy,

In response to your below email to review the RIRS Coding Change Proposal, California has provided a few comments on the attached document. A brief detail of the summary of California's responses are as follows:

- On page 1, number 2 under "Overview" regarding the New Modification Indicator field, California uses the same file number for actions until the final resolution has been reached. This includes any modifications or changes made to existing actions. New file numbers are only assigned to new action; therefore, California does not use the modification function on the same file number.
- On page 1, number 3 under "Overview" regarding the New Line of Business field, California acknowledges the majority of licensees have multiple lines of authority, but California does not track the type of business conducted.
- On page 4 under "Reason for Action (Revised)," California recommends adding "failure to notify Department of change in background." California currently has to enter this under "Other" and then manually type in the information.

We apologize for the delay in sending these comments to you. Please let me know if you have any questions or need clarification on California's comments.

Thank you,

Holly Kinney
Chief, Curriculum and Officer Review Bureau
320 Capitol Mall
Sacramento, CA 95814
Office: (916) 492-3040

NAIC National Association of Insurance Commissioners

Regulatory Information Retrieval System (RIRS)
Proposed Coding Structure Changes

Overview

Outlined below are the Market Information Systems Research and Development (D) Working Group proposed revisions to the Regulatory Information Retrieval System (RIRS) coding structure. These revisions address the serious deficiencies of the current coding structure. They are designed to render greater coherency to the data structure and make the system more compatible with other market information systems.

In brief, this proposal consists of:

1) New Record Type field to distinguish routine administrative actions from actions that are a result of an infraction or financial impairment. This distinction is important for market analysis purposes.
2) New Modification Indicator field to link related RIRS records. Some RIRS records represent a termination, modification, or extension of a previous RIRS record. This new field can be used to eliminate duplicate records when counting unique actions.
   California comment: Other states may use the modification function; however, California does not modify or change an existing case file number.
3) New Line of Business field to reflect infractions that arise out of activity specific to a line of business.
   California comment: Other states may track the type of business conducted. California tracks the license qualifications issued to individuals and business entities; however, California does not track the 'type of business conducted'.
4) Significant Revisions to the Origin of Action, Reason for Action, and Disposition for Action codes to provide a more logical overall data structure.

Record Type (New)

Code	Code Name	Definition	Code Status	Notes
XXX	Financial Impairment	Action was taken by the state regulatory authority with respect to the financial condition of an insurer or other regulated entity.	New	
XXX	Violation	Action was taken regarding a violation of statute or regulation. Excludes routine or administrative actions that do not involve such a violation.	New	
XXX	Administrative Action Only (no violation)	A formal action taken by the state regulatory authority in which no violation of statute or regulation has occurred related to the action. Could include such actions as rate filing review or transfer from a state's wind pool.	New	
XXX	Other	Any formal action that is not adequately described by any of the above three record types.	New	

Modification Indicator (New)

Code	Code Name	Definition	Code Status	Notes
Y	Yes	Action is a Modification to Existing RIRS Record	New	If Yes, provide previous RIRS identifier in new field
N	No	Action is Not a Modification to Existing RIRS Record	New	

Line of Business (New)

NAIC National Association of Insurance Commissioners

Code	Code Name	Definition	Code Status	Notes
XXX	Accident and Health - Group	Corresponds to financial annual statement	New	
XXX	Accident and Health - Individual	Corresponds to financial annual statement	New	
XXX	Annuity – Group	Corresponds to financial annual statement	New	
XXX	Annuity – Individual	Corresponds to financial annual statement	New	
XXX	Auto – Commercial	Corresponds to financial annual statement	New	
XXX	Auto – Private Passenger	Corresponds to financial annual statement	New	
XXX	Bail Bonds	Corresponds to financial annual statement	New	
XXX	Commercial Liability	Corresponds to financial annual statement	New	
XXX	Commercial Property	Corresponds to financial annual statement	New	
XXX	Credit	Corresponds to financial annual statement	New	
XXX	Fidelity and Surety	Corresponds to financial annual statement	New	
XXX	Homeowner	Corresponds to financial annual statement	New	
XXX	Life - Group	Corresponds to financial annual statement	New	
XXX	Life - Individual	Corresponds to financial annual statement	New	
XXX	Long Term Care	Corresponds to financial annual statement	New	
XXX	Medical Malpractice	Corresponds to financial annual statement	New	
XXX	Medicare Supplement	Corresponds to financial annual statement	New	
XXX	Title	Corresponds to financial annual statement	New	
XXX	Workers Compensation	Corresponds to financial annual statement	New	
XXX	None	Corresponds to financial annual statement	New	
XXX	Other	Corresponds to financial annual statement	New	

Origin of Action (Revised)

The Origin of Action field is meant to provide information about the origin (source) of the regulatory action. The code(s) used should be reflective of the source of information or activity that resulted in the regulatory action. Information about the reason (allegations) and/or disposition (outcome) of the action should be reported in those respective fields. (max 4)

Code	Code Name	Definition	Code Status	Notes
1002	FINRA	Reporting by a state insurance department of an action taken by FINRA associated with a domicile or resident entity or individual subject to the jurisdiction of said state insurance department.	Keep	
1003	Market Analysis	Action resulting from market analysis, including but not limited to actions resulting from Baseline, Level 1, or Level 2 market analysis reviews.	Keep	
1005	Complaint Investigation	Action resulting from an investigation of one or more complaints against the entity or individual.	Keep	
1007	Field Investigation	Action resulting from a regulatory investigation and verification of circumstances through direct communication with an entity or individual. These investigations often involve on-site work and would include investigations completed by those in fraud and/or investigation units of the department.	Keep	
1008	Public Inquiry	Concern resulting from close examination of a matter to determine information or truth provided by an outside party (other than the Insurance Department, insurer, or producer).	Delete	Used by 12 states, 17 times. Proposed alternative: (1055) "Third Party Information"
1010	Routine Dept. Action	Action resulting from recurring insurance departmental activity not triggered by a regulatory issue contemplated in other origin	Keep	May also consider Code 1020

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Code	Code Name	Definition	Code Status	Notes
		codes. Examples of actions included in this code include, but are not limited to, instances where the entity fails to file a report timely.		
1013	Financial	Action resulting from activity associated with or related to financial aspects of the entity, including, but not be limited to, actions taken as result of financial filings (e.g., Risk Based Capital (RBC) filings), financially hazardous conditions, suspensions, rehabilitation, liquidations, mergers, domestications, etc.	Keep	
1015	Information/Action by Other State(s)	Action resulting from information or an action taken against the Entity or individual by another state's Department of Insurance or other state agency.	Code Name Change	Previous Code Name "Other States Action"
1016	Annual Statement Filing	Action resulting from the review of an insurers financial annual statement or market conduct annual statement.	Code Name Change	Previous Code Name "Annual Statement"
1018	Information/Referral from Another State Agency	Action resulting from information or referral from another state agency within the entering state.	Keep	
1020	Insurer Report	Action taken as the result of any type of report filed with the Department of Insurance not explicitly contemplated by another origin code. This would include, but not be limited to Statistical Filings and other state mandated filings.	Keep	May also consider Code 1010
1023	Statistical Filing	Action resulting from litigation or other legal proceeding. This would include, but not be limited to, actions resulting from class actions lawsuits and other legal proceedings.	Delete	Used by 10 states, 59 times. Proposed alternative: (1020) "Insurer Report"
1025	Legal	Action resulting from litigation or other legal proceeding. This would include, but not be limited to, actions resulting from class actions lawsuits and other legal proceedings.	Keep	
1030	Market Conduct Exam	Action resulting from a market conduct examination, including but not limited actions resulting from targeted, comprehensive, or desk examinations.	Keep	
1035	Financial Exam	Action resulting from a financial examination of a regulated entity, including but not limited to actions taken because of routine examinations and premium tax audits.	Keep	
1040	Workers Comp Exam	Concern resulting from examination of a workers compensation insurer's business practices and operations in order to determine its compliance with state insurance laws and regulations.	Delete	Used by 3 states, 7 times. Proposed alternatives: (1030) "Market Conduct Exam", (1035) "Financial Exam", or both
1045	Combined Exam	Concern resulting from a combined Financial and Market Conduct Examination.	Delete	Used by 7 states, 43 times. Proposed alternative: (1030) "Market Conduct Exam" and (1035) "Financial Exam"
1050	Bankruptcy Notices	Concern resulting from a notice that an insurer or producer has filed for legal insolvency, indicating that the insurer is unable to meet financial obligations to customers and stockholders, or that a producer or agency has financial issues that may impact compliance with state insurance laws and regulations.	Delete	Used by 5 states, 6 times. Proposed alternative: (1025) "Legal"
1055	Third Party Information	Action resulting from information obtained from an outside source that is not explicitly	Keep	

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Code	Code Name	Definition	Code Status	Notes
		contemplated by another origin code. This would include, but not be limited to actions resulting from information contained in media coverage and other sources of public information.		
1060	Licensing / Company Administration	Action resulting from a regulated entity's licensing status. This would include but not be limited to actions resulting from the submission of applications by the regulatory entity, failure of the entity to provide information in response to an application.	Code Name Change	Previous Code Name "Licensing Administration"
1063	Background Check	Action resulting from the review of a background check of a producer or employee of a regulated entity. This would include but not be limited to actions stemming from a review of criminal, financial, or disciplinary events regardless of the source that are not explicitly contemplated by another origin code.	Keep	
1065	Other*	Action taken that was prompted by information, an activity or event not contemplated by another origin code.	Code Name Change	Previous Code Name "Other if checked you must enter description, up to 100 characters"
XXXX	Form/Rate/Rule Filing	Action taken as a result of a review/analysis of a regulated entity's policy form, rate, and/or rule filing. This would include a review/analysis of underwriting guidelines where such filings are required to be made.	New	
XXXX	Information/Referral from Federal Agency	Action resulting from information or referral from a Federal agency.	New	
XXXX	Market Conduct Initiative	Action resulting from a market conduct initiative along the continuum of regulatory responses, including but not limited actions resulting from interrogatories, targeted information gathering (i.e. surveys, data calls, etc.), and policy & procedure reviews.	New	
XXXX	Multi-state Regulatory Action/Settlement	Action resulting from a multi-state regulatory action and/or settlement of a regulated entity. This would include, but not be limited to, actions resulting from a multi-state examination, settlement or other coordinated activity along the continuum or regulatory responses.	New	
XXXX	Prior Dept. Action	An action taken as the direct result of a prior action taken against the entity or individual. This would include but not be limited to failure to comply with a previous order, lifting of prior orders, suspensions, or restrictions.	New	
XXXX	Self-reported Information	Action taken as the result of information voluntarily reported by the entity or individual.	New	

*If checked, you must enter a description of up to 100 characters.

Reason for Action (Revised)

The Reason for Action field is meant to provide information about the reason (allegations) for the regulatory action. The code(s) used should be reflective of allegations associated with the action (i.e. the nature of the violation found). Information about the origin (source) and/or disposition (outcome) of the action should be reported in those respective fields. (max 20)

California comment: California proposes the addition of "Failure to notify the State of change in background."

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Claims

Code	Code Name	Definition	Code Status	Notes
2015	Claim Handling	Finding of cause resulting from the process of dealing with demands for payment of contract/policy benefits by the insured or the insured's beneficiary or representative.	Delete	Proposed alternative: use new, more specific code(s) related to claim handling issues
XXXX	Claim Denials Due to Improper Rescission	Improper rescission of a policy subsequent to the presentation of a claim.	New	
XXXX	Failure to Pay Mandated Coverages	Improper denial or reduction of coverages that are mandated by statute or regulation.	New	
XXXX	Failure to Provide Appropriate Claims Materials or Other Reasonable Assistance	Failure to provide required claim forms, notifications of coverage, coinsurance, deductibles, or other items necessary to properly process a claim.	New	
XXXX	Failure to Resolve Timely / Prompt Pay	Failure to resolve and if appropriate pay claims within statutory timeframes. This would include failure to comply with 'prompt pay' statutes and/or regulations.	New	
XXXX	Files Not Adequately Documented	Inadequate documentation of claims and/or retention of claims records.	New	
XXXX	Improperly Compelling Claimant to Litigate	Delay or inadequate settlement offer made after claim liability has become reasonably clear, thus compelling a claimant to litigate.	New	
XXXX	Inadequate Explanations of Claims Denied / Closed Without Payment	Deficient correspondence with a claimant or policyholder regarding the reasons for a claim denial, including failure to explain the policy basis for a denial and appeal rights or other related issue in violation of statute or regulation.	New	
XXXX	Inadequate Loss Valuation Practices / Procedures	Improper damage estimates, total loss valuations or other claim valuation procedures and practices.	New	
XXXX	Inadequate / Untimely Investigation	Inadequate or untimely investigation to determine available coverage or liability.	New	
XXXX	Inappropriate Subrogation Practices / Procedures	Inappropriate recoupment of a loss from a liable third party, improper distribution of such a recoupment, and/or other inadequate subrogation practice and/or procedure.	New	
XXXX	Initial Contact Not Timely / Not Made	Failure to make initial contact or failure to make initial contact with an insured or claimant within timeframes established by statute and/or regulation.	New	
XXXX	Misrepresentation of Coverage	Available coverage was not adequately communicated to a policyholder or claimant.	New	
XXXX	Other Claims Handling Issue*	Any other claims handling issue not described by any other reason code and/or combination of reason codes.	New	
XXXX	Other Improper Claims Settlement Practice*	All other improper claim handling procedures or practices not described by any other reason code and/or combination of reason codes.	New	
XXXX	Other Improper Denial of Claim*	All claim denial violations not included in an above category not described by any other reason code and/or combination of reason codes.	New	

Complaint Handling

Code	Code Name	Definition	Code Status	Notes
XXXX	Failure to Maintain Complaint Log	Improper documentation of consumer complaints, both those received directly from a consumer and via insurance departments.	New	

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Code	Code Name	Definition	Code Status	Notes
XXXX	Failure to Provide Adequate Response / Resolution to Complaints	Failure to address issues that rose in a complaint and take appropriate remedial actions, as necessary.	New	
XXXX	Failure to Timely Respond / Manage Complaints	Failure to respond to consumer complaints within required time frames. This would include but not be limited to the failure to respond to the insurance department and/or the complainant.	New	
XXXX	Other Complaint Handling Issue*	Other deficiency in complaint handling practices and/or procedures (including the failure to have complaint handling procedures.) not described by any other reason code and/or combination of reason codes.	New	

Escrow/Settlement, Closing or Security Deposit Funds

Code	Code Name	Definition	Code Status	Notes
XXXX	Funds Submitted for Collection / Deposited in Non-qualified Institution	Failure to collect and deposit funds in an appropriate institution, such as an institution insured by the FDIC.	New	
XXXX	Inappropriate Disbursement Procedures / Practices	Failure to disburse funds in conformity with all applicable statutes and regulations. This would include, but not be limited to escrow funds that are applied in a way that is not in accordance with statutes and/or regulations regarding the handling of funds, escrow shortages, failure to provide good funds, or Improper or Inadequate Escrow Accounting Procedures or Controls.	New	
XXXX	Inappropriate Interest Paid	Failure to pay appropriate interest in accordance with statute or regulation.	New	
XXXX	Other Escrow / Settlement, Closing or Security Deposit Funds Issue*	Any other issue not described by any other reason code and/or combination of reason codes.	New	

Marketing & Sales

Code	Code Name	Definition	Code Status	Notes
2010	Marketing & Sales	Finding of cause resulting from an entity's activities involving the marketing, advertising and sales of products that are regulated by the Department of Insurance.	Delete	Proposed alternative: use new, more specific code(s) related to marketing and sales
2012	Unsuitable / Inappropriate Replacement	Failure to comply with mandated replacement and/or suitability statutes and/or regulations.	Code Name Change	Previous Code Name "Life Insurance Replacement Violation" Typically related to life insurance or annuities
2014	Misrepresentation of Insurance Produce / Policy	Deceptive representations regarding the nature of an insurance product.	Keep	
2025	Misleading Advertising	Use of advertising that does not comply with applicable state statutes and/or regulations, including but not limited to false and/or misleading advertising.	Code Name Change	Previous Code Name "Advertising"
2045	Rebating	Improperly providing monetary inducements to purchase coverage.	Keep	
2111	Inappropriate Sales or Solicitation to a Military Service Member	Inappropriate sales and/or solicitation of insurance products to military service member, including but not limited to violations of the Military Sales Practices Model Regulation or	Keep	

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Code	Code Name	Definition	Code Status	Notes
		similar state statute and/or regulation.		
2112	Inappropriate Sales or Solicitation on a Military Installation**	Inappropriate sales or solicitation of insurance products on a military installation, including but not limited to violations of the Military Sales Practices Model Regulation or similar state statute and/or regulation.	Keep	
XXXX	Disclosure / Outline of Coverage Inadequate / Not Timely / Not Provided	Inadequate procedures to provide full disclosure or appropriate outline of coverage to consumers in connection with the sale of an insurance product.	New	
XXXX	Failure to Provide Adequate Producer Training, Education, Compliance Oversight	Training materials and communications with producers fail to comply with statute or regulation.	New	
XXXX	Illustrations Inadequate / Not Timely / Not Provided	Sales materials and exhibits fail to contain all required information, disclaimers, or are otherwise misleading.	New	
XXXX	Other Marketing & Sales Issue*	Any of marketing and sales violation not described by any other reason code and/or combination of reason codes.	New	
XXXX	Other Unfair Marketing & Sales Practice*	Any other unfair marketing and sales practice not described by any other reason code and/or combination of reason codes.	New	

Operations & Management

Code	Code Name	Definition	Code Status	Notes
2028	TPA Violation	Finding of cause resulting from non-compliance with a state's Third Party Administrator (TPA) laws and regulations.	Delete	Proposed alternative: (XXXX) "Failure to Adequately Supervise MGAs, TPAs, or Other 3rd Party Contractor"
2039	Failure to Maintain Adequate Books & Records	Records are incomplete, inaccessible, inconsistent, or disordered, or fail to conform to state record retention laws.	Code Name Change	Previous Code Name "Failure to Maintain Books & Records"
2065	Notice of Financial Impairment from Another State	Notification from another state of financial impairment.	Keep	
2070	Financial Impairment	Finding of cause resulting from an insurer having insufficient assets, capital, policyholder surplus, or reserves to meet financial obligations to customers and stockholders and is therefore ineligible to transact insurance business in the state.	Keep	
2072	Cure of Financial Impairment	Used when *Financial Impairment* was reported, where an insurer was found to be ineligible to transact insurance business, has remedied the problem; is now considered solvent and eligible to transact insurance business.	Keep	
2080	Dissolution	Finding of cause resulting from notification that a producer firm or insurer has been dissolved, disbanded, or liquidated as a corporation.	Keep	
2100	No Certificate of Authority	Finding of cause resulting from an insurer engaging in the business of insurance in a state without authorization from the Department of Insurance.	Keep	
2101	Exceeded Certificate of Authority	Engaging in activities not contemplated within the scope of authority of an existing certificate of authority. This could include, but not be limited to, writing lines of business not covered by the existing certificate of authority and/or exceeding	Code Name Change	Previous Code Name "Certification Violation"

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Code	Code Name	Definition	Code Status	Notes
		geographical boundaries associated with the existing certificate of authority.		
2102	Unauthorized Insurance Business	Finding of cause resulting from an entity engaging in actions that are regulated as the business of insurance without authorization from the Department of Insurance in the state.	Delete	Proposed alternative: (2100) "No Certificate of Authority" and/or (2101) "Exceeded Certificate of Authority"
XXXX	Failure to Adequately Supervise MGAs, TPAs, or Other 3rd Party Contractor	Failure to exercise an appropriate level of oversight of third parties that assume a business function and act on behalf of an insurer. Example: An MGA that is not operating in accordance with statutes and/or regulations regarding the supervisory responsibility for the local and field operations of an insurer.	New	
XXXX	Inadequate Appeals Practices / Procedures	Improper or inadequate procedures to appeal unsatisfactory claim outcomes. Examples: First-level appeals are reviewed by a qualified medical practitioner. Second-level review processes conform to applicable statute and/or regulation.	New	
XXXX	Inadequate External / Independent Review Practices / Procedures	Failure to provide appropriate cost-free access to an independent external body to review medical determinations in relations to the terms of a policy or applicable statute and/or regulation.	New	
XXXX	Inadequate Grievance Practices / Procedures	Failure to adhere to policy provisions regarding the handling of complaints or appeals by consumers or health care providers.	New	
XXXX	Inadequate Internal / External Audit Practices / Procedures	Company failed to implement proper surveillance procedures to ensure the absence of significant structural or systemic problems with core functions.	New	
XXXX	Inadequate Network	Failure to provide timely and local access to healthcare providers in accordance with policy provisions or state and/or federal requirements. Example: A health plan network that is not in accordance with requirements mandated by statute and/or regulation related to a network adequacy.	New	
XXXX	Inadequate Provider Credentialing / Monitoring	Failure to ensure that contracted providers are properly licensed and practicing within the scope of their license and at the contracted location.	New	
XXXX	Inadequate Safeguards for Security of Data & Information	Failure to adequately preserve the privacy of confidential or sensitive information. This would include but not be limited to, improper disclosure within a regulated entity, failure of procedures to maintain the integrity of company information stored in electronic or other media, failure to provide appropriate privacy disclosures to consumers, or to notify consumers of security breaches. Example: Failure to maintain adequate information controls, data backup and recovery systems, or to restrict access to sensitive information.	New	
XXXX	Inadequate Utilization Review Practices / Procedures	Improper procedures or practices associated with monitoring the use, delivery, or efficiency of medical services by insureds.	New	

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Code	Code Name	Definition	Code Status	Notes
XXXX	Quality Assurance Violation	Inappropriate or inadequate procedures or practices associated with conducting quality assessments and improving health outcomes, including adequately communicating such procedures to health care providers.	New	
XXXX	Other Operations & Management Issue*	Any other management and operations issue not described by any other reason code and/or combination of reason codes.	New	

Policyholder Service

Code	Code Name	Definition	Code Status	Notes
2020	Policyholder Service	Finding of cause resulting from a company's service to owners of insurance policies, including complaints, customer service, claims or any other service.	Delete	Proposed alternative: use new, more specific code(s) related to policyholder service
XXXX	COBRA Non-compliance	Improper documentation of eligibility for group health insurance coverage.	New	
XXXX	HIPPA Non-compliance	Improper handling of private electronic claims records or other patient information.	New	
XXXX	Improper Processing of Free Looks	Failure to remit a full refund if a policy is returned with required timeframes; or to adhere to any other free-look provisions prescribed by the policy or by statute or regulation.	New	
XXXX	Improper Processing of Nonforfeitures	Failure to secure a policyholder's interest in a policy in the event the policy lapses, in accordance with policy provisions or statute and/or regulation.	New	
XXXX	Improper Processing of Reinstatements	Differential treatment of similarly situated individuals with respect to reinstatement rights provided under the policy or as required by state law or regulation.	New	
XXXX	Premium / Billing Notices Inadequate / Not Timely / Not Provided	Failure to provide billing notices and/or notify consumers of premiums due within timeframes established by statute and/or regulation. This would include instances where billing notices are inadequate and/or did not contain information required by statutes and/or regulations.	New	
XXXX	Other Required Notification / Correspondence Inadequate / Not Timely / Not Provided	Failure to make any other required notification and/or made the notification in a timely manner. This would include instances where notices are inadequate and/or did not contain information required by statutes and/or regulations.	New	
XXXX	Reasonable Attempts to Locate Policyholder Not Made	No reasonable attempt was made to locate policyholders or beneficiaries.	New	
XXXX	Other Policy Holder Service Issue*	Any other policyholder service issue not described by any other reason code and/or combination of reason codes, including but not limited to a failure to provide notification of changes in customer service telephone numbers or locations, failure to promptly answer telephone calls or electronic inquiries, or failure to clearly identify the name of the underwriter on correspondence.	New	

Producer Licensing

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Code	Code Name	Definition	Code Status	Notes
2026	Premium Finance Act Violation	Finding of cause resulting from non-compliance with the premium finance act, including but not limited to licensing, record-keeping, policy notices and contractual charges.	Delete	Used by 4 states, 5 times. Proposed alternative: use appropriate "other" code
2027	Surplus Lines Violation	A producer committed a violation of statutes and/or regulations related to surplus lines business.	Keep	
2030	Failure to Meet Continuing Education Requirements	A producer failed to meet the mandatory continuing education requirements. This would also include instances where the producer failed to maintain one or more qualifications to hold a license.	Keep	
2032	Continuing Education Requirements Met	A producer deficient in respects to meeting mandated continuing education requirements is now compliant. This would also include instances where the failure to maintain a qualification required to hold a license has been rectified.	Keep	
2037	Failure to Notify Department of Address Change	A producer failed to notify the department of a change in address in accordance with statutes and/or regulations. This would include instances where the producer failed to notify the department in a timely manner.	Keep	
2042	Failure to Pay Child Support / Student Loans	A producer license was denied, suspended, or revoked due to the producer failing to pay child support and/or student loans.	Code Name Change	Previous Code Name "Failure to Pay Child Support"
2055	Producer / Adjuster / Other Not Properly Licensed	A producer is not properly licensed to transact business for a given line of insurance; or adjuster not properly licensed according to statute or regulation.	Code Name Change	Previous Code Name "No License"
2056	Demonstrated Lack of Fitness or Trustworthiness	Action taken on a producer license due to a demonstrated lack of fitness and/or trustworthiness. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2058	Misstatement on Application	Action taken on a producer license due to a misstatement on the application. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2059	Failure to Make Required Disclosure on Application	Action taken on a producer license due to the failure to make a required disclosure on the application. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Code Name Change	Previous Code Name "Failure to Make Required Disclosure on application"
2060	Producer / Adjuster / Other Not Properly Appointed	A producer or adjuster is not properly appointed to an insurer as required by statute or regulation.	Code Name Change	Previous Code Name "Not Appointed"
2061	Selling for Unlicensed Insurer	A producer solicited on behalf of an unlicensed insurer.	Keep	
2062	Allowed Business from Agent Not Appointed / Licensed	Finding of cause resulting from an insurer accepting policy applications from producers at a time when they were not licensed or under appointment with that insurer as required by the state's laws and the company's requirements.	Delete	Proposed alternative: (2055) "Producer / Adjuster / Other Not Properly Licensed" and/or (2060) "Producer / Adjuster / Other Not Properly Appointed"
2063	Employed Unlicensed Individuals	Finding of cause resulting from employees of a producer or insurer conducting the business of insurance without required authorization or license from the Department of Insurance.	Delete	Proposed alternative: (2055) "Producer / Adjuster / Other Not Properly Licensed"
2064	Paid Commission to Un-appointed Agents	Finding of cause resulting from an insurer or producer providing payment or sharing of commissions to producers who are not	Delete	Proposed alternative: (2060) "Producer / Adjuster / Other Not Properly Appointed"

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Code	Code Name	Definition	Code Status	Notes
		appointed with the issuing insurer.		
2097	Bail Bond Forfeiture Judgment	Action taken on a producer license was due to a bail bond forfeiture judgment. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2075	Failure to Report Other State Action	Action was taken on a producer license due to the failure to report an action taken by another state. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2104	Failure to Remit Premiums to Insurer	A producer failed to remit premiums to an insurer.	Keep	
2105	Misappropriation of Premium	A producer misappropriated premium.	Keep	
2106	Forgery / Fraud	A producer committed forgery and/or fraud. This would include, but not be limited to, forgery of an insurance application, providing false evidence insurance, misrepresentation to insurer to obtain policy benefits and/or commission, and other acts of dishonest or fraud. Example: Misrepresentation to insurer to obtain a life insurance policy with the intent to sell interests in the proceeds.	Code Name Change	Previous Code Name "Forgery"
2107	Criminal Record / History	Action taken on a producer license due a criminal record and/or history. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2108	Criminal Proceedings	Action taken on a producer license due to criminal proceedings. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
XXXX	Producer / Adjuster Not Properly Terminated	Failure to adhere to all statutes and regulations regarding the termination of a producer, such as notification requirements to both the producer and the relevant regulation bodies.	New	
XXXX	Other Producer / Adjuster Licensing Issue*	Any other violation with respect to licensure and appointment of producers or adjusters not described by any other reason code and/or combination of reason codes.	New	
XXXX	Failure to Account for Premium Funds	Failure to maintain records showing the deposit, handling, and proper remittance premium funds.	New	
XXXX	Failure to Maintain Separate Fiduciary Account	Failure to create a fiduciary account for the deposit and remittance of premiums separate from agency operating funds.	New	
XXXX	Commingling of Premiums with Personal Funds	Failure to keep premium funds separate from personal funds.	New	
XXXX	Other Fiduciary/Accounting Violation*	A fiduciary violation not included in an above category, not described by any other reason code, or combination of reason codes	New.	

Underwriting & Rating

Code	Code Name	Definition	Code Status	Notes
2005	Underwriting	Finding of cause resulting from the process of selecting, classifying, and rejecting risks in order to assign appropriate rates to insureds.	Delete	Proposed alternative: use new, more specific code(s) related to underwriting
2050	Rate Violation	Finding of cause resulting from use of premium rates not filed with the Department of Insurance,	Delete	Proposed alternative: use new,

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Code	Code Name	Definition	Code Status	Notes
		or not aligned with rates that have been filed, or use of inadequate procedures to determine premium rates.		more specific code(s) related to rating violations
XXXX	Inadequate or Excessive Rate	Rates are either excessive or inadequate in relation to expected exposure presented by the risk and/or expected losses, as defined by statute and/or regulation.	New	
XXXX	Incorrect Application of Rate	Actual rates charged deviate from the insurer's established rates or rating plan. This would include, but not be limited to, instances where rates charged are not in accordance with state mandates, filed, do not adhere to filings, and/or improper documentation of modifications exists. Example: Inconsistent application of scheduled rating plan across eligible risks.	New	
XXXX	Rates Not Filed / Approved	The use of rates that have not been filed or approved by the state insurance department as required by statute or regulation.	New	
XXXX	Rates Unfairly Discriminatory	Like risks are charged different rates in a way not justified by expected loss costs.	New	
XXXX	Use of Prohibited Rating Factors	Use of factors for rating prohibited by statute or regulation.	New	
XXXX	Other Rating Issue*	Any improper rating practice not described by any other reason code and/or combination of reason codes.	New	
2053	Forms Not Filed &/or Approved	The use of insurance forms that have not been properly filed or approved by the appropriate regulatory authority.	Code Name Change	Previous Code Name "Use of Unapproved Forms"
XXXX	Improper Question on Application	Insurance application contains improper questions or otherwise not in accordance with applicate statutes and/or regulations.	New	
XXXX	Mandated Coverages / Offerings Not Provided	Failure to provide coverage for benefits required by statute or regulation. This would include, but not be limited to, using forms that do not comply with statutes and/or regulations regarding mandated and/or required coverages.	New	
XXXX	Other Forms Issue*	Any other form violation not described by any other reason code and/or combination of reason codes.	New	
2003	Cancellation / Non- Renewal Notice Inadequate / Not Timely / Not Provided	Notice of the termination of coverage was not issued, was not issued within timeframes prescribed by statute or policy provisions. This would include instances where notices are inadequate and/or did not contain information required by statutes and/or regulations.	Code Name Change	Previous Code Name "Failure to Send Required Cancellation / Non-Renewal Notice"
XXXX	Mandatory Disclosures / Notifications Inadequate / Not Timely / Not Provided	Improper issuance of disclosures or notifications, in violation of policy provisions, statute, or regulation. This would include notices of mandated coverage, disclosure of preexisting condition exclusions, or disclosure that credit insurance is optional and not a condition for loan approval. It does not include cancellation or nonrenewal notices, which have a separate code.	New	
XXXX	Unfairly Discriminatory Underwriting Practices / Procedures	Underwriting practices that treat like risks differently and violate statutes and/or regulations regarding the fair treatment of risks.	New	

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Code	Code Name	Definition	Code Status	Notes
XXXX	Other Cancellation / Nonrenewal / Recession Issue*	Any other improper termination of coverage not described by any other reason code and/or combination of reason codes. Example: Rescissions made for non-material misrepresentations.	New	
XXXX	Declination Notice – Inadequate / Not Timely / Not Provided	Failure to issue notify an applicant or failure to timely notify an applicant that coverage is rejected as required by statute and/or regulation. This would include instance where notices where inadequate and/or did not contain information required by statutes and/or regulations.	New	
XXXX	Other Declination Issue*	Other inappropriate declination not described by any other reason code and/or combination of reason codes. Example: Failure to adhere to internal underwriting guidelines.	New	
XXXX	Other Underwriting Issue*	Any other violation related to the determination of eligibility for coverage, not described by any other reason code and/or combination of reason codes.	New	

Miscellaneous

Code	Code	Definition	Code Status	Notes
2007	Market Conduct Examination	Finding of cause resulting from examination of the business practices and operations of an entity in order to determine its compliance with state insurance laws and regulations.	Delete	Describes origin of action Proposed alternative: (1030) "Market Conduct Exam" Origin of Action code and select the appropriate Reason Code(s) that apply to underlying reason for the action.
2074	Other States Action	Finding of cause resulting from another state's Department of Insurance activity about an issue which also affects the entering state.	Delete	Describes origin of action Proposed alternative: (1015) "Other States Action" Origin of Action code and select the appropriate Reason Code(s) that apply to underlying reason for the action.
2029	Unfair Insurance Practices Act Violation	Finding of cause resulting from unfair methods of competition or deceptive acts being used, from this Act or the Unfair Trade Practices Act as applied to the business of insurance.	Delete	Proposed alternative: use new, more specific code(s) related to unfair insurance practices
2035	Failure to Cooperate with Examination / Investigation / Inquiry	Other failure to cooperate with an examination or investigation. This would include, but not be limited to, failure to respond to appropriate requests for information and/or providing inaccurate or misleading information.	Code Name Change	Previous Code Name "Failure to Respond" If the issue is late or incomplete response, then use 2036.
2036	Late or Incomplete Response	Failure to respond timely and/or failure to provide a complete response in response to a request for information. This would include, but not be limited to failure to submit timely and complete mandated filings such as statistical reports and annual reports.	Keep	

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Code	Code	Definition	Code Status	Notes
2038	Failure to Comply with Previous Order	Failure to comply with an order pertaining to corrective action, as determined by a follow-up examination, investigation, or other means.	Keep	
2040	Failure to Timely File	Failure to make a filing in a timely manner.	Keep	
2085	Failure to Pay Tax	Failure to pay tax.	Keep	
2087	Failure to Pay Fees	Failure to pay fees.	Keep	
2090	Failure to Pay Fine	Failure to pay fine.	Keep	
2095	Failure to Pay Assessment	Failure to pay an assessment.	Keep	
2103	Fiduciary Violation	Finding of cause resulting from producers violating positions of trust in relation to insurers and policyholders.	Delete	Proposed alternative: use new, more specific code(s) related to fiduciary violations
2110	Reconsideration	The Department of Insurance has re-evaluated a Regulatory Action because of new information received or because the entity has corrected the cause of action.	Keep	
2115	Other Miscellaneous*	Any other reason not described by any other reason code and/or combination of reason codes.	Code Name Change	Previous Code Name "Other* (enter up to 100 char)"

*If checked, you must enter a description of up to 100 characters.

**If code (2112) is checked, please enter the name of the Military Base in the '(xxxx) Other Marketing & Sales Issue*' box.

Disposition for Action (Revised)

The Disposition field is meant to provide information about the disposition (outcome) of the regulatory action. The code(s) used should be reflective of the outcome of the action. In other words what happened as a result of the action. Information about the reason (allegations) and/or origin (source) of the action should be reported in those respective fields. (max 4)

Code	Code Name	Definition	Code Status	Notes
3001	License, Denied	The entity or individual applied for a new license or attempted to renew a license and it was denied	Keep	
3003	License, Suspended	The entity or individual's license was suspended. The entity or individual is temporarily prohibited from engaging in the business of insurance.	Keep	
3004	License, Cancelled	The entity or individual's license was cancelled.	Keep	
3006	License, Revoked	The entity or individual's license was revoked; The entity or individual is prohibited from engaging in the business of insurance.	Keep	
3009	License, Probation	The entity or individual's license is subject to a probationary period during which the entity or individual is obligated to comply with certain standards and/or conditions specified by the issuing authority or the license can be cancelled, revoked or suspended.	Keep	
3010	License, Conditional	The entity or individual's license is issued on a conditional basis under which the entity or individual must meet certain standards and/or conditions specified by the issuing authority before an unrestricted license can be issued. Failure to meet the conditions may result in license being cancelled, revoked, or suspended by the issuing authority.	Keep	
3011	License, Supervision	The entity or individual's license is under supervision of the issuing authority and the	Keep	

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Code	Code Name	Definition	Code Status	Notes
		entity or individual is subject to a formal supervisory plan regarding a hazardous financial condition or non-compliant business practice. Failure to comply with the supervisory plan may result in the license being cancelled, revoked, or suspended by the issuing authority.		
3012	License, Reinstatement	The license of an entity or individual was reinstated.	Keep	
3013	License, Granted	A license was granted to an entity or individual as a result of an administrative process regarding a prior action to deny, cancel or revoke a license.	Keep	
3014	License, Surrendered	The entity or individual's license was ordered to surrender the license.	Keep	
3015	License, Voluntarily Surrendered	The entity or individual's license was voluntarily surrendered by the entity or individual. This disposition is typically associated with situations where the entity or individual agreed to voluntarily surrender the license in lieu of the issuing authority pursuing additional administrative action.	Keep	
3016	License, Other*	Any other disposition related to an entity or individual license not described by any other disposition code or combination of codes.	Keep	
3021	Certificate of Authority, Denied	The entity's application for a certificate of authority or an expansion of an existing certificate of authority was denied by the issuing authority.	Keep	
3023	Certificate of Authority, Suspended	The regulated entity's certificate of authority was suspended for a specific time period. During this time period, the entity is prohibited from engaging in the business of insurance in the affected jurisdiction.	Keep	
3025	Certificate of Authority, Suspension Extended	The suspension of regulated entity's certificate of authority was extended beyond the initial suspension period. The temporary prohibition from engaging in the business of insurance in the affected jurisdiction is continued.	Keep	
3026	Certificate of Authority, Revoked	The regulated entity's certificate of authority was revoked. The entity prohibited from engaging in the business of insurance in the affected jurisdiction.	Keep	
3028	Certificate of Authority, Expired	The entity failed to take the appropriate action to renew or continue its certificate of authority.	Keep	
3029	Certificate of Authority, Probation	The regulated entity's certification of authority is subject to a probationary period during which the entity is obligated to comply with certain standards and/or conditions specified by the issuing authority or the certificate of authority can be cancelled, revoked or suspended.	Keep	
3031	Certificate of Authority, Reinstated	The regulated entity's certificate of authority was reinstated.	Keep	
3034	Certificate of Authority, Surrendered	The entity surrendered its certificate of authority.	Keep	
3036	Certificate of Authority, Other*	Any other disposition related to a certificate of authority not described by any other disposition code or combination of codes.	Keep	
3042	Cease and Desist from Violations	The entity was ordered to cease and desist	Keep	

NAIC National Association of Insurance Commissioners

Code	Code Name	Definition	Code Status	Notes
		from engaging in specific activities that are not compliant with insurance statutes, rules, and/or regulations of the issuing jurisdiction.		
3043	Cease and Desist from all Insurance Activity	The entity or individual was ordered to cease and desist from engaging in the business of insurance.	Keep	
3044	Remedial Measures Ordered	The entity or individual was ordered to take specific action in order to remediate a situation which caused harm to one or more persons as a result of one or more acts taken by the entity or individual.	Keep	
3045	Consent Order	The entity or individual entered into a voluntary agreement in order to resolve the issue regulatory issue that is the subject of the action.	Keep	
3046	Stipulated Agreement/Order from a commissioner	The entity or individual entered into a stipulated agreement which was approved via a formal process (i.e. approved by an administrative law judge or hearing examiner) in order to resolve the issue regulatory issue that is the subject of the action.	Keep	
3047	Previous Order Vacated / Stayed / Set Aside	A previous order under which the entity or individual was subject has been set aside, nullified, cancelled, or rescinded. Or an order that postpones or suspends a previous order.	Code Name Change	Previous Code Name “Previous Order Vacated”
3048	Ordered to Provide Requested Information	The entity or individual has been ordered to produce information requested by the jurisdiction under its statutory authority.	Keep	
3049	Stayed Order	The Department of Insurance stops a previously issued order from being put into effect.	Delete	Used by 3 states, 10 times. Proposed alternative: (3047) “Previous Order Vacated / Stayed / Set Aside”
3051	Final Agency Order	The final agency order was issued against the entity or individual.	Keep	
3052	Ordered to Comply with Specific Statute or Regulation	The entity or individual was ordered comply with a specific insurance statute, rule, and/or regulation.	Keep	
3055	Reprimanded / Censured	The entity or individual was formally reprimanded or censured.	Code Name Change	Previous Code Name “Reprimanded”
3060	Hearing Waiver	The entity or individual waived their right to a hearing.	Keep	
3065	Show Cause	An order directing the entity or individual to appear before the reporting jurisdiction to explain why they took or failed to act or why the reporting jurisdiction should or should not grant some relief.	Keep	
3070	Re-exam	The Department of Insurance orders a follow-up examination of an entity to ensure compliance with state laws and regulations.	Delete	Used by 4 states, 11 times. Proposed alternative: (3105) “Other”
3075	Rescission of	The Department of Insurance retracts a previous action or order. An additional Disposition code must be selected to identify what was rescinded. If Other is selected, text explanation must be entered into the Other action disposition field.	Keep	
3076	Involuntary Forfeiture	The Department of Insurance requires the surrender of the authority of an individual or firm to engage in the business of insurance in the state because of a crime, offense, or	Delete	Used by 0 states, 0 times. Proposed alternatives: (3102) “Monetary Penalty” or (3103)

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Code	Code Name	Definition	Code Status	Notes
		breach of contract.		"Aggregated Monetary Penalty"
3078	Restitution	The entity or individual was ordered to pay restitution in order to compensate one or more persons or entities harmed by actions of the regulated or unauthorized entity or individual.	Keep	
3079	Suspended from Writing New Business; Renewals Ok	The entity is prohibited from writing new business. However, it is still permitted to service current policyholders.	Keep	
3080	Supervision	The financial condition of the entity was placed under supervision and being closely monitored by the jurisdiction.	Keep	
3085	Rehabilitation	The entity was found to be financially impaired or insolvent. Action is being taken to restore the impaired or insolvent entity to sound financial standing.	Keep	
3090	Liquidation	The entity was found to be insolvent and unable to become viable. Action is being taken to liquidate the entity.	Keep	
3095	Conservatorship	The entity and its financial condition are being evaluated to determine whether the policyholders and creditors will be best served by liquidation, rehabilitation, or returning the entity to private management.	Keep	
3097	Hearing	A hearing was brought about as are result of the action against the entity or individual.	Keep	
3100	Receivership	The entity was placed into receivership by jurisdiction in which the entity is legally domiciled.	Keep	
3101	Ancillary Receivership	The entity was placed into receivership by a jurisdiction other than the jurisdiction in which the entity is legally domiciled.	Keep	
3102	Monetary Penalty	Monetary fine or penalty imposed on a single entity or individual in a single action for one or more violations of insurance statutes, rules, and/or regulations.	Keep	
3103	Aggregate Monetary Penalty	Monetary fine or penalty imposed on one or more entities or individuals in a single action for one or more violations of insurance statutes, rules, and/or regulations.	Keep	
3104	Settlement	The Department of Insurance negotiates an agreement with an entity without legal action or litigation being undertaken.	Keep	
3105	Other*	Any other disposition not described by any other disposition code or combination of codes.	Keep	

* If checked, you must enter a description of up to 100 characters.

NAIC

Market Information Systems Research and Development (D) Working Group USER form status update

Displaying **31** issues at **23/Jul/21 11:44 AM**.

Key	Request Summary	Date Created	Current Status	Detailed Description	Estimated Effort	Last date Updated	Request Type	Is this linked to a larger effort
MKTG-178	MCAS Reports 2020 - Annual updates	12/1/2020	Closed	Update the MCAS application to reflect changes as approved for 2020		7/23/2021	Business Request	
MKTG-193	MIS - 2020 Annual Updates to Isite reports	12/1/2020	Closed	Update the MCAS reporting suite to reflect changes as approved for 2020		7/23/2021	Business Request	
MCAS-157	MCAS - UPDATE PICS Notification for Correspondence for MongoDB (5/1/21) Writer	10/20/2020	Closed	For 2020 there is a new LOB so we will need to update the PICS application to include Private Flood filings	8	7/23/2021	Business Request	
MCAS-110	Update Correspondence for Private flood due by 5/1	11/17/2020	Closed	For 2020 there is a new LOB so we will need to update the Correspondence application to include Private Flood filings	3	7/23/2021	Business Request	
MKTREGREQ-62	USER form 10082 - Track complaints associated with Pandemic and Business Interruption	7/9/2021	Closed	*What:* This request will allow jurisdictions to track complaints related to pandemic events such as the COVID-19 pandemic. *Who:* Randy Helder (NAIC Staff) on behalf of multiple regulators *When:* No deadline *Why:* In a catastrophic event. business interruption is a critical coverage and may generate many complaints. This request will allow jurisdictions to track business interruption complaints. *Request Date:* 9/25/2018		7/23/2021	Regulator Request	
MKTG-271	MFL-MIS Team Q2 Cloud Migration Work	3/30/2021	Closed	This ticket encompasses all AWS cloud migration tasks as outlined in https://jira.naic.org/browse/ITGP-80 to be completed in Q2.	120	7/23/2021	Technical Request	
MKTREGREQ-38	2021 Updates to MIS Data Analysis Metrics	12/3/2020	In Progress - MIS team has completed several updates to reports that are being reviewed internally and prepared for distribution to the working group	This Epic contains all of the requests as approved by MISTF for 2021. This group of stories will be worked as individual requests and pushed to production as requirements are developed..		7/21/2021	Regulator Request	
MKTREGREQ-57	MFL-MIS Team Q3 Cloud Migration Work	2/19/2021	In Progress - NAIC Teams are actively testing cloud migrations in QA	This ticket encompasses all AWS cloud migration tasks as outlined in https://jira.naic.org/browse/ITGP-122 to be completed in Q3.		7/21/2021	Technical Request	
MKTREGREQ-44	USER form 10051 - Implement MATS service in SBS	2/12/2021	In Progress - SBS and MIS team are coordinating necessary coding changes to complete development. Testing planned for Q3 2021	*What:* Implement MATS Web Service in SBS to Provide SBS Examination module integration for automated submission of information to MATS. *Who:* Regulators that use the SBS Examination module *When:* As soon as possible *Why:* SBS users are duplicating effort by entering information into 2 separate systems that are not in sync *Request Date:* 4/19/2014		6/11/2021	Regulator Request	
MKTREGREQ-50	Separate MCAS from FDR - 2021 work	7/27/2020	Prioritized	As Market Regulation staff we would like to have MCAS running in a system separate from FDR so that we can more quickly and easily modify and test MCAS changes requested by regulators as we move to production. Our current system setup requires that multiple departments coordinate and depend on each other. Those departments include Market Regulation, Financial Services, and ITG.		6/1/2021	Business Request	
MKTREGREQ-40	Phase 1 - MCAS/FDR separation planning	3/11/2020	Prioritized	As NAIC staff we will need to spend time to assess the full scope of the MCAS/FDR separation project, and develop a plan in order to accomplish the task while keeping MCAS available to collect filings and updated yearly as requests are received.		4/29/2021	Business Request	MCAS/FDR Separation - Phase 1
MKTREGREQ-43	MIS Metrics available for Regulator self-service	9/24/2019	Prioritized	We are developing reports that have been generated manually using queries in the past. The vision is to place these reports in iSite+ by data source and allow the State Regulators access as needed.		2/11/2021	Business Request	
MKTREGREQ-51	MCAS MVP for 2021 filing year	2/12/2021	Open	As a Market Regulator I want to be able to collect all MCAS data for data year 2021 by the filing deadline of 4/30/2022.		5/18/2021	Business Request	

MKTREGREQ-66	USER Form 10065 - Provide functionality to access and download data from NAIC systems.	7/16/2021	In Progress	State Ahead – Enterprise Data Asset Management Phase II The next phase of the data governance and data warehouse initiative will leverage the lessons learned in Phase I to build out the architecture and tools needed to increase NAIC and NIPR's ability to make data available to regulators in a timely and cost effective manner and improve our data capabilities. The new AWS data platform will consist of three layers: a Data Lake (raw data) layer to contain all data in its original format, a lightly curated layer where data cleansing and some data structure may be applied to data sets (more geared towards data exploration and machine learning., and a business data layer where data will be highly structured (more geared towards data access and usage by state regulators and NAIC applications). Data stewardship will be applied to the remaining financial and market regulation data sets and those data sets will be loaded to the Enterprise Data Platform for use by other State Ahead projects. Additional data policies, standards, and processes will be created and enhancements to the data architecture and toolsets will be implemented.		7/21/2021	Regulator Request	
MKTREGREQ-67	USER Form 10071 - Redesign and enhance I-SITE reports using interactive data visualization and add data analytics.	7/16/2021	In Progress	State Ahead – Market Regulation Self-Service Dashboard The purpose of this project is to create Tableau dashboards to replace current iSite+ market regulation tools and applications to provide visual representation of the data. This includes reports containing regulatory actions (RIRS data), complaint data (CDS data), MCAS data, financial data, producer data, and antifraud data. Finally, this project will help ensure NAIC staff continues to provide the necessary support to the NAIC members for the ongoing development of MCAS blanks and market analysis.		7/21/2021	Regulator Request	
MKTREGREQ-65	USER Form 10047 - Add option to display data by group code.	7/16/2021	In Progress	State Ahead – Market Regulation Self-Service Dashboard The purpose of this project is to create Tableau dashboards to replace current iSite+ market regulation tools and applications to provide visual representation of the data. This includes reports containing regulatory actions (RIRS data), complaint data (CDS data), MCAS data, financial data, producer data, and antifraud data. Finally, this project will help ensure NAIC staff continues to provide the necessary support to the NAIC members for the ongoing development of MCAS blanks and market analysis. This project will replace the Financial MAPT. The Tableau version of the Financial MAPT will likely include filtering by group code. The Market Conduct Data Improvements (MAPT) Phase II State Ahead project addresses the ability to review MCAS data by group.		7/21/2021	Regulator Request	
MKTREGREQ-33	USER Form 10054 - Support for Attachments: Facilitate submission of supporting documentation.	9/5/2019	Prioritized	*What:* Describing WHAT the user is requesting. *Who:* Describing WHO this request will impact *When:* Describing WHEN this request is required (if there's a deadline) *Why:* Describing WHY this request is needed, including why it's important to more than one jurisdiction. This should also include what happens if this request is not approved. *Request Date:* 4/9/2014 As per the MIS Task Force State Survey Project Action Plan #23: Support for Attachments: Facilitate submission of supporting documentation. (ex: orders) USER Form 10021: Allow entry of multiple state regulatory actions in RIRS. (added 3/20/13)		6/11/2021	Regulator Request	
MKTREGREQ-34	USER Form 10075 - MAPT Add Overall Score, National Score etc. to MAPT	9/5/2019	Prioritized	*What:* The Market Analysis Prioritization Tool (MAPT) currently provides three years (CY, PY & PY1) of the underlying data relied upon for each of the main component and subcomponent scores and the CY Overall Score, National Score and State Score. To assist in trending analysis of the data during the baseline process, we would also find it useful if the MAPT reports included the current year and previous two years of the Overall Score, National Score, and State Score, as well as the main component and sub-component scores. This request is similar to USER Form 10067 regarding the creation of an MCAS Ratio Trend Report; *Who:* Cheryl Hawley - AZ *When:* As soon as possible *Why:* Making technical changes to the MAPT reports or creating a new MAPT Scoring Report will allow users to have three years of scoring data available through one source rather than having to save the PY & PY1 data while it is available on iSite+ and then merging it with the CY data for analysis of trends and patterns to identify potential areas for improvement and/or concern. *Request Date:* 11/9/2016		6/11/2021	Regulator Request	

MKTREGREQ-37	USER Form 10077 - MAPT allow a user to select a new function "All Policy" to kick off all (18) reports.	9/5/2019	Prioritized	*What:* The data available in this report (Market Analysis Market Share Search Criteria) is not available through any other search tool at the level of detail (Policy Type). Please see attached Excel file. Please give me a call if you need more information. Either have an “All Policy Types” option or have the option to highlight more than one policy type (which is available in other reports). *Who:* Ibrahim Al-Hajiby (MN) - All state regulators who access MAPT *When:* Describing WHEN this request is required (if there’s a deadline) *Why:* I currently have to go run 18 different reports and compile them manually which is time consuming and increases chances of error. *Request Date:* 4/24/2017	320	6/11/2021	Regulator Request	
MKTREGREQ-46	USER form 10081 - Make MCAS data available in MAPT	2/12/2021	Prioritized	*What:* Make MCAS data available in MAPT to make it easier to access all of the relevant state's data *Who:* Cheryl Hawley (AZ) *When:* No deadline *Why:* Easier access to all of a state’s data to conduct effective and efficient analysis; saves time and more efficient/effective use of limited resources *Request Date:* 3/6/2019		7/16/2021	Regulator Request	
MKTREGREQ-41	USER form 10053 - Review of RIRS codes	2/11/2021	Prioritized	*What:* Review of RIRS codes by the RIRS Code Review Working Group to clarify definitions for consistent usage and provide recommendations for revisions. *Who:* All states. *When:* No deadline *Why:* Modernizes outdated reporting of regulatory actions / addresses known issues. *Request Date:* 4/9/2014		7/21/2021	Regulator Request	
MKTREGREQ-45	USER form 10080.1 - Update action date on systems participating report	2/12/2021	Preliminary Review	*What:* The Earliest Action Date on the Regulatory Systems Participating State Report Is Misleading, can we help to provides better context and understanding of the data available *Who:* Rachel Cloyd (TX) - All regulators who use RIRS *When:* No deadline *Why:* Provides better context and understanding of the data available *Request Date:* 9/25/2018		7/9/2021	Regulator Request	
MKTREGREQ-61	USER form 10080.4 - Define RIRS data dictionary	7/9/2021	Preliminary Review	*What:* Create/Update a RIRS data dictionary. *Who:* Rachel Cloyd (TX) - All regulators who use RIRS *When:* No deadline *Why:* Provides better context and understanding of the data available *Request Date:* 9/25/2018		7/9/2021	Regulator Request	
MKTREGREQ-47	USER form 10066 - MARS Merge Level 1 & 2 reviews	2/12/2021	Preliminary Review	*What:* Merge MARS Level 1 and MARS Level 2. *Who:* MAP (D) WG - Teresa Cooper NAIC *When:* This will happen with the rewrite of MARS *Why:* The Market Analysis Review System (MARS) will be redesigned to combine MARS Levels 1 and 2 into a single level designed to provide a more focused review of a company and still allow an analyst access to all the relevant data available to a company in the market information systems databases *Request Date:* 11/6/2015		6/11/2021	Regulator Request	MARS Rewrite
MKTREGREQ-48	USER form 10074 - Allow user comments to be added to level 1 review	2/12/2021	Preliminary Review	*What:* Allow for comments to be added to a Level 1 review after it has been approved. *Who:* John Haworth (WA) *When:* This will happen with the rewrite of MARS *Why:* Current system constraints do not allow comments to be added once the level 1 review has been approved. We would like to be able to do this. *Request Date:* 9/20/2016		6/11/2021	Regulator Request	MARS Rewrite
MKTREGREQ-49	USER form 10078 - Add links for reviewer	2/12/2021	Preliminary Review	*What:* Add links for reviewer. *Who:* Tom Whitener (WV) *When:* This will happen with the rewrite of MARS *Why:* ??? *Request Date:* 4/24/2017		6/11/2021	Regulator Request	MARS Rewrite

MKTREGREQ-36	USER Form 10043 - MARS - import average industry loss and expense ratio to MARS Level 1 question 11a and 11b	5/15/2018	Preliminary Review	*What:* As a user I want the MARS level 1 Review to populate question 11a and 11b with the data I am asked to review so that I can be more efficient in completing reviews. When completing a Level 1 review, analysts are asked to compare the company's loss and expense ratios to the industry average. Question 11a asks for the comparison on a national level, and Question 11b asks for the comparison on a state level. However, the industry averages are not provided for comparison. There is a link to the company's Exhibit of Business report, which provides the national average industry loss ratio, but does not provide the state average. *Who:* Randy Helder *When:* No deadline *Why:* Modernizes outdated reporting of regulatory actions / addresses known issues. *Request Date:* 2/24/2014		6/11/2021	Regulator Request	MARS Rewrite
CIS-391	USER Form 10083.1 - Add Subject Codes to CIS Complaints by Code	8/14/2020	Prioritized	Under Construction because the committee is still working on requests involving Subject Codes As a member of the Working Group, I want to be able to display complaints tied to the new Pandemic Subject Code so that consumers can be more informed. The Pan Subject Code stands for Pandemic. There are eight other Subject codes that are also available for display - see attachment. Need sign off from Chris & revisit this with Lois	13	7/23/2021	Regulator Request	
MKTREGREQ-63	USER Form 10083.2 - Add subject codes to iSite Reports	7/16/2021	Prioritized	As regulators we would like to see Subject Codes in the CDS iSIte+ reports. * For iSite+ this would require a code change for each report that we wanted to display Subject Codes on. Subject Code is available in the data source currently used to generate the CDS reports. The effort to display Subject Code on selected iSite+ reports would be a *small to medium* effort. * For estimation purposes we expect to add the ability to select Subject Code as a value to be reported on to the Closed Complaint Counts By Code Criteria page, Closed Complaints Counts By State, and Closed Complaint Trend criteria pages. Additionally we would add the ability to select and display the Subject Code to the criteria and results page for the Detailed report. *Note*: this request may be fulfilled by changes to newly developed CDS dashboards.		7/16/2021	Regulator Request	
MKTREGREQ-64	USER Form 10083.3 - Develop a new CDS Summary Report.	7/16/2021	Prioritized	As regulators we would like to see a new CDS Summary Report. * ** This request would require the creation of a new report. The information required to create this report is available. The effort to create this report would be *medium*.		7/16/2021	Regulator Request	
MARS-318	MARS Rewrite	12/12/2019	New	The Market Analysis Review System(MARS) will be redesigned to combine MARS Levels 1 and 2 into a single level designed to provide a more focused review of a company and still allow an analyst access to all the relevant data available to a company in the market information systems databases. The rewrite will also provide more visualization of the data through the use of Tableau.		7/16/2021	Regulator Request	