COMMENTS
Anti-Rebating Draft NAIC Model Unfair Trade Practices Act (Model #880) Amendments

American Bankers Association Office of Insurance Advocacy (ABAOIA)
American Council of Life Insurers (ACLI)
America’s Health Insurance Plans (AHIP)
American InsurTech Council (AITC)
American Property Casualty Insurance Association (APCIA)
California Department of Insurance
Center for Economic Justice
Idaho Department of Insurance
Locke Lord LLP
National Association of Mutual Insurance Companies (NAMIC)
National Association of Professional Insurance Agents (PIA National)
Nevada Division of Insurance
Oregon Department of Consumer and Business Services
Paul Zuckerman Consulting, LLC
Risk Management Society (RMS)
The Council of Insurance Agents and Brokers (“The Council”)
Washington State Office of the Insurance Commissioner

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August 27, 2020

Commissioner Jon Godfread  
Chair, NAIC Innovation & Technology Task Force  
1100 Walnut St  
Suite #1500  
Kansas City, MO 64106

Re: Task Force Request for Comments on Anti-rebating Revisions to Model #880  
Comments of American Bankers Association/Office of Insurance Advocacy/Second Draft of the Revisions

Dear Commissioner Godfread:

We provide these comments on behalf of the American Bankers Association Office of Insurance Advocacy (“ABAOIA”) to the Innovation & Technology Task Force concerning the second draft of the proposed revisions to the NAIC’s Model Unfair Trade Practices Act, dated 8/10/2020 (the “Model Act”). The ABAOIA advocates for bank-owned insurance agencies.

The ABAOIA notes one change of concern from the earlier draft with respect to what are often called “value-added services,” services that add value to the insurance relationship. Specifically, Section H.(2)(e)(1) has been changed as follows, showing the original wording in strikeout and the substituted wording in boldface: Insurers and producers are permitted to offer “value-added non-cash products or services at no or reduced costs when such products or services are not specified in the policy of insurance if the product or service. . . .”

We believe the original wording, “value-added products or services” that was used in that phrase, is more appropriate, and that the substitution of the phrase “non-cash” for the original wording would be a step backward. With respect to anti-rebating/anti-inducement statutes and what they permit, there are two categories of products and services. The first category, non-cash products or services, normally describes promotional, advertising or similar items that an insurer or producer gives in connection with marketing an insurance product. Section H.(2)(f)(1) generally describes this category as “non-cash promotional or advertising items or meals to or charitable donations on behalf of a client. . . .”

The other category, value-added products or services, describes products or services an insurer or a producer provides at no cost or at a discount that are designed to enhance an existing relationship with an insured. Section H.(2)(e)(1) generally describes these as products or...
services that relate to particular insurance coverage and that satisfy one or more of several listed criteria. For example, Louisiana’s Advisory Letter No. 2015-01 (Revised March 14, 2017) uses the phrase “value-added” this way: “The term ‘value-added’ services necessarily implies that the services offered to a party do in fact add value to a prior, ongoing, future, or continual purchase or other agreement between a buyer and seller of goods.” (Emphasis added.) And a 2019 West Virginia Information Letter (No. 205) recognizes the distinction between value-added products or services and non-cash gifts or advertising: “[T]he [Commissioner] believes that providing a good product or service that adds value to the type of insurance offered is distinct from providing a policyholder with unrelated benefits or merchandise such as tickets to a concert or sporting event, televisions, coolers, BBQ grills or restaurant gift cards.” (Emphasis added.)

Several other state insurance regulators are on record as using the phrase “value-added” when describing what is and is not permitted by an anti-rebating statute: Iowa Insurance Bulletin No. 08-15 (Sept. 30, 2008); Maine Bulletin 426 (Oct. 25, 2017), which interprets 24-A M.R.S. 2163-A(2); Missouri Insurance Bulletin 10-07 (Nov. 5, 2010); New Hampshire Bulletin INS No. 12-005-AB (Jan. 18, 2012); and New York Circular Letter No. 9 (Mar. 3, 2009).

In summary, the term “value-added” services is a term that is commonly understood in the insurance arena to describe products or services that add value to the insurance relationship. Therefore, we urge the task force to reverse the change in Section H.(2)(e)(1).

Additionally related to value-added services, we request that the task force re-consider the addition of the following language as a new Section H.(2)(e)(9), to permit value-added services that:

“(9) Arise out of the relationship between the producer and/or insurer and a commercial or institutional insured where the nature of the relationship and the compensation arrangement are memorialized in writing.”

As we said during the July 23 task force meeting, the addition of this language would recognize that when it comes to commercial or institutional insureds, the parties may want to enter in to an arrangement whereby an insurer or an insurance broker can offer the client a beneficial product or service that is specifically tailored for the client – one that might otherwise go beyond what would be permitted by the currently proposed additions to Section H.(2)(e).

Thank you and the members of the Task Force for considering these comments. We look forward to the next call of the task force to discuss these issues.

Very truly yours,

Chrys D. Lemon
Jeffrey M. Klein

cc.: Denise Matthews
August 28, 2020

Elizabeth Kelleher Dwyer, Esq.
Superintendent of Financial Services
1511 Pontiac Avenue
Cranston, RI 02920
(sent via email to Denise Matthews)

Dear Superintendent Dwyer:

On behalf of the American Council of Life Insurers, thank you for your continued leadership toward modernizing the anti-rebating provisions of NAIC Uniform Unfair Trade Practices Act (UTPA). ACLI is supportive of the current exposure draft, although we do have a set of questions/concerns that we hope can be addressed before completion of the model. These are set forth immediately below.

ACLI Questions & Concerns Regarding the 8/7/20 Draft UTPA (Model #880) Language Addressing Rebating

Section (e)(1): Replacement of “value added” products and services with “non-cash” products and services

We understand the fact that because the term “value added” is not defined in the draft it is better to replace it with the term “non-cash”. However, “value added” is a term that is used by a number of states, and the term “non-cash” is presently undefined as well. A specific question/concern we have is the allowance for gift and other value cards, which are used by some companies. The term “non-cash” could be interpreted as disallowing this practice.

Recommendation: either go back to the term “value added”, clarify that “non-cash” does not preclude gift or value cards, or simply do not use a term at all and let the rest of Section e define what products and services are allowable.
Section (e)(2): Information regarding assistance with certain products and services

We understand this section to be directed toward products and services provided by third-parties, and the understandable requirement that the insurer provide some information about its role in this fact pattern. It is unclear where this information can be provided, and this could lead to compliance challenges.

**Recommendation:** Clarify where this information is to be provided, with a view toward flexibility. For example, by inserting the phrase "in the marketing materials or other location accessible to the client."

Section (e)(4) Accessibility to all clients.

We believe this section as drafted is somewhat confusing. The term “fair” is troubling as it is largely subjective and can mean many different things based on the context of its use. The term “risk characteristics” seems misplaced here—this is not an underwriting provision, and in addition it could lead to the mistaken conclusion that risk characteristics is the only objective criteria by which distinctions can be made among policyholders. While it is true that not “all” clients may be offered the same product or service, there are myriad reasons why this may be the case. For example, an insurer may offer a product or service only to new clients, or only to new clients that purchase a particular type of coverage, or only to groups of a certain size or geographic area. We understand an insurer should not be able to pick and choose who receives a product or service in an arbitrary or discriminatory way, but as long as a reasonable and objective criteria is documented that should suffice.

We also have a question regarding the form that the written criteria should take. We are presuming that written criteria kept by the insurer and available for review if requested suffices, but clarifying this would be helpful.

**Recommendation:** Remove the terms “fair” and “risk characteristics”. Insert the phrase “in a particular” class after clients in the first sentence. This will help clarify that those grouped in a particular class must not be treated in a discriminatory manner, and that criteria must be objective and written. In addition, clarification that internal written criteria satisfies record-keeping compliance.

Section (e)(6) Reasonable Cost

Our concern here is with individual client vs aggregate cost. Life insurers typically do not allocate the cost of a benefit to each policyholder—it would be very burdensome to do so. Rather, benefits are calculated with respect to a class of policyholders or some other logical grouping. In addition, some beneficial product or service (e.g., grief counseling) may be disproportionately expensive relative to the premium paid by a single policyholder, because very few will access the product or service. If looked at as a cost spread over a class or group the cost is not disproportionate to the premium at all.

**Recommendation:** We would urge removal of this section as it does not in our view provide any meaningful consumer protection, and it could be interpreted in a troubling manner. At a minimum, we suggest adding that the cost comparison may be done in “an aggregate manner.”
The above recommendation applies to an identical concern we have with Section (f)(2) as it relates to comparing costs to premiums on a policyholder basis. Our preference would be to revert back to the Section (f)(2) language from the prior draft.

Section (e)(7) Improved Accuracy and Efficiency

We strongly support this section as currently drafted. We do suggest, however, expanding this section to also allow for improved accuracy, timeliness, consumer ease and efficiency. As follows:

Incent behavioral changes that improve the health or reduce the risk of death of the insured, or that improve accuracy, timeliness, customer ease, or efficiency in the administration of the insurance coverage; or

Section (e)(8) Underlying Policies/Member Benefits

We are concerned that the term “underlying” here is too restrictive, by potentially prohibiting services that assist in administration of the insurer’s own policies but could also help in administration of other insurers’ policies. From our perspective, allowing services that help in administration of all of a client’s policies (regardless of which insurer provides the policies) is beneficial to the customer, and we do not see this as problematic from a regulator’s perspective. In addition, we believe the current language is not inclusive of non-employee affinity groups such as associations. Inserting the term “member” should help clarify this.

Recommendation: We suggest rewriting this section to read:
Assists in the administration of underlying employee, retiree, or member benefit policies or with compliance with a state or federal law or regulatory requirement.

Section (f)(3) Raffles

We continue to be concerned with how the draft addresses the subject of raffles. Very few states impose any sort of restrictions on raffles, and we are not aware of any consumer problems associated with their use. As long as a raffle comports with other state law, is open to the public, free of charge and not tied to the purchase of insurance it should be permissible.

Recommendation: We suggest ending this section after the phrase “purchase of insurance” in the first sentence.

New Section g: Offer of “free” insurance

We are unclear as to the purpose of this new section. We presume this is intended to prohibit the offer of “free” insurance. But some offers of products and services may use the term “free”, which would seem to also be prohibited by this section.

Recommendation: We believe more consideration needs to be given to this section. We suggest the following language:
An insurer, producer or representative of either may not offer or provide insurance as an inducement to or interdependent with the purchase of another policy or give or offer to give “free” insurance or otherwise use the word “free” in any offer.

Thank you for the opportunity to provide these comments, and we look forward to future discussions on the draft model.

Sincerely,

David M. Leifer

David M. Leifer
August 28, 2020

John Godfread, Chair
Innovations & Technology (EX) Task Force

Via email to Denise Matthews, dmatthews@NAIC.org

Re: Revised UTPA Language on Rebating

Dear Commissioner Godfread;

We appreciate the opportunity to offer comments to the exposed Revised Draft Unfair Trade Practices Act language of August 10 addressing rebating. We continue to support the overall effort to provide more clarity in rebating issues, and believe this effort goes a long way toward doing so. We have a few suggestions which will build upon and improve the good work already prepared on this project.

- In Section (e)(1)(b)(7), some small changes should be made to ensure there is no misunderstanding that the intended behavioral changes must actually succeed in their improvement of health/reduction of risk of death of each individual, as follows:

  (e)(1) is primarily intended to satisfy one or more of the following:

  (7) incent behavioral changes that improve the health or reduce the risk of death of the insureds

- In Section (e)(4), some clarity can be added by indicating that “all” policyholders or clients means those in the same policy series or class. Further, the word “fair” – unlike “unfair discrimination” – is undefined, and should be deleted. The changes, after accepting all the proposed revisions, would appear as follows:

  (4) If the product or service is not made available to all clients (defined as policyholders, potential policyholders, certificate holders, potential certificate holders, insureds, potential insureds or applicants of the same policy series or class), its availability must be based on fair written objective criteria and offered in manner that is not unfairly discriminatory including, by example, offering the product or service based on risk characteristics of a client.
Again, in Section (e)(5) and in the last sentence of (f)(1), the word “fair” is used, and is somewhat redundant to the words, “not unfairly discriminatory.” Therefore, it should be deleted as follows:

(e)(5) If an insurer does not have such objective criteria, but has a good-faith belief that the product or service meets the criteria in (H)(2)(e)(1), the insurer or producer may provide the product or service in a fair manner that is not unfairly discriminatory as part of a pilot or testing program for a reasonable period of time upon approval of the Commissioner.

(f)(1)....The offer must be made in a fair manner that is not unfairly discriminatory and may not be contingent on the purchase, continued purchase, or renewal of a policy.

Sections (e)(6) and (f)(2) both appear to require an analysis of the reasonableness of the cost of a product or service to be determined by comparing it to the premium cost of the individual client. Such an analysis could be administratively burdensome, particularly among AHIP’s life insurer members. It would be more appropriate to compare the cost of an average of related costs for all policyholders in the same policy series or class, since those policyholders are likely to share in the overall benefits gained from the use of the product or service. We would urge the modification of those provisions as follows:

(c)(6) The cost to the insurer or producer offering the product or service to any given client should be reasonable in comparison to the average that client’s premiums or insurance coverage for the policy class without the provided product or service.

(f)(2) offer or give gifts or services to commercial or institutional clients in connection with marketing for the sale or retention of contracts of insurance, as long as the cost is reasonable in light of the relationship between the parties; premium or proposed premium and the cost of the gift or service is not included in any amounts charged to another person or entity; and/or

The main distinction between these two provisions is that (f)(2) concerns dealings with commercial or institutional clients, in which there is usually an increased level of financial and business sophistication so that the parties’ relationship is a pivotal factor in their dealings with each other.

Finally, in Section (f)(3), some clarification will help avoid misunderstandings that the word “cost” means efforts and expenditures other than of a financial nature, e.g., time and effort. This easy correction would be as shown here:

(f)(3) . . . as long as there is no financial participation cost to entrants to participate ...
Sincerely yours,

America’s Health Insurance Plans

Bob Ridgeway
Bridgeway@AHIP.org
501-333-2621
August 28, 2020

Commissioner Jon Godfread
National Association of Insurance Commissioners
444 North Capitol Street NW
Suite 700
Washington, DC 20001
Attention: Denise Matthews, Director, Data Coordination and Statistical Analysis

Commissioner Godfread:

Thank you for the opportunity to provide public comments on the NAIC’s Section 4(H) of NAIC Model Unfair Trade Practices Act (“Rebates”). This comment letter is submitted on behalf of the American InsurTech Council (“AITC”). AITC is the independent voice for insurtechs, traditional insurance companies and agencies, and other stakeholders sharing common goals and objectives before state insurance regulators and the National Association of Insurance Commissioners, federal and state legislators, other policymakers, the media and the general public.

While AITC remains generally supportive of the changes to section 4(H) of the model concerning Rebates, we write to voice our concern with the proposed change in Section H(2)(e)(1) that would replace “value-added services” with “non-cash products or services.”

These concepts are not interchangeable. “Value added services” relate to products or services provided by an insurance company or producer at no cost, or at a reduced cost, that adds value to the relationship with the insured. The criteria listed in subsection (e)(1) describe what are commonly recognized by the industry and regulators alike as “value-added services.” Such services are different from “non-cash products or services,” which are described in Section H.(2)(f)(1) as “non-cash promotional or advertising items or meals to or charitable donations on behalf of a client. . . .”

Moreover, “value-added services” is an accepted term that is understood by the industry and regulators alike. Replacing the concept of “value added” with “non-cash” is an unnecessary change that detracts from the goal of modernizing regulatory policy regarding rebates and is likely to create unnecessary confusion. We respectfully suggest therefore that this change be rejected and the term “value added services” restored to the model.
Thank you for the opportunity to provide public comments on this important document. We look forward to working with you. If you have any questions please do not hesitate to contact us at the email addresses below.

Respectfully Submitted,

Scott Harrison (sharrison@americaninsurtech.com), Jack Friou (jfriou@americaninsurtech.com), The Hon. Thomas Mays (tmays@americaninsurtech.com), JP Wieske (jpwieske@americaninsurtech.com), Teri Hernandez (thernandez@americaninsurtech.com) Co-Founders, American InsurTech Council
08/28/2020

Commissioner Jon Godfread, Chair  
Superintendent Elizabet Kelleher Dwyer, Vice Chair  
Innovation and Technology (EX) Task Force  
National Association of Insurance Commissioners  
1100 Walnut Street  
Suite 1500  
Kansas City, MO 64106

Via Electronic Mail: DMatthews@naic.org

Re: Updated Amendments to Section 4 of the Unfair Trade Practices Act

Dear Commissioner Godfread and Superintendent Dwyer:

The American Property Casualty Insurance Association (APCIA) appreciates the opportunity to provide feedback on the updated “Draft UTPA Amended Language Addressing Rebating” (updated draft). APCIA strongly supports the work of the Innovation and Technology Task Force (Task Force) to modernize state rebating laws and are pleased with the stakeholder engagement to develop a meaningful and well-balanced approach forward. In the spirit of collaboration, we offer the comments and suggested edits below.

**Non-cash**

Replacing “value-added” with “non-cash” only adds confusion, particularly in the context of discounted product or service offerings. While value-added is a recognized term in the insurance industry and arguably a better fit for this document, APCIA suggests that neither adjective provides anything of substance. The types of products and services permitted are better explained through the criteria identified in subsections (a) and (b). As such, APCIA recommends deleting “value-added” and “non-cash” throughout the document.

**Subsection (H)(2)(e)(1) - Technical Changes**

As a technical matter, we suggest replacing “third party representative” with the broader term “third parties.” Subsection (2)(e)(2) contemplates that someone other than a representative or affiliate of the insurer or producer may provide the product or service and so this modification would be consistent with what we understand as the intent of this section. Also, APCIA offers an alternative to “specified” as requested during the Task Force meeting.
**Suggested Edit:**
The offer or provision by insurers or producers, by or through employees, affiliates or third party representatives, of non-cash products or services at no or reduced cost when such products or services are not referenced in the policy of insurance, if the product or service:

**Environmental Resources**
Consistent with NAIC’s discussions around climate risk, APCIA respectfully recommends that categories of permissible products and services would benefit from a provision that allows products or services that help promote or educate about environmental impacts and benefits. For example, siding or roofing materials that can help increase energy efficiency.

**Suggested Edit:**
New Subsection 2(e)(b)(4) – Provide for or education about methods for mitigating environmental benefits and impacts

**Section H(2)(e)(2) - Consumer Assistance**
APCIA interprets the intent of new Subsection 2(e)(2) as making sure the recipient of a product or service provided by the insurer or producer is aware of how he or she can ask questions specific to such product or service. This is an important objective, but as a practical matter it is harder to dictate statutorily without significant flexibility to avoid the perils of consumer confusion. For instance, an insurer may utilize many different vendors for the products or services provided. If the consumer were to obtain this broad list they may not readily identify who they should contact, additionally the list may change over time. Further, it may not be practical to develop individually tailored notices for this limited purpose. Ultimately, APCIA does not believe this section is necessary and insurers and producers will look out for the consumer; however, we welcome clarity on the drafters intent and will work on alternative language for your consideration.

**Section H(2)(e)(4) – Fair and Not Unfairly Discriminatory**

**Fair**
APCIA requests omitting inclusion of the word “fair” in Subsections (H)(2)(e)(4); (e)(5); f(1) and (f)(3). In all four instances where it is used, it is used in connection with the term, “unfairly discriminatory.” “Unfairly discriminatory” has an established meaning in the industry; however, “fair” does not. “Fair” is inherently vague and does little to enhance the meaning of the sentences where it is used. If anything, it adds uncertainty into the statute. Respectfully, there should be a larger NAIC conversation with stakeholders about what “fair” means to regulators and how that should be reflected in law, but including “fair” in the statutory amendments at this stage is premature.

**Written Objective Criteria**
APCIA agrees that there should be objective criteria, but respectfully suggests eliminating “written.” The term creates confusion as to where it must be written and whether a filing is required. APCIA is unaware of another context where insurers have an affirmative duty to maintain similar written objective criteria.
Client
The definition of a client is unnecessarily broad and creates an almost impossible foundational standard to meet. Use of the term “potential” suggests that every individual in a state would have to be offered the product or service.

Criteria Trigger
APCIA respectfully suggests that a more streamlined approach to the non-discrimination section would be to simply require that objective criteria be developed that implements the offer of product and services in a manner that is not unfairly discriminatory. If this is the objective, it is unnecessary to preface the requirement with a statement that suggests all the products and services have to be offered to everyone.

Suggested Edit:
If the product or service is not made available to all clients (defined as policyholders, potential prospective policyholders, certificate holders, potential certificate holders, insureds, potential insureds or applicants), it’s The availability of a product or service must be based on fair written objective criteria and offered in a manner that is not unfairly discriminatory. Objective criteria may include, but is not limited to, offering the product or service based on risk characteristics of a client (defined as policyholders, potential policyholders, certificate holders, potential certificate holders, insureds, potential insureds, and applicants).

Subsection (H)(2)(e)(4) – Pilot Program
As drafted, the current pilot program section is confusing. The objective criteria is targeted at identifying how the product or services will be offered, not necessarily whether or not it will be offered. Typically, the need for a pilot project is because the insurer does not have sufficient evidence to say whether the benefit of the product or service outweighs the costs or similarly there isn’t sufficient evidence that the product actually will do what it is intended to do. The suggestions below are meant to clarify the role of the pilot program.

APCIA also respects that this paragraph is limited to a pilot program and that the commissioner wants to protect consumers, but we continue to have concerns that the approval may discourage innovation. If an insurer or producer will have to get approval from 12 states to identify an adequate sample size, for example, the insurer’s innovation team may decide the project is not worth pursuing. For this reason, we continue to urge you to avoid an approval requirement and have suggested an alternative for your consideration.

Suggested Edit:
If an insurer or producer does not have sufficient evidence that a product or service is cost effective or meets the criteria in (H)(2)(e)(1) objective criteria, but has a good faith understanding belief that the product or service is intended to meets the criteria in (H)(2)(e)(1), the insurer or producer may provide the product or service in a fair manner that is not unfairly discriminatory as part of a pilot or testing
program for a reasonable period of time after notifying the Commissioner. upon approval of the Commissioner.

**Subsection (H)(2)(f)(3) – Commercial or Institutional Client Offers**

What is meant by: “the cost of the gift or services is not included in any amounts charged to another person or entity?” If the reference to “other person or entity” is a charge to another insured/policyholder, it should be more clearly stated. Also, given that client is so broad and includes more than a current policyholder, how would the carrier know the customer’s premium?

**Subsection (H)(2)(g) – “Free”**

We continue to have concerns and seek clarity that nothing in this section is intended to prohibit an insurer or producer from conditioning a gift or entrance into the raffle on obtaining a quote. This is particularly concerning however, given the clause at the end of new Subsection (g), “or otherwise using the word “free” in any offer.” Would this new clause prohibit an insurer or producer from advertising “free quotes” or offering a gift card for obtaining a quote? In addition, there is concern that subsection (g) as drafted could prohibit multipolicy discounts. These are all potential unintended consequences that we do not believe are intended and would recommend deleting Subsection (g).

**Drafting Note**

Finally, the existing drafting note at the end of Section 4 states, “Each state may wish to examine its rating laws to assure that they contain sufficient provision against rebating. If they do not, this section might be expanded to cover all lines of insurance.” It is APCIA’s understanding that the scope of the current draft reform language is robust and would cover all lines of insurance. What would be the intent of this drafting note following this update exercise?

Thank you again for the opportunity to comment and we are happy to answer any questions that you may have.

Respectfully,

Angela Gleason
August 28, 2020

Commissioner Jon Godfread
Chair, NAIC Innovation and Technology (EX) Task Force
Via Email: DMatthews@naic.org

SUBJECT: UTPA Draft Language Regarding Rebates

Dear Commissioner Godfread:

On behalf of California Insurance Commissioner Ricardo Lara, I thank you for the opportunity to comment on the proposed amendments to the NAIC’s Model Law 880 (Model Law), otherwise known as the Unfair Trade Practices Act (UTPA). Specifically, the proposed amendments to the Model Law are intended to introduce and clarify certain exceptions to the UTPA’s anti-rebating provision.

In 1988, California voters passed Proposition 103. This citizen-led initiative expanded the authority of the California Department of Insurance to regulate most property and casualty insurance rates, including personal automobile and homeowners, and made several other substantive changes to California insurance law including the repeal of the anti-rebate provisions in the California Insurance Code.

The rebating provisions of the UTPA, and the proposed amendments thereto, are inconsistent with California’s voter-mandated prior approval rating system for certain property and casualty rates.

Specifically, subject to certain exceptions, Proposition 103 repealed the prohibitions under the California Insurance Code against producer rebating. The sponsors of Proposition 103 promoted the repeal of the anti-rebate provisions as a consumer benefit. The sponsors felt that authorizing producers to provide rebates to consumers would reduce the cost of insurance. The amendments to the Model Law assume, however, that rebates are generally prohibited and then provide certain exceptions to the prohibition.

Because California law generally permits producer rebates since the enactment of Proposition 103, the proposed amendments to the Model Law are inconsistent with current California law and would not further one of the principal purposes of Proposition 103 of reducing the cost of insurance for California consumers. Accordingly, because the proposed amendments to the Model Law would not further the purpose of Proposition 103, the proposed amendments could
not be enacted by the California Legislature, and instead would require a successful ballot initiative. As a result, if the proposed amendments are incorporated into the Model Act, it would be exceedingly difficult to enact the proposed amendments in California.

Additionally, under California’s prior approval system, if a rebate reduces the cost of providing a policy benefit, the aggregate value of such rebate is required to be included in the insurer’s rate application as an administrative expense, and the aggregate value of the rebate must be passed directly to the consumer in the form of lower rates and premiums. As a result, in California, the aggregate value of a rebate by an insurer that reduces the cost of providing a policy benefit is already included in the approved rate.

Because insurers cannot legally charge any rate in California other than an approved rate, any rebate already reflected in an approved rate that results in a deviation from the approved rate cannot legally be returned to the policyholder by the insurer. Further, if a proposed rebate that reduces the cost of a policy benefit is not reflected in the approved rate and such rebate is not offered or made available to all similarly situated policyholders, similar policyholders would pay different rates or premiums, which would violate California’s prohibition against unfairly discriminatory rates.

Though the proposed provisions are incompatible with California’s prior approval system and Proposition 103, we understand that other jurisdictions’ laws may align with the proposed amendments to the Model Law.

On behalf of Commissioner Lara, we appreciate the opportunity to comment and support the overall mission of the Innovation and Technology Task Force to introduce new technology and innovative loss reduction and rate reduction products, programs, and services to the insurance market.

Cordially,

Bryant Henley
Special Counsel to Insurance Commissioner Ricardo Lara
Comments of the Center for Economic Justice

to the NAIC Innovation and Technology Task Force

Proposed Revisions to Anti-Rebating Provisions of NAIC Unfair Trade Practices Act

August 28, 2020

CEJ submits the following comments on the proposed revisions to the anti-rebating provisions of the UTPA.

As a preliminary matter, we have great concern that the proposed changes will result in unfair discrimination against vulnerable populations. One of the core purposes of the current anti-rebating provisions is to prevent such unfair discrimination resulting from arbitrary rebates to favored customers. Our concern over such outcomes is exacerbated by insurers’ use of big data analytics to assess customers’ profitability through a variety of unaccountable algorithms, including customer lifetime value, price optimization or propensity for fraud. The absence of any meaningful regulatory oversight over systemic bias in insurers’ big data algorithms means that the proposed changes create new flexibility for insurers and producers without adequate accountability to regulators or consumers. Innovation that benefits consumers is a great thing, but the innovation must be accompanied by accountability and such accountability is missing in current insurance market regulation.

Further, given the recent adoption of Principles for Artificial Intelligence by the NAIC which include a responsibility by insurers to proactively avoid proxy discrimination against protected classes within the risk-based framework of insurance, the revisions to the anti-rebating provisions of the Unfair Trade Practices Act Model should include provisions to cause insurers to avoid such proxy discrimination.

Section (e)

The proposed section (e) attempts to carve out the provision of non-cash products or services not specified in the policy of insurance as an exception to the overall prohibition against rebates. This proposed section should not encourage practices that could otherwise easily be incorporated into the policy of insurance to be provided outside of the policy of insurance. Incorporating incentives into the policy has the great advantage of better ensuring fair treatment of consumers and avoiding unfair discrimination in the offer of the non-cash product or service incentive. Consequently, we suggest the addition, somewhere in section (e), of the following:
(7) The following are not permitted under this section

(a) The offer of a future premium discount or rebate for engaging in certain activities or providing data through a device provided by the insurer or producer. Such discount programs must be specified in the policy of insurance.

(b) The offer of an initial premium discount for utilizing a device that collects personal consumer information for use by the insurer. Such discount programs must be specified in the policy of insurance.

(c) Any non-cash product or service that could reasonably be included in the policy of insurance.

We add that incorporating risk management incentives into the policy of insurance does not stifle innovation. Requiring insurers to describe the risk management tools and benefits resulting from the use of such tools in the policy of insurance does not create a barrier to insurers’ utilizing these risk management tools. But, by incorporating the description of the risk management tools and benefits into the policy of insurance, insurers are more accountable to consumers and regulators. In fact, these types of risk management tools have long been incorporated into insurance policies, including, for example, discounts for hail resistant roofing, for wind-resistant construction, for not smoking, for taking driver training courses, for not speeding while driving and many more. Given the far less accountability of insurers to consumers and regulators if the risk management incentive is not incorporated into the policy of insurance (or rating plan), an insurer utilizing this rebate carve-out provision should be required to explain why it is not practical to provide the risk management incentive in the policy of insurance.

The effect of permitting widespread changes in net premiums paid by consumers or widespread changes in the policy terms outside of filed rates is effectively rate and policy form deregulation. If such rate and form deregulation is the policy goal, then it should be done directly by abolishing existing rate and policy form statutes – not indirectly through a rebating provision in the unfair trade practices act.

Consistent with the recently-adopted Principles for Artificial Intelligence, we suggest the following addition to section (e)

(8) Any insurer or producer offering or providing a non-cash product or service pursuant to this section shall proactively avoid proxy discrimination against protected classes within the risk-based framework of insurance.
Section (e)(1)(b)

Section (e)(1) sets out two criteria for provision of the non-cash product or service. We suggest that “primarily intended” is vague and likely to cause a lack of uniform interpretation across the states. Given that the list of functions in section (e)(1)(b) is so extensive, “is primarily intended to satisfy” should be replaced with “satisfies.”

(b) Is primarily intended to satisfy one or more of the following:

Section (e)(1)(b)(5)

This provision states the purpose to “enhance health or financial wellness.” The term “financial wellness” is vague, overbroad and should be deleted. The term “financial wellness” has no recognized or accepted definition and could encompass almost anything.

(5) Enhance health or financial wellness;

Section (e)(1)(b)(5)

This provision is actually two separate provisions. The first – assist in the administration of underlying employee or retirement benefit policies – relates to the insurance coverage, but the placement of “underlying” is problematic. It is unclear what “underlying policies” refers to. Further, since (e)(1)(a) refers to “insurance coverage,” this provision should use that term instead of “underlying policies.”

The second part – compliance with a state or federal law or regulatory requirement – is inappropriate and exactly the type of kickback that has been at issue with force-placed insurance. Were this provision in effect, force-placed insurers’ practice of providing free insurance tracking, or free flood insurance determinations to mortgage servicers would be permissible despite the fact that such activities – required of mortgage servicers or lenders by law and regulation – are the responsibility of the mortgage servicer or lender and for which the mortgage servicer or lender is compensated. We object to this second part and urge its deletion.

(8) Assist in the administration of the underlying employee or retiree benefit insurance coverage policies or with compliance with a state or federal law or regulatory requirement.

Section (e)(2)

This provision uses the term “clarify” inappropriately. The intent of the provision appears to be a requirement for the insurer to disclose whether assistance with the use of the product or service is available and, if so, how the consumer can obtain such assistance. We suggest the following revisions to clarify the intent.
(2) The insurer or producer making the offer or provision must provide the following disclosures at the time of the offer or provision.

(a) clarify that the product or service is not part of the insurance policy; and

(b) whether the insurer will provide assistance with the use of the product or service and, if so, how the consumer can obtain the assistance, and must provide information regarding the assistance, if any, that the insurer will provide should the consumer have an issue with the product or service.

(c) contact information for filing a complaint with the commissioner if the consumer is dissatisfied with the product or service.

Section (e)(4)

Although the intent of this provision is laudable, the wording is problematic. We suggest the following, which, in combination without our proposed additional section (8) above regarding proxy discrimination, will more clearly implement the intent.

(4) The offer or provision of the non-cash product or service is not made available to all clients (defined as policyholders, potential policyholders, certificate holders, potential certificate holders, insureds, potential insureds or applicants), its availability must be based on fair written objective criteria and offered in manner that is not unfairly discriminatory including, by example, offering the product or service based on risk characteristics of a client.

The term “unfairly discriminatory” does not need an example. It does need reference to avoiding proxy discrimination. In fact, the premise behind the AI principle regarding avoidance of proxy discrimination is to identify characteristics that are superficially risk-based, but are, in reality, proxies for protected classes and/or spurious correlations.

The term “fair” before “written objective criteria” is also unnecessary given the reference to “not unfairly discriminatory.”

The reference to, and definition of, “all clients” is unnecessary given the reference to “not unfairly discriminatory.”

Section (e)(5)

We assume that the intent of this section is to permit pilot testing if the insurer does not have sufficient data to document the relationship between the product or service offered and the list of risk management outcomes in section (e)(1) – as opposed to permitting a pilot project if the insurer does not have objective criteria. Even in the instance of a pilot project, the insurer will need objective criteria for the offer or provision of the product or service to be able to assess the efficacy of the product or service. Further, there is no impediment to objective criteria in the offer or provision even in the absence of data supporting the efficacy of the product or service. We suggest the following to clarify and simplify and to specifically reference subparts (4) – written objective criteria – and (8) – avoid proxy discrimination against protected classes.
If an insurer does not have sufficient evidence to demonstrate compliance with such objective criteria, but has a good-faith belief that the product or service meets the criteria in (H)(2)(e)(1), the insurer or producer may provide the product or service in a fair manner that is not unfairly discriminatory as part of a pilot or testing program for a reasonable period of time upon approval of the Commissioner consistent with the provisions of parts (4) and (8) of this section.

Section (e)(5)

We understand the intent of this provision is to avoid massive rebates. However, it is unclear what is meant by the reasonableness of cost in comparison to insurance coverage. Section (e)(1)(a) already requires that the product or service offered be related to the insurance coverage.

We are concerned about the reference to premiums – plural of premium. The plural suggests multi-policy discounts or gifts that would be covered in a rating plan or section (f), respectively.

We are also unclear what the reference to “premiums or insurance coverage without the provided product or service” means or is trying to accomplish. The premise behind this entire drafting effort is the provision of products and services outside of the insurance policy contract – the document that defines the coverage provided. The provision of a risk mitigation product or service under this new section outside of the policy contract cannot modify the coverage provided and, consequently, there can be no comparison (or difference) between insurance coverage with or without the provided product or service.

(6) The cost to the insurer or producer offering the product or service to any given client should be reasonable in comparison to that client’s premiums or insurance coverage without the provided product or service.

Section (f)(1) and (f)(3)

As discussed in our comment on section (e)(4), above, it is unnecessary and confusing to refer to a “fair manner that is not unfairly discriminatory” and we suggest deleting “fair manner that” and adding avoiding proxy discrimination against protected classes.

Section (f)(2)

We greatly appreciate the revisions to address kickbacks in reverse-competitive markets. We suggest that “in light of” be revised to “in comparison to” for consistency with the terminology used in section (e)(6) and because “in light of” is a vague term.
Hi Denise,

Please excuse the tardiness! Bureau Chief Randy Pipal and I from Idaho DOI have a few comments for consideration regarding the proposed changes to Model #880.

1. We support the addition in the proposed language of section (2)(f), which allows a producer or insurer to provide items, etc., as long as each provision includes a limitation “not to exceed an amount reasonably determined by the Commissioner per policy year per person.” Idaho has the following language currently in statute, which even more broadly allows producers and insurers to already provide non-cash items to insureds up to $200 per calendar year:

   “Nothing in this section shall be construed as prohibiting a life insurer, disability insurer, property insurer or casualty insurer, or producers who are marketing life insurance, disability insurance, property insurance or casualty insurance, from providing to a policyholder or prospective policyholder of life, disability, property or casualty insurance, any prizes, goods, wares, merchandise, articles or property of an aggregate value not to exceed two hundred dollars ($200) in a calendar year.”

2. We support the addition of an exclusion for risk mitigating devices, with the following caveats:

   **Producers:** Idaho has a large percentage of smaller, “mom and pop” insurance agencies. They are often very involved in their communities and provide a much needed service, however they are not able to compete with the large brokerage houses when it comes to “freebees”. The large brokers may have the ability to negotiate more favorable commission structures and contingent commissions as a result of their premium volume that are not available to the smaller agents. As proposed, either the brokerage house could directly fund large incentives that smaller agencies couldn’t dream of matching, or the insurer could further favor the large brokerage houses through exclusive non-cash products or services. To maintain a more level playing field, we recommend producers be removed completely from the proposed exemption language. They will still be able to provide products and services under the maximum annual dollar limit.

   **Services:** We also have a number of smaller regional companies that operate in Idaho and compete fairly well, particularly in the agricultural space. While they may be able to provide their clients some sort of risk mitigation product, the services area becomes more difficult. For years we have struggled with what is the value of a service. While it may cost $X for the consumer to purchase in the open market, larger carriers (and producers) can hire in house trainers/instructors/specialists to provide that same service “for free” to their clients. To maintain a more level playing field, we recommend non-contractual, value-added services not be part of the exemption language.

Addressing both of these concerns would not hinder the key change to the model: permitting insurers to make innovative offerings of risk mitigating devices related to the covered risk, without a dollar limit. Producers would still be able to offer non-cash products, within the statutory dollar limit, which we believe improves fair competition in the markets. Again we want to thank NAIC and particularly the Innovation and Technology Task Force for their work in this area.

Wes Trexler  
Deputy Director  
Idaho Department of Insurance  
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Office: (208) 334-4214
NAIC’S INNOVATION AND TECHNOLOGY (EX) TASK FORCE

Comments on the Draft Revised Unfair Trade Practice Act (Model #880) – Post Meeting Changes

August 28, 2020

Locke Lord LLP is a global law firm with more than 85 insurance lawyers and professionals addressing the needs of the insurance industry. In serving our clients in this role, we are often called upon to advise insurance carriers, agencies and start-ups on the myriad of insurance regulations impacting the distribution of insurance to consumers and commercial insureds. Of those issues, by far the most misunderstood and frustrating to both industry incumbents and disrupters is in the area of anti-inducement / anti-rebating laws affecting and restricting the ability to provide value-added services and products to insurance customers, enhancing the delivery of insurance products and claims services, improved risk underwriting and better customized insurance solutions.

To that end, we fully support the work of the NAIC Innovation and Technology (EX) Task Force (the “Task Force”) to modernize the NAIC’s Unfair Trade Practice Act (Model #880) (the “UTPA”) to reflect the influx of innovation within the insurance industry and society in general and appreciate the discussion and debate of those amendments to the UTPA during the NAIC’s recent summer meeting.

At the outset, we reiterate our support for those revisions to the UTPA that we proposed in our July 15, 2020 letter for the reasons set forth therein.

Furthermore, we believe the following revisions would provide additional clarity and allow for greater innovation in the industry:

- With respect to Subsection H(2)(e)(1)(a), we believe that the criteria should be expanded to include not only insurance coverage, but also “eligibility for or underwriting of insurance”, in order to clarify and expand the scope of this provision.

- With respect to Subsection H(2)(e)(1)(b)(7), the provision should be revised such that includes products or services which reduce the risk of “disability” as well as death.

- We also propose that a new Subsection be added to Subsection H(2)(e)(1)(b), to address those products or services which “Reduce the administrative cost of selling, underwriting or maintain a policy of insurance or enrollment of an insured.”
• With respect to Subsections H(2)(e)(4) and (5), that the obligation for equal treatment be limited to “insureds within the same underwriting class.”

Again, we thank the Task Force for their hard work on this very important issue and for allowing us to comment. Should the Task Force wish to discuss any of our comments, we are of course happy to provide additional information.

Thank you-

Brian Casey                  Ben Sykes
Partner                    Partner
Locke Lord LLP             Locke Lord LLP
August 28, 2020

Commissioner Jon Godfread, Chair
NAIC Innovation and Technology (EX) Task Force
c/o Denise Matthews – dmatthews@naic.org
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: NAMIC comments - Amended Model Language Addressing Rebating – August 7, 2020 Exposure

Dear Commissioner Godfread and Members of the EX Task Force,

Please find herein comments on behalf of the National Association of Mutual Insurance Companies (hereinafter “NAMIC”) regarding the amendatory language addressing anti-rebating modernization in the NAIC model law #880 - Unfair Trade Practices Act. These comments are intended to address the August 7, 2020 exposure. NAMIC wants to thank the task force for the ability to provide comments on this important modernization effort as it progresses.

NAMIC continues to applaud the task force for taking the initiative on modernizing anti-rebating language that will allow much-needed innovation and regulatory clarification which, in turn, will foster better outcomes for consumers of insurance products. More specifically, the inclusion of amendatory language that allows for the usage of innovative and cost-saving, value-added products or services for consumers and that provides for loss control, reduction in claim costs or settlement costs, education, risk ascertainment, enhancements for policyholders, loss mitigation, and post-loss services to name a few are all very important to achieving intended contractual policy objectives and obligations for all parties as we have previously mentioned.

In an effort to assist the task force, we have provided, as an attachment to these comments, some brief suggestions to the draft language that might be considered by the task force. Additionally, we would provide the following additional conceptual comment for your consideration.

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1NAMIC membership includes more than 1,400 member companies. The association supports regional and local mutual insurance companies on main streets across America and many of the country’s largest national insurers. NAMIC member companies write $278 billion in annual premiums. Our members account for 58 percent of homeowners, 44 percent of automobile, and 30 percent of the business insurance markets. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
We continue to respectfully encourage the task force to avoid any new amendatory language which would have the practical result of implementing traditional filing requirements for the usage of value-added products. These requirements in the current draft, while well-intended, can have the effect of reinstating the status quo and thereby negating the overall intention of the intended reforms. By way of example, we would point to sections (e)(4) and (e)(5). We would implore the task force to clarify in (e)(4) what “written objective criteria” means and how insurers’ offerings will be measured against such “objective criteria.” Further, it is not clear by using an example in a model statute whether the intention is to use it as support of the statement or as a concern. For those reasons unless clarified, the example may cause confusion and should be revised or deleted.

Nevertheless, in (e)(5), it is stated that if there is a lack of “objective criteria,” the insurer should seek approval of the Commissioner. This appears to move away from the original goal of alleviating filing requirements and reinstates such directive due to potential and unknown concerns on how the section will be implemented. We would suggest a consideration of the juxtaposition of not being overly prescriptive in a model law but provide sufficient guidance for industry to comply with expected parameters if the wording of those sections remain. Any elaboration or consideration of this concern would be greatly appreciated. If intent upon keeping in the concept, we have suggested possible notification language as an option.

In closing, NAMIC continues to support the task force’s effort to modernize anti-rebating regulatory requirements and, we want to thank the Chair and Superintendent Dwyer for their leadership in moving forward with these targeted and specific amendments to the UTPA. We further look forward to assisting the task force as it finalizes its work in this regard.

Sincerely,

Andrew Pauley, CPCU
Government Affairs Counsel
National Association of Mutual Insurance Companies (NAMIC)
NAMIC Recommendations to NAIC Innovation and Technology Task Force – UTPA Model Law amendments

August 28, 2020

NAMIC would suggest the following points be considered in the draft language.

- (e) (1) (a) Relates to the insurance coverage
- (e) (1) (b) (1) Provide loss avoidance, mitigation, or loss control
- (e) (1) (b) (2) Reduce claims costs or claim settlement costs, facilitate the claim-handling process, or support recovery after a loss
- (e) (1) (b) (8) Assist in the administration of underlying employee or retiree benefit policies or with compliance with a state of federal law or regulatory requirement or
  (c) Is offered regardless of whether someone is a policyholder or potential policyholder and no quote or policy purchase is required to obtain it.
- (e) (2) The insurer or producer making the offer when needed/when necessary must clarify that the product or service is not part of the insurance policy and must provide information regarding the assistance, if any, that the insurer will provide should the consumer have an issue with the product or service.
- (f) (2) conduct raffles or drawings to the extent permitted by state law, as long as there is no participation cost to entrants, the drawing or raffle does not obligate participants to purchase insurance, the prizes are not valued in excess of a reasonable amount determined by the Commissioner and the drawing or raffle is open to the public. The raffle or drawing must be offered in a fair manner that is not unfairly discriminatory and may not be contingent on the purchase, continued purchase, or renewal of a policy.
- (e)(4) If the product or service is not made available to all clients (defined as policyholders, potential policyholders, certificate holders, potential certificate holders, insureds, potential insureds or applicants), its availability must be based on fair written objective criteria and offered in manner that is not unfairly discriminatory. Objective criteria may include, but is not limited to, including, by example, offering the product or service based on risk characteristics of a client.
- (e)(5) If an insurer does not have such objective criteria, but has a good-faith belief that the product or service meets the criteria in (H)(2)(e)(1), the insurer or producer may provide the product or service in a fair manner that is not unfairly discriminatory as part of a pilot or testing program for a reasonable period of time upon approval of after notifying the Commissioner.
August 28, 2020

Via email at dmatthews@naic.org to
Denise Matthews, Director, Data Coordination and Statistical Analysis

Commissioner Jon Godfread, North Dakota Insurance Department
Chair, Innovation and Technology (EX) Task Force

Superintendent Elizabeth Dwyer, Rhode Island Division of Insurance Regulation
Vice Chair, Innovation and Technology (EX) Task Force

National Association of Insurance Commissioners
444 N. Capitol Street, NW, Suite 700
Washington, DC 20001

Re: Draft Unfair Trade Practices Model Act: Amended Language Addressing Rebating

Dear Commissioner Godfread and Superintendent Dwyer:

On behalf of the National Association of Professional Insurance Agents (PIA National)¹, thank you again for the opportunity to continue our collaboration with the Task Force on the important issue of rebating. We are pleased to have this chance to address the newest revisions to the anti-rebating language contained in Section 4(H) of the National Association of Insurance Commissioners’ (NAIC) Unfair Trade Practices Model Act (Model #880, referred to herein as UTPMA),² which was distributed electronically by Rona Bingham of the NAIC on August 14, 2020 (referred to herein as “the August 14 draft”).

In previous comments, PIA National provided recommendations, several of which were incorporated into this draft. We appreciate the time the Task Force continues to give to collecting feedback from both regulators and interested parties, and PIA National supports the August 14 draft.

We have technical suggestions, which are set forth using tracked changes below:

1. **Section (e)(1)** would be improved with the following minor modifications:

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¹ PIA is a national trade association founded in 1931, which represents member insurance agents in all 50 states, Puerto Rico, Guam, and the District of Columbia. PIA members are small business owners and insurance professionals who can be found across America.

² See https://content.naic.org/sites/default/files/inline-files/August_7_UTPA_Section_4%28H%29_Exposure_Draft_%28clean_with_post_mtg_changes%29.pdf.
(e) (1) The offer or provision by insurers or producers, by or through employees, affiliates or third party representatives, of non-cash products or services at no or reduced cost, when such products or services are not specified in the policy of insurance, if the product or service:

(a) Relates to the insurance coverage and
(b) Is primarily intended to satisfy one or more of the following:
   (1) Provide loss mitigation or loss control;
   (2) Reduce claims costs or claim settlement costs;
   (3) Provide education about risk of loss to persons or property;
   (4) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;
   (5) Enhance health or financial wellness;
   (6) Provide post-loss services;
   (7) Incent behavioral changes that improve the health or reduce the risk of death of the insured; or
   (8) Assist in the administration of underlying employee or retiree benefit policies or with compliance with a state or federal law or regulatory requirement.

2. Section (e)(3) could be interpreted as though “consistent with applicable law” is only meant to apply to “unfair discrimination.” To clarify, we recommend the following change:

   (3) The Commissioner may adopt regulations when implementing the permitted practices set forth in this regulation to ensure consumer protection. Such regulations may address, among others, consumer data protections and privacy, consumer disclosure, and unfair discrimination, consistent with applicable law.

3. The language of Section (e)(4) could be clarified with the following edits, none of which are intended to change its meaning:

   (4) If the product or service is not made available to all clients (defined as policyholders, potential policyholders, certificate holders, potential certificate holders, insureds, potential insureds, or applicants), its availability must be based on fair, written, objective criteria and must be offered in a manner that is not unfairly discriminatory; permitted activity would include, for example, offering the product or service based on the risk characteristics of a client.

4. PIA National generally supports pilot or testing programs when approved by state insurance authorities. However, such programs should be authorized by commissioners in writing, and the UTPMA should reflect that expectation. That change is shown in our edits to Section (e)(5), below:

   (5) If an insurer does not have such objective criteria, but has a good-faith belief that the product or service meets the criteria in (H)(2)(e)(1), the insurer or producer may provide the product or service in a reasonable manner that is not unfairly discriminatory as part of a pilot or testing program for a reasonable period of time, upon the written
approval of the Commissioner.

5. Minor changes to the **first Drafting Note** could make it more readable:

   *Drafting Note – The committee would suggest that, at the time of the drafting of the current revisions to this model, the lesser of 5% of the current or projected policyholder premium or $250 would be an appropriate limit; however, specific prohibitions may exist related to transactions impacted governed by the Real Estate Settlement Procedures Act of 1974 and the laws and regulations governing the Federal Crop Insurance Corporation Risk Management Agency.*

6. We recommend the following minor changes to **Section (f)(3):**

   (3) conduct raffles or drawings to the extent permitted by state law, as long as there is no participation cost to entrants, the drawing or raffle does not obligate participants to purchase insurance, the prizes are not valued in excess of a reasonable amount as determined by the Commissioner, and the drawing or raffle is open to the public. The raffle or drawing must be offered in a fair reasonable manner that is not unfairly discriminatory and may not be contingent on the purchase, continued purchase, or renewal of a policy.

7. The language of **Section (g) could be clarified with the following edits, none of which are intended to change its meaning:**

   (g) An insurer, producer, or representative of either may not offer or provide insurance as an inducement to the purchase of another policy or give or offer to give “free” insurance or otherwise using the word “free” in any offer.

8. Minor changes to the **third Drafting Note** could make it more readable:

   *Drafting Note: Each state may wish to examine its rating laws to ensure that it contains sufficient provisions against rebating. If a state does not, this section might be expanded to cover all lines of insurance.*

PIA National recognizes and appreciates the Task Force’s attention to this issue and supports the August 14 draft. As always, we are grateful for the opportunity to provide the independent agent perspective. Please contact me at laurenpa@pianet.org or (202) 431-1414 with any questions or concerns. Thank you for your time and consideration.

Sincerely,

Lauren G. Pachman
Counsel and Director of Regulatory Affairs
National Association of Professional Insurance Agents
Denise,

I have made two comments on the UTP Model for review and consideration. Please see attached document.

The first comment is under Paragraph e(5) and it is to suggest the expansion of the last sentence to put a requirement on the insurer, who has a good faith belief that a product or service will benefit a consumer, to follow-up with an objective report to the Commissioner detailing whether it did or did not end up benefitting the consumer. This way if another carrier asks for something similar, it would be good to have that data for the Commissioner to use when making subsequent allowances for a good-faith belief.

The second comment is attached to Paragraph (f) for all three sections. I am concerned that this type of allowance will create an unlevel playing field for producers by their size in the market and that it would create anti-competitive advantages for large producers and insurance companies but not benefit the consumers as the markets restrict to only those large producers and insurance carriers who can pay for their market share. This cannot be a benefit to consumers in the long run and thus unfair.

Please let me know if you have any questions.

- Barbara

Barbara Richardson
Commissioner
Division of Insurance
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Carson City, Nevada 89706
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Re: UPTA (Model #880) Amended Language Addressing Rebating

Dear Commissioner Godfread and Superintendent Dwyer,

The Oregon Department of Consumer and Business Services’ Division of Financial Regulation appreciates the opportunity to provide comments on the recent draft of the Unfair Trade Practices Act (Model #880) proposed language addressing rebating. We support updating the model to provide better clarity around the types of practices that should be and not be considered illegal rebating. Oregon’s rebating statute provides clear guidance to industry, consumers, and regulators about rebates and inducements. We believe any model should also provide clear language that differentiates permissible from impermissible value-added products. We, like all regulators, have a duty to protect consumers from those who would take advantage of regulatory uncertainty. Any draft should provide regulators the tools needed to enforce consumer protection provisions against bad actors.

We appreciate that H(2)(e)(1)(a) requires that a product or service “relate to the insurance coverage.” However, we believe that the “primarily intended” standard is too low to be useful in a regulatory system. Any product or service intended to offset or mitigate risk should have a demonstrable connection to the risk it is mitigating. Insurers should be able to demonstrate that to their regulator. Intent is subjective and easily misrepresented to serve as a useful standard to protect consumers.

We are also concerned about how broad H(2)(e)(1)(b)(5) is. The concept of financial wellness is so broad that it could be used to cloak nearly any product or service. Either H(2)(e)(1)(b)(5) should be limited to life and annuity products or the criterion should specifically state the specific types of services (for example, education or financial planning services).
Lastly, while we appreciate that H(2)(e)(4) requires the product or service to be offered based on written objective criteria, we continue to see how disparities result when products and services can be offered as an option.

Thank you for the work you have put into this project.

Andrew Stolfi  
Director and Insurance Commissioner  
Oregon Department of Consumer and Business Services
August 24, 2020

Honorable Jon Godfrey
Commissioner, North Dakota Department of Insurance
Chair, NAIC Innovation and Technology (EX) Task Force
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Draft UPTA Amended Language Addressing Rebating

Dear Commissioner:

As a former regulator, I appreciate the opportunity to again offer comments on the NAIC’s Innovation and Technology (EX) Task Force (Innovation TF) proposed revisions of the NAIC Unfair Trade Practice Act. I previously offered comments in an October 14, 2019 letter regarding the SN earlier draft as well as in a July 11, 2020 letter regarding the earlier draft.

I was Assistant Deputy Superintendent and Counsel for the New York Insurance Department and its successor the Department of Financial Services in the Department’s Office of General Counsel until my retirement in 2019. In my nearly four decades at the New York Department, it frequently addressed rebating and inducement questions. It is axiomatic that there is nothing new under the sun and, with respect to rebating and inducement proposals, that is certainly true. I preface my remarks to note that I do not speak for the New York department nor are these comments made on behalf of any clients.

The August 7th draft contains some significant improvements but I remain mystified that the task force, while appearing to acknowledge the continuing importance of anti-rebating/anti inducement laws, has nonetheless produced a draft that significantly reduces those protections and, on the commercial side, virtually eliminates them, while offering minimal protection to prevent inducement costs to ultimately be borne by insureds, some of whom who may not even be their recipients. Indeed, there is no recognition that the proposed changes may adversely impact insureds on the lower end of the economic scale as well as producers and insureds without the financial resources to compete with those able to provide more lavish inducements.

I am attaching a suggested mark-up of the draft that addresses some inconsistent language and that would add some added protections for insureds so I will focus my comments here only on what I believe are the most egregious provisions of the draft.
We always start with the proposition that nothing that comes with strings attached is “free”—perhaps the most basic principle of Contracts 101. There is always a cost, be it financial or some other obligation, when one person must do something else to obtain the desired goal. And nowhere is that clearer than in section (e)(1) of the draft when the insured or potential insured is to be provided products or services in addition to the insurance that the insured or potential insured seeks.

The products or services contemplated in section (e)(1) go beyond services that directly relate to the sale or servicing of the policy or provides general information about insurance or risk reduction, which do not need to be specified in a policy under current law but include add-on products or services that are being used as marketing tools to distinguish the producer or insurer from their competitors. To the extent that they have a nexus to the coverage under the policy, they should be specified in the policy if they are going to be provided but the draft would allow them to be exempted from that requirement.¹

While there may be some cases where a service provider will provide those services gratis, they are going to be few and far between. More usually, the insurer or producer will be footing the bill initially (with the cost in some manner passed on to insureds) or the insured or potential insured will be offered the option to take the product or services for a separate fee. However, the draft does not require the insurer or producer to make the offer on an opt-in basis; in fact, insureds may not even be allowed to opt out or to get a credit on the premium if the insured does not want the product or service. Often, it will be a take it or leave it arrangement.

Also, while the draft permits the insurer or producer to use the product or service as an inducement to purchase the insurance, and even to require the insured or potential insured to receive the product or service, the insurer or producer does not have to stand behind what the insurer or producer deems to be critical to the policy. Instead, the insured may have to deal with the servicer or seller instead and the insurer and producer has no obligation to ensure that the product or service does in fact what is intended. As such, the intended benefits of providing those products or services may not be realized fully or at all.

While there is always a cost, it does not necessarily mean that it will be borne by the insured getting the benefit. Rather, the insurer or producer may find a way to make up their expenses by passing them on to other insureds. This concern is not speculative as demonstrated by the settlements that the New York Attorney General had with several title insurance companies in 2006, where large commercial insureds received rebates, and non-commercial consumers ended up subsidizing the insurance of the large commercial insureds. There is nothing in the draft that would protect against that happening.

Indeed, the draft almost makes it a certainty because commercial and personal coverages are treated differently under subsection (f), which undercuts the limitations under subsection (e).

¹ Reference is again made to NY Circular Letter 9 (2009), which discusses those services that may properly be provided by insurers or producers under current laws without being specified in the policy and those services or products that have sufficient nexus to the coverage that could properly be included in a policy. https://www.dfs.ny.gov/insurance/circltr/2009/cl09_09.htm
While personal line insureds will be capped in the size of gifts that they can receive, the only standard for commercial lines is that the gift must be "reasonable" in light of the premium or proposed premium and that the cost of the gift or service is not included in any amount charged to another person or entity. What does it mean that the amount is not to be charged to another person or entity? Will it prevent an insurer from building into its rates the cost of providing these inducements, or a producer for increasing its service charges to other insureds? How will the insurance departments be able to police this requirement?

Furthermore, what is "reasonable?" Is there a vaguer or more ambiguous standard that could have been adopted? And who determines what is reasonable? Virtually anything could be termed reasonable except in the most extreme circumstances. Essentially, there is no practical limitation on what kind of products or services may be provided to commercial entities. (The draft is also unclear whether the limitations in (e)(1) are applicable because of the broadness of (f)(2)—there seems to be no need for the requirements under the former if the latter applies—and whether the fairness language in (f)(1) applies to (f)(2)—while (f)(3) restates the language, (f)(2) is strangely silent.)

What the draft does is provide for a potential war between insurers and producers to give larger and more lavish gifts to their larger customers, all while purporting to being "reasonable". This is what New York saw happening in the title insurance market, where title insurers and title insurance agents bestowed expensive gifts, including sporting tickets, lavish meals and even attendance at strip clubs, on attorneys and other real estate professionals to induce them to bring business to their companies. This will benefit larger insurers and producers who will be able to provide these add-on benefits, disadvantaging smaller insurers and producers, without the resources, especially in the inner cities, where the current economic crisis is greatest.

The draft also uses the phrase that the offers must be made "in a fair manner that is not unfairly discriminatory..." Does "a fair manner" have some broader meaning more than just not being unfairly discriminatory? Will insurers and producers be able to provide gifts that would only be available practically to richer suburban clients? For example, would an insurer be able to provide widgets to their homeowners in the suburbs but not their clients who are apartment dwellers in the city? In fact, the draft permits discrimination that broadly reflects different risk characteristics of insureds without imposing restrictions and thus an insurer or producer could easily direct these inducements primarily or only to more affluent clients.

The draft still does not address the role of an unlicensed third party in marketing the product or service. The draft permits third parties to offer their products or services to insureds of particular insurers at different costs than they would to the general public. Affiliated companies often market the relationship with the insurer or producer. In New York, this often meant that the unlicensed entity was deemed to be acting as an agent or broker without a license. Nor does the draft address marketing arrangements with surplus lines insurers. How can these things be done without running afoul of other laws?

The draft also specifically permits insurers and producers to tie the sale of insurance to their making charitable gifts in the insureds' names. Insurers and producers are free to make
charitable gifts currently and to advertise them doing so. Tying insurance sale to making charitable gift (and it is not clear that the proposed dollar limitations would apply to this provision and, in any event, there is no real dollar limit on commercial business), manipulates insureds to purchase insurance from specific insurers or producers instead of focusing on the factors that should be considered in buying insurance.

Insurance should not become a commodity for the sale of other products; nor should consumers be lured into buying insurance just to get “free” things. This model provides for the equivalent of banks giving away toasters to lure customers to them. An insurer or producer should sell its insurance on the value of that insurance and the services that it provides, not add-on items. The draft will significantly alter a law has worked well to protect consumers from unnecessary costs and sales tactics that obscure and deflect attention from the things that the consumer should be focused on. While the anti-rebating/anti-inducement laws could stand clarification, this broad gutting of consumer protections is ill-advised.

Thank you again for your attention. I would be glad to address any questions that the Task Force may have.

Yours truly

Paul A. Zuckerman
Unfair Trade Practices Act Proposed Amendments
August 10, 2020

*Proposed additions underscored and deletions bracketed*

Section 4(H) of NAIC Model Unfair Trade Practices Act

Any of the following practices, if committed in violation of Section 3, are hereby defined as unfair trade practices in the business of insurance:

H. Rebates.

(1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any life insurance policy or annuity, or accident and health insurance or other insurance, or agreement as to such contract other than as plainly expressed in the policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such policy, or interdependent with any policy, any rebate of premiums payable on the policy, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such policy or annuity or in connection therewith, any stocks, bonds or other securities of any company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the policy.

(2) Nothing in Subsection G, or Paragraph (1) of Subsection H shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) in the case of life insurance policies or annuities, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(b) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;

(c) Readjusting the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; or


(e) (1) The offer or provision by insurers or producers, directly or indirectly, by or through employees, affiliates, or third party representatives, of non-cash products or services at no specified or reduced cost when such products or services are not specified in the policy of insurance if the product or service:
(a) Relates to the insurance coverage and

(b) [is primarily intended to satisfy] does one or more of the following:

1. Provide loss mitigation or loss control;
2. Reduce claims costs or claim settlement costs;
3. Educate about risk of loss to persons or property;
4. Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;
5. Enhance health or financial wellness;
6. Provide post-loss services;[.]
7. Incent behavioral changes that improve the health or reduce the risk of death of the insured; or
8. Assist in the administration of underlying employee or retiree benefit policies or with compliance with a state of federal law or regulatory requirement.

2. The insurer or producer making the offer or providing the services must [clarify] advise the insured that the product or service is not part of the insurance policy and must provide information regarding the assistance, if any, that the insurer will provide should the consumer have an issue with the product or service or, if the insurer will not provide assistance, information specifying who will provide the assistance and the nature of the assistance.

3. The Commissioner may adopt regulations when implementing the permitted practices set forth in this regulation to ensure consumer protection. Such regulations may address, among others, consumer data protections and privacy, consumer disclosure and unfair discrimination consistent with applicable law.

4. If the product or service is not made available to all clients (defined as policyholders, potential policyholders, certificate holders, potential certificate holders, insureds, potential insureds or applicants, and, if a business entity, the partners, officers, employees or directors of the business entity), its availability must be based on written objective criteria and offered in a fair written objective criteria and offered in manner that is not unfairly discriminatory manner that is fair and not unfairly discriminatory, including, by example, offering the product or service based on risk characteristics of a client.

5. If an insurer does not have such objective criteria, but has a good-faith belief that the product or service meets the criteria in (H)(2)(e)(1), the insurer or producer may provide the product or service in a fair manner that is not unfairly discriminatory manner as part of a pilot or testing program for a reasonable period of time upon approval of the Commissioner. (The paragraph does not follow from the previous ones. The objective criteria mentioned previously in (4) relates to the manner in which
(6) The cost to the insurer or producer offering the product or service to any given client should be reasonable in comparison to that client's premiums or insurance coverage without the provided product or service.

(7) The product or service must be offered on an optional basis. If the insurer offers the product or service and the insured rejects it, the insurer shall reduce the premium in an amount equal to the insurer's costs for providing the product or service. If the producer offers the product or service, it shall specify to the insured the additional cost, if any, of the product or service.

(f) Notwithstanding any other provision, an insurer or a producer may:

(1) offer or give non-cash promotional or advertising items or meals to or charitable donations on behalf of a client, as long as the actual cost of the non-cash promotion or advertising items or meals or charitable donations, for all named [or additional] insureds in the policy in total, does not exceed an amount reasonably determined by the Commissioner per policy year per person and purchase, continuation or renewal of an insurance policy is not required; provided that under a group policy, the limitations shall apply under each certificate of insurance to the named certificate holders. The offer or provision of any such items must be made in a fair manner that is fair and not unfairly discriminatory manner and may not be contingent on the purchase, [continued purchase] continuation or renewal of a policy. For purposes of this section, "cash" includes money or money substitute, a debit or other payment card, store credit, or anything similar;

Drafting note — The committee would suggest that, at the time of the drafting of this model, the lesser of 5% of the current or projected policyholder premium or $250 would be an appropriate limit, however specific prohibitions may exist related to transactions impacted by the Real Estate Settlement Procedures Act of 1974 and the Federal Crop Insurance Corporation Risk Management Agency.

(2) offer or give gifts or services to commercial or institutional clients in connection with marketing for the sale, continuation or [retention of contracts] renewal of insurance policies, as long as the cost is reasonable in light of the premium or proposed premium and the cost of the gift or service is not included in any amounts charged to another person or entity; and [or]

(3) conduct raffles or drawings to the extent permitted by state law, as long as there is no participation cost to entrants, the drawing or raffle does not obligate participants to be subjected to solicitation of insurance or otherwise have to purchase insurance, the prizes are not valued in excess of a reasonable amount determined by the Commissioner and the drawing or raffle is open to the public. The raffle or drawing must be offered in a fair manner that is fair and not unfairly discriminatory and may not be contingent on the purchase, [continued purchase] continuation or renewal of a policy.

(g) An insurer, producer or representative of either may not offer or provide insurance as an inducement to the purchase of another policy except as specified in the other policy. No person shall [or] give or offer
to give “free” insurance. No insurer, producer or other person shall or otherwise [using] use the word “free” in any offer that involves insurance.

Drafting Note: Section 104 (d)(2)(B)(viii) of the Gramm-Leach-Bliley Act provides that any state restrictions on anti-tying may not prevent a depository institution or affiliate from engaging in any activity that would not violate Section 106 of the Bank Holding Company Act Amendments of 1970, as interpreted by the Board of Governors of the Federal Reserve System. The Board of Governors of the Federal Reserve System has stated that nothing in its interpretation on combined-balance discount arrangements is intended to override any other applicable state and federal law. FRB SR 95-32 (SUP). Section 5(a) of the Home Owners’ Loan Act is the analogous provision to Section 106 for thrift institutions. The Office of Thrift Supervision has a regulation 12 C.F.R. 563.36 that allows combined-balance discounts if certain requirements are met.

(h) Notwithstanding any other provision of this section, an insurer shall not directly or indirectly build into any of its rates the expense of providing any of the items specified in (H)(2)(f).

(i) Notwithstanding any other provision of this part, no representative of any insurer or producer or other third party that is not licensed as a producer may sell, market or otherwise call attention to any insurance product in conjunction with its product or service in a manner that would require licensing as a producer.

Drafting Note: Each state may wish to examine its rating laws to assure that they contain sufficient provision against rebating. If they do not, this section might be expanded to cover all lines of insurance.
August 28, 2020

Via dmatthews@naic.org

Commissioner Jon Godfread
Chair, NAIC Innovation & Technology Task Force
1100 Walnut St
Suite #1500
Kansas City, MO 64106

Re: Task Force Request for Comments on UTPA (Model #880) –
Second Round of Amended Language Addressing Rebating

Dear Commissioner Godfread:

RIMS, the Risk Management Society ("RIMS"), provides these comments to the Innovation & Technology Task Force on the 8/10/2020 revised draft of changes to the NAIC’s Model Unfair Trade Practices Act (No. 880) (the “Model Act”).

RIMS is concerned with one significant change from the preceding draft -- replacing the phrase “value-added” with the phrase “non-cash” when referring to certain services that add value to the insurance relationship (commonly called value-added services). For example, in the preceding draft, Section 4.H.(2)(e)(1) permitted insurers and producers to offer “value-added products or services at no or reduced costs when such products or services are not specified in the policy of insurance if the product or service" satisfies several requirements. In the new version of the draft, Section 4.H.(2)(e)(1) permits the offering of “non-cash products or services at no or reduced costs...” We urge the task force to reconsider this change for several reasons:

First, the phrase “value-added products or services” or just “value-added services” is a term of art that is commonly used in the industry and among insurance regulators to describe additional products or services that add value to the insurance relationship and that are routinely evaluated against state anti-rebating and anti-inducement laws. For example, in interpreting the state’s anti-rebating statute, Louisiana Advisory Letter No. 2015-01 (Revised March 14, 2017) defines value-added services in the general context as follows: “The term ‘value-added’ services necessarily imply that the services offered to a party do in fact add value to a prior, ongoing, future, or continual purchase or other agreement between a buyer and seller of goods.” (Emphasis added.)
Applying the concept to the insurance industry, the advisory letter discusses value-added services as follows: “Services Offered to Insureds. Any person engaging in the business of insurance may offer certain services to insureds without charge and that do not constitute rebating if the services fall within the scope of services that an insurance producer may lawfully provide in connection with insurance when the services are incidental to the policy of insurance and are offered to all insureds.”

Likewise, Maine’s Bulletin 426 (Oct. 25, 2017), which interprets Maine’s anti-rebating statute in its Insurance Code, 24-A M.R.S. 2163-A(2), “address[es] the circumstances under which value-added services may be provided for free or at a reduced fee . . . .” Other issuances by state insurance regulators that use the phrase “value-added services” include:

- Iowa Insurance Bulletin No. 08-15 Sept. 30, 2008), which permits “value-added services if they are related to the type of insurance purchase and are intended to reduce claims.”
- Missouri Insurance Bulletin 10-07 (Nov. 5, 2010), which “recognizes the importance of value-added services that producers and agencies provide.”

In contrast, we have not been able to find any statutes or insurance departmental interpretations that refer to “non-cash services” when describing value-added services. In fact, a West Virginia Information Letter from September 1, 2019 (No. 205) recognizes the distinction between value-added services and gifts or advertising: “[T]he [Office of the Insurance Commissioner] believes that providing a good product or service that adds value to the type of insurance offered is distinct from providing a policyholder with unrelated benefits or merchandise such as tickets to a concert or sporting event, televisions, coolers, BBQ grills or restaurant gift cards.” (Emphasis added.)

A second reason to use the phrase “value-added” as opposed to “non-cash” is that the phrase “non-cash” is generally used to describe promotional, advertising or similar items that are given in connection with marketing, rather being used to refer to something that adds value to the insurance relationship. That appears to be the task force’s intention regarding most of the changes it has made that are in the current draft of the revisions to Section 4(H.). Specifically, Section 4(H.)(2)(f)(1) permits an insurer or producer to “offer or give non-cash promotional or advertising items or meals to or charitable donations on behalf of a client, as long as the actual cost of the non-cash promotion or advertising items or means or charitable donations” is “reasonable” and “the purchase or renewal of an insurance policy is not required.” (Emphasis added.) Consistent with this reasoning, it appears that the task force has drafted all of Section 4.H.(2)(e) to address solely value-added services, while it has focused Section 4.H.(2)(f) solely on non-cash gifts, advertising and similar items used primarily for marketing purposes. Indeed, in the current draft, the task force recently moved old Section 4.H.(2)(e)(5), which described when the value of a gift is deemed to be de minimis, and apparently created a note on the subject in Section 4.H.(2)(f).

The third reason the phrase “value-added services” is so important in the anti-rebating/anti-inducement context is that the list of value-added services that enhance the insurance relationship likely will continue to grow, as the marketplace continues to evolve with innovation and technology. That is unlikely to be the case with non-cash marketing items such as meals and contributions to charities. For purposes of evaluating services designed to add value -- particularly as they continue to evolve -- it is important that they be grouped under a single, historical term: “value-added services.”
In summary, while changing a single phrase may seem to be insignificant, it is very significant when, as here, the phrase is commonly understood by regulators and the regulated community to define services whose purpose is to add value to the insurance relationship.

Consequently, we urge the task force to replace the phrase “non-cash” with “value-added” in Section 4.H.(2)(e)(1).

Additionally, as the preeminent global not-for-profit organization dedicated to promoting the profession of risk management for more than 3,500 industrial, service, nonprofit, charitable and government entities, RIMS urges the task force to reconsider its decision not to include in the revised draft, language that would apply only to value-added services provided to a commercial or institutional insured and that are designed to enhance the relationship between the producer or the insurer and the insured. Here is the language, which we proposed in our first comment letter to be added as new Section 4.H.(2)(e)(9), to permit value-added services that:

“(9) Arise out of the relationship between the producer and/or insurer and a commercial or institutional insured where the nature of the relationship and the compensation arrangement are memorialized in writing.”

This language is important, as it is common for producers and insurers to enter into a written agreement that defines a sophisticated insurance relationship with a commercial or institutional insured to include value-added services that go beyond what would be permitted by the currently-proposed additions.

We thank the members of the Task Force for considering these comments, and we stand ready to work with the Task Force as it moves ahead in its consideration of these issues.

Very truly yours,
Whitney B. Craig, J.D.
Director, Government Relations

cc.: Ms. Matthews-NAIC
August 28, 2020

VIA ELECTRONIC MAIL – dmatthews@naic.org

Commissioner Jon Godfread
Chair, Innovation and Technology (EX) Task Force
National Association of Insurance Commissioners
c/o Ms. Denise Matthews
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

RE: Comments on Revised Exposure Draft of UTPA Rebating Provisions

Dear Commissioner Godfread,

The Council of Insurance Agents and Brokers (“The Council”) appreciates this opportunity to comment on the Task Force’s most recent draft revisions to the Unfair Trade Practice Act (“UTPA”) rebating provisions.1 The Council strongly supports and applauds the Task Force’s efforts to modernize the rebating regime, which has become cumbersome for regulators and industry participants alike, and – in its current prescriptive form – is stifling innovation and client services in the commercial insurance space without a counterbalancing policy justification.

Below are our detailed comments on changes made in the latest exposure draft. We look forward to continued discussion with the Task Force on these important issues.

1. The Task Force should retain commonly used “value-added” language in section (e)(1).

The Council urges the Task Force to retain language from previous exposure drafts referring to “value-added” products or services in section H(e)(1), rather than “non-cash” products or services. “Value-added” is a term of art in the industry and the terminology used in rebating guidance issued by most states. Use of “non-cash” products/services also could confuse this section (e) – focused on valuable services and products related to insurance coverage – with section (f), which deals with gifts, raffles, drawings, and the like. We therefore recommend keeping the “value-added” language to avoid creating any unnecessary confusion in the marketplace or within the model’s own structure.

2. To provide the greatest value to both prospective and current insureds and to help reduce the cost of insurance coverage, the Task Force should not include “underlying” in section (e)(1)(b)(8).

The Council agrees with the suggested addition of “or with compliance with a state or federal law or regulatory requirement.” We do not, however, support the addition of “underlying” in this provision.

First, we believe inclusion of “underlying” is unnecessary. The overarching “relates to the insurance coverage” requirement in section H(e)(1)(b) for value-added products and services is sufficient to ensure a nexus between those products/services and the insurance.

Second, commercial insurance brokers provide valuable services to clients before, during, and after placement of an insurance policy. Clients may, for instance, seek consultation on what type of health benefit arrangement – e.g., a high-deductible health plan, a PPO plan, a fully insured or self-insured plan, etc. – would be best for their business and their employees. Indeed, much of the value provided by brokers is in the pre-placement planning and advising phase to help ensure that clients get the best possible insurance products to fit their unique risk profiles and needs. These pre-placement services also are important to help manage and minimize the cost of insurance coverage (e.g., helping clients determine which group benefits coverage is the most cost-effective for employers and their employees). Including “underlying” would effectively limit value-added services to the post-placement context, which is less advantageous for clients and decreases the cost-saving potential of value-added services.

Third, the “underlying” policy language does not appear to contemplate ongoing client relationships that may involve the purchase of multiple insurance policies. The same client may use a broker to place a health benefit policy and then, months or years later, use that broker to purchase a group life insurance product. Reference to an “underlying” policy suggests that value-added services could not be provided to the client on a consistent basis between those placements (one being in a post-placement posture and the other being in a pre-placement context). This is unnecessarily disruptive to the broker-client relationship and stifles brokers’ ability to satisfy clients’ evolving needs and demands over the course of a long-term business relationship.

For all of these reasons, The Council urges the Task Force to remove “underlying” from paragraph (e)(1)(b)(8).

3. Proposed (e)(2) from the latest exposure draft is unnecessary and should not be included.

The Council does not support inclusion of section (e)(2) in the most recent exposure draft. Insurance policies clearly set forth coverages and exclusions, so a separate statement regarding what is not included in the policy is unnecessary. Moreover, as drafted, the paragraph suggests that brokers would have to coordinate with insurers about the services brokers are providing. Brokers are not able to bind insurers to provide any service, and brokers render value-added services independent of their carrier partners.
Finally, paragraph (e)(3) in the latest exposure draft authorizes regulators to address consumer disclosures and other consumer protections in implementing regulations. This, we believe, renders (e)(2) superfluous. **We therefore urge the Task Force to refrain from adding paragraph (e)(2).**

4. **Paragraph (e)(4) should be amended to allow for more flexibility and innovation in the offering of value-added products/services, to account for different types of client relationships, and to maximize the cost savings benefit of value-added services.**

Limiting offerings of value-added products/services to a static set of written criteria is overly prescriptive, particularly for commercial and institutional client relationships. Often, those sophisticated clients wish to negotiate for such services as part of an arm’s length, business-to-business negotiations; they should not be unnecessarily hampered in getting the best deal and most value possible.

As noted above, there also is an important cost-saving benefit to value-added services in the group plan context. Allowing arm’s length negotiations for value-added products/services for commercial or institutional clients helps reduce the overall cost to these clients of their insurance policies and programs. For example, in the employee benefits area, pre-placement value-added services help reduce overall cost of employers’ benefit plans, thus making them more affordable for their employees.

For these reasons, we urge the Task Force to amend the language in paragraph (e)(4) to remove the requirement that objective criteria be written (i.e., static) and to add language allowing value-added services/products that result from an arm’s length negotiation between an insurer/producer and a commercial or institutional client.

5. **Council members question the efficacy of pilot or test programs for value-added services covered by the regulation.**

Section (e)(5) of the exposure draft contemplates pilot or test programs for value-added products and services that meet certain criteria. Some Council members have raised concerns that this type of short-term offering could overwhelm state insurance authorities and create inconsistencies and confusion in the market regarding what may or may not be offered to clients as a value-added service/product. We therefore recommend that the Task Force consider removing this paragraph.

If the Task Force retains paragraph (e)(5), we recommend – for clarity – adding “or producer” at the beginning of the paragraph to match the rest of the regulation and the second clause of the paragraph. Additionally, to help alleviate the potential burden on Departments of Insurance and reduce some “patchwork” concerns related to permitted short-term offerings, the Task Force could consider removing the affirmative requirement of Commissioner approval and instead, consider an approach that would allow a pilot/test program to become permanent unless disapproved by the Commissioner after a certain period of time.
6. Paragraph (e)(6) provides an example of fair and objective criteria on which to base availability of value-added services, and is therefore already encompassed in paragraph (e)(4).

Paragraph (e)(4) stipulates that value-added services and products must be made available based on fair objective criteria and may not be offered in a manner that is unfairly discriminatory (e.g., based on the risk characteristics of a client). Paragraph (e)(6) then states that the cost of offering such value-added services/products should be “reasonable in comparison to that client’s premiums or insurance coverage without the provided product or service” – precisely the type of metric we believe is contemplated under paragraph (e)(4) (e.g., the size of the client and the amount of compensation derived from the client). We therefore do not think (e)(6) is necessary as a standalone provision.

Further, as drafted, (e)(6) references premiums, but does not contemplate fee compensation arrangements that are permitted for producers in many states. Ultimately, if the Task Force retains the contents of (e)(6), we recommend moving the information to (e)(4) as an example and generalizing the language to refer to reasonable offerings “based on size of the client and compensation derived from the client.”

7. If the final model law references a dollar limit on non-cash items given to or on behalf of clients, such dollar limit should be specified in the text of the regulation and permitted non-cash items should include entertainment.

The most recent exposure draft provides a “soft” recommended limit of $250 or 5% of the current or projected policyholder premium for non-cash items given to clients in a drafting note after paragraph (f)(1). Differing limits across 50-plus jurisdictions would generate tremendous compliance challenges and costs for industry participants. The Council therefore recommends that the Task Force stipulate its recommended limit in the text of the regulation to promote the greatest possible uniformity across states.

Additionally, paragraph (f)(1) should be amended to include entertainment, along with meals, charitable donations, etc. We perceive no practical difference between taking a client to a restaurant versus to a baseball game or other event with the same dollar value, so we encourage the Task Force to expand this provision to encompass “entertainment” generally.

8. Paragraph (f)(2) should be amended to refer more generally to the size of, and compensation derived from, the client as reasonable bases for the cost of gifts and services given to commercial or institutional clients, and the reference to amounts charged to other persons should be deleted.

We reiterate our support for the current construct of the revised draft, which appropriately distinguishes between individual insureds and commercial/institution clients with respect to the giving of gifts and services. Commercial insureds are sophisticated purchasers and insurance sales are arm’s length, business-to-business transactions. There is therefore no material concern that gifts or services will improperly or unfairly induce these clients to purchase insurance.
Of course, commercial and institutional insureds vary considerably in size and amount of insurance purchased, which may factor into the overall reasonableness of a gift. For example, a $250 meal for a Fortune 500 company executive likely would not have any impact on a purchasing decision. But a trip to Hawaii for a small business owner could have quite an impact.

Ultimately, therefore, a one-size-fits-all approach – i.e., specifying a uniform dollar limit for gifts to commercial insureds – does not make sense in the commercial space and we support the Task Force’s avoidance of such a model in the exposure draft. As contemplated in the framework of the draft, a better way to assess the reasonableness of gifts and services is based on objective criteria. Such criteria, as discussed above under paragraph (e)(6), should include size of the client and the compensation derived from the client by the broker providing the gift. Because some brokers are paid on a fee basis (not commission), the language in paragraph (f)(2) should be generalized to contemplate these different compensation methods.

Finally, we recommend deleting “and the cost of the gift or service is not included in any amounts charged to another person or entity” from the end of the paragraph. We assume that this language is aimed at preventing shifting the cost of gifts and services for some clients to other clients, but we welcome clarification from the Task Force on the intent of this language. We are concerned that this clause, as drafted, is confusing and overly broad. We recommend removing it from the revised draft or, at a minimum, revising the language to make some important clarifications.

If our assumption about the clause’s purpose is correct and it is aimed at prohibiting direct charges of gift costs for one client to another client, we encourage the Task Force to make that clarification and substitute the following language:

“and the cost of the gift or service will not be charged directly to another client.”

Without this amendment, the current language would appear to prohibit firms from having aggregate marketing budgets – a budget item common across all types of businesses – even if there is no intent to shift a particular client’s marketing costs to another particular client. So, for instance, a brokerage firm that purchases firm-branded pens would have to charge a particular client file for the pens distributed to that client. This model would be virtually impossible to implement and track for compliance purposes.

Further, by using “another client” instead of “another person or entity,” vendors would still be permitted to offer their products and services on a promotional basis through brokers (e.g., providing a sample of a product/service as an introductory demonstration). In this scenario, the vendor bears the cost of the promotion/gift. Under the current language, the broker would have to pay the vendor (i.e., not charge the vendor) for the gift. Notably, the largest brokers may be able to pay vendors for these gifts, but it would appear to disadvantage smaller brokers who could not.

Again, paragraph (f)(2) is specific to sophisticated commercial and institutional insureds, so the likelihood of broker- or vendor-provided gifts resulting in an improper inducement to purchase
insurance is minimal. **We therefore urge the Task Force, to the extent it retains some version of this clause in (f)(2), to narrow the language as suggested above.**

9. *If the final regulation references a dollar limit on raffles or drawings, the text of the regulation should stipulate such dollar limit.*

For the reasons stated above in the discussion of paragraph (f)(1), we recommend that – if it chooses to reference a dollar limit in paragraph (f)(3) with respect to raffles and drawings – the Task Force specify a dollar limit in regulation text.

* * *

Again, we appreciate the Task Force’s continued efforts on rebating reform and your consideration of our comments. Please do not hesitate to contact us if we can provide additional information or answer any questions.

Respectfully submitted,

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August 26, 2020

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North Dakota Insurance Commissioner  
Chair, NAIC Innovation and Technology (EX) Task Force  
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Re: UPTA (Model #880) Amended Language Addressing Rebating

Dear Commissioner Godfread and Superintendent Dwyer:

The Washington State Office of the Insurance Commissioner appreciates the opportunity to provide comments on the most recent draft of the Unfair Trade Practices Act (Model #880) proposed language addressing rebating. We support an expansion of practices that are excepted from being considered illegal rebating, and request greater clarity in the language describing how a state determines whether a product or service is allowed as an exception. Washington State knows from extensive experience that not all actors approach a regulatory framework in good faith. Therefore, any draft must take into account and provide the necessary tools to respond to the worst case scenario – ill intent by individual actors in the market.

We believe the “primarily intended” standard in H(2)(e)(1)(b) is too low, and that the non-cash product or service should actually satisfy one of the criteria in a manner that can be demonstrated to a state regulator. We suggest removing “Is primarily intended to” from the beginning of the phrase, and making the second requirement, “Satisfies one or more of the following”. As regulators, we know from experience that intent is inherently subjective and easily misrepresented. As a practical matter, basing a determination on company intent is unworkable and inappropriately deferential to industry at the expense of consumers.

We continue to struggle with the breadth of H(2)(e)(1)(b)(5), “Enhance health or financial wellness”, and specifically “financial wellness”. Anything that is a non-cash product or service
could be considered to increase “financial wellness” by virtue of being a product or service. The effect of H(2)(e)(1)(b) is an empty requirement as we cannot identify what would not meet the criteria of enhancing “financial wellness” if it is a product or service. We have two suggestions on how this concern could be addressed. Either H(2)(e)(1)(b)(5) as written could be limited to life and annuity products or the criterion could be expanded to “enhance financial wellness through education or financial planning services.” If appropriate, “Enhance health” could then be broken out as a separate criterion and limited to “health, life, and annuity products”.

We look forward to the discussion of comment letters from the diverse stakeholder group.

Thank you,

Molly Nollette
Deputy Insurance Commissioner
Rates, Forms, and Provider Networks

c: Denise Mathews, Director, Data Coordination and Statistical Analysis, NAIC