NAIC/CONSUMER LIAISON COMMITTEE

NAIC/Consumer Liaison Committee Aug. 11, 2026, Minutes

Draft Pending Adoption

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NAIC/Consumer Liaison Committee
Columbus, Ohio
August 11, 2026

The NAIC/Consumer Liaison Committee met in Columbus, OH, Aug. 11, 2026. The following Liaison Committee members participated: D.J. Bettencourt, Chair (NH); Marie Grant, Vice Chair (MD); Heather Carpenter (AK); Mark Fowler (AL); Charles Bassett (AZ); Ricardo Lara (CA); Michael Conway (CO); Joshua Hershman represented by MaKayla Erazo (CT); Trinidad Navarro represented by Christina Miller (DE); Dean L. Cameron represented by Randy Pipal (ID); Ann Gillespie represented by Austin Mejdrich (IL); Anita G. Fox represented by Renee Campbell (MI); Julie Dreier represented by Peter Brickwedde (MN); Angela L. Nelson (MO); Mike Chaney represented by Aaron Cooper (MS); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by John Arnold (ND); Susan Ochs represented by David Wolf (NJ); Ned Gaines represented by Gennady Stolyarov II (NV); Judith L. French represented by Jana Jarrett (OH); Glen Mulready represented by Brian Downs (OK); TK Keen (OR); Michael Humphreys (PA); Jon Pike (UT); Scott A. White (VA); Kaj Samson represented by Mary Block (VT); Patty Kuderer represented by Andrew Davis (WA); Nathan Houdek represented by Sarah Smith (WI); and Erin K. Hunter (WV).

1. Adopted its Spring National Meeting Minutes

Commissioner Grant made a motion, seconded by Commissioner Conway, to adopt the Liaison Committee's March 22 minutes (*see NAIC Proceedings – Spring 2026, NAIC/Consumer Liaison Committee*). The motion passed unanimously.

2. Received a Status Report on the NAIC/Consumer Participation Board of Trustees Activities

Commissioner White said the NAIC/Consumer Participation Board of Trustees met March 31, June 1, and Aug. 11. During its March 31 meeting, the Board discussed the transition of the Consumer Participation Program to new NAIC committee support within the Insurance, Research, Analytics, and Property/Casualty (P/C) Policy Division, along with initial next steps to strengthen program structure, engagement, and operations. Commissioner White said the discussion focused on identifying priority areas for improvement and developing a framework to solicit broader feedback from consumer representatives, state insurance regulators, and NAIC committee support to inform future program enhancements.

Commissioner White said that, during its June 1 meeting, the Board discussed implementation of the Consumer Participation Scholarship Program, including outreach strategies and selection considerations for the 2026 Summer National Meeting. He said the first two scholarship recipients were in attendance, Dr. Chia-Li Chien from the Texas Tech University School of Financial Planning and Ann Baddour representing the Texas Appleseed Fair Financial Services Project. Commissioner White said the Board reviewed feedback from consumer representatives identifying opportunities to improve engagement, including increasing the program's visibility, enhancing communication pathways, and creating additional opportunities to participate in NAIC committee work. He said the Board discussed next steps, including completing focus groups, developing a broader survey to prioritize program improvements, and exploring enhancements to the consumer representative application process.

Commissioner White said that, during its meeting Aug. 11, the Board reviewed consumer scholarship applicants for the fall 2026 National Meeting and heard an update from NAIC committee support on efforts to improve the consumer representative application process for 2027, including a new tool intended to provide a more user-friendly experience when applications open Aug. 31. He said NAIC committee support also shared final findings from NAIC-led focus groups and a survey, and the Board discussed recommendations for enhancements to the Consumer Participation Program based on stakeholder feedback. Commissioner White said these efforts are intended to inform a comprehensive approach to strengthening the program and enhancing the effectiveness of

consumer engagement in NAIC activities, and that insights from the stakeholder feedback would be shared with program participants and NAIC Members in the weeks ahead.

3. Heard an Update on the LTCI Market and Consumer Challenges

Bonnie Burns (California Health Advocates—CHA) referred to an issue brief included in the meeting materials that reviews life and annuity products being sold with riders for long-term care insurance (LTCI) expenses. Burns said only one of those riders is an actual long-term care (LTC) rider, while the remainder are various types of riders with benefits that could be used to pay for LTC expenses, depending on the benefit triggers in each rider.

Burns said the issue brief was written before the Senior Issues (B) Task Force conducted a survey on how states receive filings and perform reviews and approvals for LTC products attached to life and annuity products. She said the survey appears to show significant variation across states in how these products are reviewed and approved because life and annuity products are governed by one set of standards, while riders are governed by a variety of other standards, with some states treating them as health products and others not.

Burns said there are questions about how consumers, and those who work with them, can understand these riders and know how the benefits can be used to pay for LTC expenses. She described a rider of particular concern—a chronic illness rider marketed as "free" and attached to a life policy—explaining that the cost is not realized until the time of claim and that, in some cases, the charge for the rider can exceed the death benefit available to pay for care. Burns said it is unlikely that a purchaser would understand this at the time of sale, because the benefit amount cannot be determined when the policy is purchased. She asked state insurance regulators to review these questions to help consumers understand how the products work, what information is provided at the point of sale, and the benefits families can rely on at the time of a claim. Burns said consumer protections exist in law that could help, but whether they are applied when policies are reviewed and approved depends on the state conducting the review.

4. Heard a Presentation on State Coverage of Biomarker Testing and Defrayal Implications

Anna Schwamlein Howard (American Cancer Society Cancer Action Network—ACS CAN) and Anna Hyde (Arthritis Foundation) presented on state mandates and biomarker testing. Howard said the Affordable Care Act (ACA) requires qualified health plans (QHPs) to cover 10 essential health benefits (EHBs) but also recognizes that states may enact mandates to keep coverage aligned with innovation. She said that, in the cancer context, state mandates can take the form of coverage for preventive products and services that are not part of the EHBs. She noted that since 2012, 17 states have enacted legislation to preserve fertility for individuals undergoing cancer treatment, nine states have enacted legislation to cover prostate cancer screening (which does not have an A or B rating from the U.S. Preventive Services Task Force), and 28 states have enacted legislation to eliminate out-of-pocket costs for follow-up breast imaging.

Howard said biomarker testing represents a shift in health care, explaining that biomarkers are characteristics measured in blood or tissue (often gene mutations or protein expression in cancer care) that allow physicians to prescribe treatments aligned with an individual's biomarkers and avoid ineffective courses of chemotherapy. Hyde said biomarker testing is also relevant in rheumatology. She noted that, for a patient with rheumatoid arthritis, a biomarker test can indicate whether a tumor necrosis factor (TNF) inhibitor will be effective, which she said can prevent six or more months of lost time and disease progression from an ineffective medication. Hyde said the testing produces cost savings, citing data showing that access to biomarker tests reduced the difference between efficient and wasted spending by about half. She said a report published the prior week by ACS CAN, included in the digital briefing materials, provides a more comprehensive map of states with biomarker testing legislation.

Hyde then addressed defrayal, explaining that under the ACA, a state may require a QHP to cover benefits in addition to the EHBs, but if it does, the state must defray the cost and make payments to the enrollee or the QHP. She said certain actions do not trigger defrayal, such as changes to cost sharing or benefit delivery (e.g., capping the cost of insulin) and covering a prescription drug in excess of one per class unless added after 2011. Hyde said 2011 is a key milestone and that, in 2018, the federal Centers for Medicare & Medicaid Services (CMS) stated that benefits added to benchmark plans would not trigger defrayal unless they were mandated after 2011 through a regulatory or legislative process separate from benchmark plan selection. She identified Maine, Massachusetts, Minnesota, Montana, Utah, and Virginia as states with defrayal obligations, such as for pediatric hearing aids, and said three states that recently submitted benchmark plans are in a period of uncertainty because those reviews have been paused.

Hyde said the final 2027 Notice of Benefit and Payment Parameters (NBPP) rule provides that, beginning in plan year 2028, states will be required to defray the cost of any state mandate meeting specified criteria. She said that this has caused confusion because of the room for interpretation. She said some benefits, including those that add to or improve the benchmark plan, could be subject to defrayal, and that states may repeal benefit requirements to avoid it. Hyde said it remains unclear which state mandates are specifically subject to defrayal. She noted that the NAIC's comments on the NBPP asked to explicitly exclude benefits added through the benchmarking process but that this was not codified in the final rule.

Howard offered recommendations in light of the uncertainty. She encouraged state insurance regulators to proceed with caution because the requirement does not take effect until plan year 2028, allowing time to act after all facts are in place; to involve stakeholders, particularly those who helped enact state mandates; to reach out to one another and share information to promote consistency across state action; and to seek clarification from CMS and share any guidance received. Howard directed regulators to additional resources, including the ACS CAN report on biomarker coverage laws and examples of state compliance efforts, noting that Indiana has issued a guidance bulletin outlining procedure codes and that Louisiana and Oklahoma have issued bulletins clarifying interpretation. She encouraged states with biomarker laws to ensure the laws are enforced and referenced a white paper on defrayal, issued by the National Health Law Program (NHeLP) and authored by consumer representative Wayne Turner, included in the meeting materials.

Commissioner Lara said the importance of biomarker testing relates to work underway in California, where the state is sponsoring legislation, modeled on a Florida law, to prohibit genetic discrimination in life and disability insurance. He said fear of discrimination keeps people from pursuing testing that could guide treatment, and he requested specific recommendations on the regulatory and legislative steps needed to close remaining gaps so patients can access biomarker and genetic testing consistently and safely across all lines of insurance, and to prepare for defrayal. Howard said the report authored by Turner includes a recommendations section and offered to serve as a resource on how the recommendations might apply to specific case examples. Hyde said it is important to ensure consumers have access to accurate information, given the amount of misinformation, and she encouraged working together to educate consumers so they can make appropriate choices.

5. Heard a Presentation Titled "Marketplace Open Enrollment Outlook: QHP Rate Filings and QHP Alternatives"

Brenda Claire Heyison (Center on Budget and Policy Priorities—CBPP) and Lucy Culp (Blood Cancer United) presented on key issues heading into the 2027 open enrollment period for the ACA marketplace, with a focus on QHP rate filings and products marketed as QHP alternatives. Heyison said nearly every state has seen ACA marketplace enrollment contract following the expiration of the premium tax credit enhancements at the end of 2025. She said that, according to CMS, effectuated enrollment fell by 2.9 million people, or 13%, between 2025 and 2026, with variation across states. Ohio and Oklahoma saw marketplace enrollment shrink by nearly one-third. Heyison attributed the variation to factors such as state-funded premium assistance, Medicaid expansion

status, and premium alignment policies. She noted that the data is from February 2026 and that enrollment is expected to decline further.

Heyison said enrollees who kept marketplace coverage are paying higher premiums, with premium tax credit recipients paying an average of $178 per month in 2026, or $65 more than in 2025. She said that, in 2026, 8% of enrollees in healthcare.gov states had monthly premiums above $500, compared with 4% in 2025, and that consumers are not necessarily receiving better coverage. Heyison said bronze plans carry higher deductibles, out-of-pocket limits, and copays than silver plans, particularly silver cost-sharing reduction (CSR) plans available to people with incomes below 250% of the poverty level. She said that, in 2026, 40% of marketplace enrollees chose bronze plans, the highest share on record. Only 45% of people eligible for CSRs selected a silver plan in 2026, down from 66% in 2025. Heyison cited a KFF survey indicating that about half of returning enrollees expressed concern about affording routine medical care and prescription drugs, and that more than four in 10 said health care costs have made it more difficult to afford basic expenses such as food, gas, and rent.

Heyison reviewed federal policy changes affecting the ACA marketplace for the next plan year, noting that many have been blocked or paused by litigation. She said consumers, brokers, and enrollment assistors are likely to have questions, and state insurance departments can help through trainings, bulletins, and outreach. She said that, beginning in plan year 2027, only U.S. citizens, U.S. nationals, lawful permanent residents, Cuban and Haitian entrants, and Compact of Free Association (COFA) migrants will be eligible for premium tax credits and cost-sharing assistance, while others, including refugees, asylees, people with student or work visas, and certain victims of domestic violence or trafficking, will no longer be eligible for financial assistance. Heyison said the same restrictions will apply to federal Medicaid funding beginning Oct. 1, and changes to the public charge determination are expected to cause additional people to drop coverage.

Heyison said 2027 rate filings reflect these conditions, with preliminary individual-market filings published at the end of the prior month showing insurers nationwide proposing a median gross premiums increase of about 15%, on top of a 20% median final rate increase in 2026. She cited medical trends, economic inflation, and a worsening marketplace risk pool as common drivers. Heyison said premium tax credit-eligible enrollees will be somewhat protected because the underlying formula is not changing, but that technical changes to the required premium contribution amounts will slightly reduce premium tax credit amounts. For example, an individual earning $42,000 per year, or about 260% of the federal poverty level (FPL), would pay $98 more in premiums and see the maximum out-of-pocket limit increase by $400.

Culp discussed a secret shopper study released that day by the Georgetown University Center on Health Insurance Reforms (CHIR), which was supported by Blood Cancer United. She said consumers searching online for affordable coverage are steered away from comprehensive marketplace plans and toward limited benefit products. Culp said researchers created two profiles (one eligible for premium tax credits and one ineligible), searched using common terms, and spoke with 20 sales representatives. She said the representatives used similar language, characterizing ACA marketplace coverage as appropriate only for people who are sick or low-income, while routing healthier consumers toward limited benefit products. She said they often provided incomplete, misleading, or inaccurate information, marketing the limited benefit plans as replacements for major medical coverage rather than as supplements. Culp said consumer representative Amy Killelea, one of the study's researchers, would share more during the Health Care Affordability and Mitigation (B) Working Group's meeting on Aug. 13.

Culp said that as marketplace premiums increase, consumers are left with fewer options. She said that limited-benefit products may serve as a backstop but lack key consumer protections, often without guaranteed issue and without coverage of EHBs. This can leave consumers with more out-of-pocket exposure and medical debt. She flagged additional rulemaking anticipated later in the year that is expected to increase the availability of limited-benefit products, particularly short-term plans and association health plans (AHPs), as well as the potential for a settlement in a case concerning a data marketing arrangement that she said could allow such arrangements to

circumvent state regulation. Culp urged state insurance regulators to rein in these marketing activities, place guardrails around the products, help consumers afford QHPs through state-funded premium assistance, offer additional enrollment support, and help consumers make informed choices. She noted a report issued the prior fall on the impact of federal policy shifts on health insurance access, included again in the materials.

Director Carpenter said Alaska has the highest cost of health care and that consumers are struggling to afford marketplace plans, with even higher-income consumers above 400% of the FPL unable to afford coverage. Carpenter said the state's reinsurance program is no longer absorbing costs and that Alaska may be a few years away from its market becoming nonviable. She said regulators need to consider alternative products as tools while ensuring marketing is structured so consumers understand what is and is not covered.

Culp agreed that there is a real issue. She cautioned that offering underwritten alternative products risks drawing lower-risk consumers out of the marketplace and worsening conditions for those who need comprehensive coverage. Heyison said the Georgetown report highlights how limited-benefit products are marketed to healthy people while the marketplace is presented as coverage for people with health issues, and she suggested that regulators consider focusing on the marketing of these products.

Commissioner Fowler asked whether the enrollment decline differed between states with state-based exchanges and those with federal exchanges. Heyison said state-based exchanges generally experienced less disenrollment than states in the federally facilitated marketplace, though not uniformly, and attributed some of the difference to: 1) state funding that partially or fully replaced the premium tax credit enhancements; and 2) premium alignment policies that made gold plans more affordable.

Block said Vermont is closely following Alaska's experience on price and is considering how to manage alternative products from a regulatory perspective. She said consumers are already leaving the marketplace and, in many cases, going uninsured, and she requested ideas from consumer representatives on placing guardrails around short-term, limited-duration (STLD) plans and AHPs, as well as on managing a potential transition away from silver loading. Culp said prior reports address the regulation of those products and offered to follow up with specifics on AHPs, STLD plans, and silver loading, and to circulate the materials more broadly. Commissioner Bettencourt offered to distribute the reports to the commissioners on the Liaison Committee.

Commissioner Grant asked Culp to comment further on the data marketing case and the potential for settlement, which she described as a significant concern because it could remove health coverage from state insurance regulators' jurisdiction. Culp said the case involves a company that offered consumers a non-state-regulated arrangement in exchange for downloading software that tracked and sold their internet history, under which the consumer became a "working owner." She said the arrangement generated significant consumer complaints, that the company sought a bona fide employer designation from the U.S. Department of Labor (DOL) and was denied, and that the company sued. Culp said the parties entered settlement talks about six weeks earlier and that an update to the court was expected later in the month. She said the concern is that the company, or others like it, could receive approval or another arrangement, allowing large numbers of consumers into plans not regulated by the states. She noted that the NAIC and many consumer and patient groups filed amicus briefs in the original 2018 case.

Commissioner Humphreys requested that the consumer representatives research direct primary care arrangements that go beyond traditional primary care to include pharmacy, durable medical equipment, imaging, and laboratory services. He also asked them to examine arrangements that partner with commercial high-deductible plans in which the membership fee is embedded in the plan, and he suggested continuing the conversation during a future meeting.

6. Received an Update on the 2026 Report of NAIC Climate Risk Disclosure Survey Data

Jaclyn de Medicci Bruneau (Ceres) said Ceres has conducted the analysis of the NAIC Climate Risk Disclosure Survey on behalf of the NAIC for the past four years. She said the latest report offers, for the first time, a qualitative analysis of all carrier submissions, rating both the robustness and the decision usefulness of the information provided. Additionally, the report again includes an interactive data dashboard and is available to download at no cost. She said the analysis found that participation remains high across four years of reporting, but that the decision usefulness and thoroughness of responses remain low, with about 20% of data points fully meeting the criteria for decision usefulness. She said she prepared handout materials to distribute after the meeting.

Commissioner Lara said that in 2021, he and then-Florida Commissioner David Altmaier led the adoption of the Climate-Related Financial Disclosures (TCFD) Framework as co-chairs of the Climate and Resiliency (EX) Task Force. He said that in five years, the NAIC has built one of the largest and most comprehensive climate risk data sets in the world. He note that more U.S. insurers have published TCFD-aligned reports than the rest of the world combined, including the European Union (EU), and that the report indicates 83% of insurers now address all four TCFD pillars. Commissioner Lara said the effort moved from six jurisdictions to 30 in four years, achieving nearly universal adoption and a unified national data set.

7. Heard a Presentation Titled "Unclaimed Policy Funds: Tracking and Reducing Abandoned Property Transfers"

Brendan Bridgeland (Center for Insurance Research—CIR) addressed the scope of insurance contract abandoned property and the need for additional data. Bridgeland said the amount of unclaimed funds held by abandoned property funds is substantial, totaling approximately $70 billion, and that while states return about one-third of this property to consumers, in some cases, the amount returned is less than 5%. He said the CIR became aware of the issue while working on demutualizations, in which a converting mutual insurer must distribute shares or cash to participating policyholders, and that large life insurers found hundreds of thousands of missing policyholders. Bridgeland offered a personal example of locating a demutualization payment associated with a policy that had been gifted to a newborn, allowing the family to claim both a death benefit and a demutualization payment years after the individual's death.

Bridgeland said that, under the law in most jurisdictions, a life insurance policy is not transferred into abandoned property until three years after the insured would have reached the limiting age of 100. This means that if a person dies at 80, an unclaimed policy would not appear in abandoned property records for another 23 years. He said press accounts in 2010 raised concerns about the use of retained asset accounts (RAAs) as a default settlement option for military families and the difficulties some faced in accessing the funds. Bridgeland said an RAA is an option for settling a death benefit that operates like a checking account, with insurers distributing checkbooks to draw on the funds, but without Federal Deposit Insurance Corporation (FDIC) protection. He said the National Council of Insurance Legislators (NCOIL) developed its Beneficiaries' Bill of Rights, adopted in 2010, which established consumer protections for RAAs, including disclosures about interest rates, fees, and withdrawal limits. For the first time, it also required data collection and disclosure of the funds held in RAAs each year via an addition to the annual statement blank.

Bridgeland said he was granted access to NAIC RAA data reported on insurer annual statements from 2020 to 2025. He said that, during that period, insurers turned over 8,309 individual and 4,621 group RAA contracts to abandoned property funds, with a total value of $113 million and an average value of $8,748 per contract. Bridgeland said one insurer accounted for 19.2% of all abandoned RAAs, or $21.7 million, and a second accounted for 14.5%, or $16.4 million. The top five insurers by RAA surrender value accounted for more than 53%, and the top 20 insurers accounted for 91% of the abandoned RAAs, with a total of 64 insurers turning over RAA accounts. He identified Connecticut, Indiana, Iowa, Maine, Michigan, New York, and Texas as the top states by RAA abandoned property transfer volume.

Brent Walker (Coalition Against Insurance Fraud—Coalition) addressed the fraud risk associated with unclaimed property. Walker said that if fraudsters identify large amounts of unclaimed property and collect enough personal information to impersonate the rightful owners, they can steal the funds, and that fraudsters tend to take the path of least resistance, finding funds held by insurers to be easier targets than funds transferred to state custody. He said that five years ago, large amounts of data were found for sale on the dark web, and that one insurer member identified 18 cases in which more than $129,000 was paid to a person in a Portuguese prison through impersonation fraud. Walker recognized California's investigations branch for actively investigating identified cases. He said the dormancy period during which the insurer still holds the funds (three to five years in some states) appears to be the area most at risk of fraud, and that when an insurer is defrauded through impersonation, the rightful owner or heir loses, and the insurer is often the party that bears the loss. Walker said publicly searchable databases, such as the NAIC Life Insurance Policy Locator, help reunite consumers with funds but can also be exploited by fraudsters. He posed questions about whether and how to quantify the scope of the fraud and whether it is best classified as insurance fraud, a crime related to insurance, or identity theft, noting that if it is not defined as insurance fraud, insurers may not report it under mandatory fraud reporting statutes.

Bridgeland concluded with recommendations, saying that the CIR intends to request that a charge be adopted by the Blanks (E) Working Group to require all insurers to report, in a single line entry, the amount turned over to state unclaimed property funds each year in order to track the totals. Once the total volume is known, work can begin on reducing the amount of proceeds that go unclaimed.

In response to a question from Commissioner Humphreys about whether the charge would be broader than RAAs and about insurers' ability to report only what they know, Bridgeland said the charge would be broad enough to cover all types of insurance. He noted that abandoned property includes small face value life policies, dividends, and demutualization payments, as well as group coverage that is often forgotten when workers change jobs, P/C refunds such as workers' compensation retrospective rating adjustments and title insurance, and health-related amounts, such as medical loss ratio (MLR) rebates. He reiterated that determining the total amount is the first step.

8. Heard a Presentation Titled "Strengthening Oversight: The Critical Role of Ethical Standards in Market Conduct Examinations"

Richard Weber (Life Insurance Consumer Advocacy Center—LICAC) discussed the Insurance Marketplace Standards Association (IMSA) and the principles it promotes, which he said could strengthen regulatory oversight through the role of ethical standards in market conduct examinations. Weber said the IMSA was inspired in the mid-1990s by issues affecting the life and annuity industry, including class action lawsuits against major carriers over "vanishing premium" universal life policy illustrations and publicity regarding nurses in Florida who were offered free medical exams without being told they were applying for life insurance policies. He said the American Council of Life Insurers (ACLI) helped create the IMSA, which became independent in 1997, and that its virtues were later highlighted by the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) in a 2004 presentation.

Weber described the principles of ethical market conduct, which he said were created to influence the sale of individually sold life and annuity products: conducting business according to high standards of honesty and fairness and rendering the service to customers that the carrier would demand for itself; providing competent and consumer-focused sales and service; engaging in active and fair competition; providing advertising and sales materials that are clear, honest, and fair; providing for fair and expeditious handling of customer complaints and disputes; and maintaining a system of supervision and review reasonably designed to achieve compliance. He said a seventh principle addresses the idea that marketplaces cannot be truly and fairly competitive without transparency. Weber said price is important but not more so than trust and transparency. In the first three-year membership cohort, from 1998 to 2000, 219 U.S. carriers participated, with membership requiring processes and

procedures evaluated by an independent auditor. He said the cost of supporting those processes, along with internal issues, led to declining membership and that the IMSA ceased to exist by 2010.

Weber said IMSA's principles are again relevant, citing a 2025 J.D. Power poll indicating consumer satisfaction with insurance at 700 out of 1,000, an AM Best report that 90% of recruited life insurance agents fail within their first four years, and academic papers from 2016 and 2021 finding that most life insurance policies fail to terminate as a death benefit. He said insurers are pursuing new and complex investments, that more consumers are buying online with little service, and that household life insurance ownership has declined to about 50% over the past 20 years while the focus of life insurance has shifted from death benefits toward tax-advantaged retirement income. Weber said his request was for the NAIC to: 1) establish a working group to reconcile the needs and concerns of carriers, state insurance regulators, and consumers toward an updated, NAIC-based version of the IMSA; 2) reformat and define the seven principles; and 3) create an IMSA-like component in the introduction to the *Market Regulation Handbook* as a starting point for new market conduct regulators. He referred members to a handout that includes additional data and four articles he wrote in the mid-1990s about the IMSA.

9. Heard a Presentation Titled "The Importance of Analyzing Complete Data Related to Alleged 'Nuclear' Verdicts"

Amy Bach (United Policyholders—UP), Peter R. Kochenburger (Southern University Law Center), and Kenneth Klein (California Western School of Law) presented on the importance of analyzing complete data related to alleged "nuclear" verdicts. Bach said insurers have cited large jury verdicts in tort reform lobbying campaigns for 50 years, often without acknowledging that the vast majority of those verdicts were significantly reduced by trial or appellate judges and that the verdicts reflected behavior found to be egregious. She cited the McDonald's hot coffee verdict, which she said began at $2.7 million and was reduced to less than $500,000, as well as a mold case verdict reduced on appeal from $4 million to under $1 million, which she said preceded an industry-wide elimination of coverage for mold.

Kochenburger said that roughly 50% to 60% of nuclear verdicts are intellectual property (IP) or other business-to-business claims that are unrelated to homeowners and auto insurance. He said that the examples cited as instances of abusive litigation often omit key facts. Much of the tort reform and social inflation argument concerns effects on homeowners, property, and auto insurance, while another significant category, product liability, affects manufacturers rather than personal lines. Kochenburger referenced reports by Marathon Strategies, including a 2025 report on 2024 verdict data, and discussed two cases cited as examples of legal system abuse. The first was a 2021 South Florida trucking case with a $900 million punitive damages award. Kochenburger said the defendant trucking company was bankrupt, had defaulted, and had had no legal representation since 2019, rendering the award uncollectible. The second case was a talc-related matter with a punitive damages award of approximately $950 million, which he said the trial judge overturned in March 2026, and is under appeal. He said both outcomes were readily discoverable and should have been disclosed or not used.

Klein said that when the individual cases cited in white papers are examined, they often do not support the claim that nuclear verdicts are evidence of frivolous litigation driving premium increases. He identified several concerns, including the absence of a consistent definition of nuclear verdicts, the inclusion of verdicts that insurance does not respond to (such as punitive damages, which several states prohibit insuring), the confusion of correlation with causation, and the absence of a causation or regression analysis that accounts for factors such as catastrophe events and building costs. Klein said the data is often misaligned with the proposed solution because business-to-business and IP verdicts have no bearing on personal auto or homeowner premiums. He said the court system aggressively screens cases for merit at multiple stages and that assuming a reduction in claims or verdicts eliminates frivolous litigation rests on the assumption that the court system is failing. Klein used the example of a $25 million verdict cited to an NAIC child care insurance group, which he said did not involve a child care provider but rather a foster family agency (FFA) that placed a child in a setting where the child was sexually abused. He

noted that the appellate court described denying liability to children wronged by negligent FFAs as a "blunt and morally fraught approach." Klein said the NAIC's meetings and its *Affordability and Availability of Homeowners Insurance Playbook* indicate that the NAIC is aware of these issues and is not accepting white papers at face value. To that end, he recommended a full-day seminar or summit bringing together parties with differing views rather than a brief presentation.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.

