

Draft: Nov. 16, 2022

Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 14, 2022
Adopted by the Antifraud (D) Task Force, Nov. 16, 2022

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC's Executive Committee is required. The NAIC's Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: New Model Law or Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

Market Regulation Consumer Affairs (D) Committee/Antifraud (D) Task Force/Improper Marketing of Health Insurance (D) Working Group

2. NAIC staff support contact information:

Market Regulation and Consumer Affairs (D) Committee – Tim Mullen
Antifraud (D) Task Force – Greg Welker
Improper Marketing of Health Insurance (D) Working Group – Greg Welker

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

Proposed are amendments to the *Unfair Trade Practices Act* (#880):

Section 2: Definitions
Section 3: Unfair Trades Practices Prohibited
Section 4: Unfair Trade Practices Defined

The Improper Marketing of Health Insurance (D) Working Group is charged to (1) coordinate with regulators, both on a state and federal level, to provide assistance monitoring the improper marketing of health plans and coordinate appropriate enforcement actions, as needed, with other NAIC Committees, Task Forces, and Working Groups; and (2) review existing NAIC Models and Guidelines that address the use of lead generators for sales of health insurance products and to identify models and guidelines that need to be updated or developed to address current marketplace activities.

In order to achieve this goal and provide regulation over lead generators, the Working Group is requesting the review the above-mentioned Model #880, Sections 2, 3, and 4.

Section 2: There is currently no definition for Health Insurance Lead Generator. This section will be amended to include a definition of Health Insurance Lead Generator.

Section 3: This section will be amended to prohibit a Health Insurance Lead Generator, as defined in Section 2, from engaging in an unfair trade practice.

Section 4: This section will be amended to define what marketing-related activity of Health Insurance Lead Generators are unfair trade practices. These amendments will provide states the means to regulate lead generators and gain a level of consumer protection that is not currently in place.

4. Does the model law meet the Model Law Criteria? Yes or No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? Yes or No (Check one)

If yes, please explain why: One of the initial efforts at developing state legislation in response to the McCarran-Ferguson Act of 1945 was the development of trade practices legislation and the adoption of the NAIC's Unfair Trade Practices Act in 1947. Health Insurance Lead Generators impact consumers in every jurisdiction. Insurance regulatory authority over Health Insurance Lead Generators and defining prohibited practices of Health Insurance Lead Generators need to be clarified.

b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
 Yes or No (Check one)

5. What is the likelihood that your committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?
 1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?
 1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

8. Is this model law referenced in the NAIC Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

No

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No

Draft: 12/2/23

Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 3, 2023
Adopted by the Antifraud (D) Task Force, Dec. 2, 2023

UNFAIR TRADE PRACTICES ACT

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Prefatory Note: By adopting amendments to this model act in June 1990, the NAIC separated provisions dealing with unfair claims settlement into a newly adopted Unfair Claims Settlement Practices Model Act, to make clearer distinction between general unfair trade practices and more specific unfair claim settlement issues and to focus on market conduct practices and market conduct regulation. By doing so, the NAIC is not recommending that states repeal existing acts, but states may modify them for the purpose of capturing the substantive changes. However, for those states wishing to completely rewrite their comprehensive approach to unfair claims practices, this separation of unfair claims from unfair trade practices is recommended.

Section 1. Purpose

The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress) and the Gramm-Leach-Bliley Act (Public Law 106-102, 106th Congress), by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. Nothing herein shall be construed to create or imply a private cause of action for a violation of this Act.

Section 2. Definitions

When used in this Act:

- A. "Affiliate" means any company that controls, is controlled by, or is under common control with another company.
- B. "Commissioner" means the commissioner of insurance of this state.

Drafting Note: Insert the appropriate term for the chief insurance regulatory official wherever the term “commissioner” appears.

- C. “Customer” means an individual who purchases, applies to purchase, or is solicited to purchase insurance products primarily for personal, family or household purposes.
- D. “Depository institution” means a bank or savings association. The term depository institution does not include an insurance company.
- E. “Health Insurance Lead Generator” means any person that utilizes a lead-generating device to:
 - (1) Publicize the availability of what is, or what purports to be, a health insurance product or service that the person is not licensed to sell directly to a customer.
 - (2) Identifies a customer who may want to learn more about a health insurance product; or
 - (3) Sells or transmits customer information to insurers or producers for follow-up contact and sales activity.
- F. “Lead-generating device” means any communication directed to the public that, regardless of form, content, or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this State for the purchase of what is or what purports to be a health insurance product or service.
- G. “Insured” means the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy.
- H. “Insurer” means any person, reciprocal exchange, interinsurer, Lloyd’s insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including producers, adjusters and third-party administrators. Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health service plans as defined in Sections [insert applicable section]. For purposes of this Act, these foregoing entities shall be deemed to be engaged in the business of insurance.

Drafting Note: Each state may wish to consider the advisability of defining “insurance” for purposes of this Act if its present insurance code is not satisfactory in this regard. In some cases, a cross reference will be sufficient.

- I. “Person” means a natural or artificial entity, including but not limited to, individuals, partnerships, associations, trusts, or corporations. For purposes of this act, “person” includes a health insurance lead generator operating as any such natural or artificial entity.
- J. “Policy” or “certificate” means a contract of insurance, indemnity, medical, health or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer.
- K. “Producer” means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

- L. “Recording” means recording of sales and verification of calls, including virtual technology calls, in their entirety, used in the marketing of insurance.

Section 3. Unfair Trade Practices Prohibited

It is an unfair trade practice for any insurer, health insurance lead generator, or person engaged in the business of insurance to commit any practice defined in Section 4 of this Act if:

- A. It is committed flagrantly and in conscious disregard of this Act or of any rules promulgated hereunder; or
- B. It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

Section 4. Unfair Trade Practices Defined

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

- A. Misrepresentations and False Advertising of Insurance Policies. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison that:
 - (1) Misrepresents the benefits, advantages, conditions, or terms of any policy; or
 - (2) Misrepresents the dividends or share of the surplus to be received on any policy; or
 - (3) Makes a false or misleading statement as to the dividends or share of surplus previously paid on any policy; or
 - (4) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates; or
 - (5) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof; or
 - (6) Is a misrepresentation, including any intentional misquote of premium rate, for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion or surrender of any policy; or
 - (7) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or
 - (8) Misrepresents any policy as being shares of stock.
- B. False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, electronic mail, internet advertisement or posting, or other publication, or in the form of a notice, circular, pamphlet, letter, electronic posting of any kind or poster, or over any radio or television station, or via the

- internet or other electronic means, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the conduct of its insurance business, which is untrue, deceptive or misleading.
- C. Failure to Maintain Marketing and Performance Records. Failure of a health insurance lead generator to maintain its books, records, documents and other business records in such an order that data regarding complaints and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two (2) preceding years shall be maintained. Failure to do so shall constitute a violation of (insert state statute).
 - D. Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure such insurer.
 - E. Boycott, Coercion and Intimidation. Entering into any agreement to commit, or by any concerted action committing any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.
 - F. False Statements and Entries.
 - (1) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of an insurer.
 - (2) Knowingly making any false entry of a material fact in any book, report or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer, or knowingly making any false material statement to any insurance department official.
 - G. Stock Operations and Advisory Board Contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to purchase insurance.
 - H. Unfair Discrimination.
 - (1) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any life insurance policy or annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such policy.

- (2) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any accident or health insurance policy or in the benefits payable thereunder, or in any of the terms or conditions of such policy, or in any other manner.

Drafting Note: In the event that unfair discrimination in connection with accident and health coverage is treated in other statutes, this paragraph should be omitted.

- (3) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless such action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience.
- (4) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on the residential property risk, or the personal property contained therein, solely because of the age of the residential property.
- (5) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex, marital status, race, religion or national origin of the individual; however, nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits. Nothing in this section shall prohibit or limit the operation of fraternal benefit societies.
- (6) To terminate, or to modify coverage or to refuse to issue or refuse to renew any property or casualty policy solely because the applicant or insured or any employee of either is mentally or physically impaired; provided that this subsection shall not apply to accident and health insurance sold by a casualty insurer and, provided further, that this subsection shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract.
- (7) Refusing to insure solely because another insurer has refused to write a policy, or has cancelled or has refused to renew an existing policy in which that person was the named insured. Nothing herein contained shall prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance.
- (8) Violation of the state's rescission laws at [insert reference to appropriate code section].

Drafting Note: A state may wish to include this section if it has existing state laws covering rescission and to insert a reference to a particular code section.

I. 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, 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
 - (d) Engaging in an arrangement that would not violate Section 106 of the Bank Holding Company Act Amendments of 1972 (12 U.S.C. 1972), as interpreted by the Board of Governors of the Federal Reserve System, or Section 5(q) of the Home Owners' Loan Act, 12 U.S.C. 1464(q).
 - (e) The offer or provision by insurers or producers, by or through employees, affiliates or third-party representatives, of value-added 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:
 - (i) Relates to the insurance coverage; and
 - (ii) Is primarily designed to satisfy one or more of the following:
 - (I) Provide loss mitigation or loss control;

- (II) Reduce claim costs or claim settlement costs;
 - (III) Provide education about liability risks or risk of loss to persons or property;
 - (IV) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;
 - (V) Enhance health;
 - (VI) Enhance financial wellness through items such as education or financial planning services;
 - (VII) Provide post-loss services;
 - (VIII) Incent behavioral changes to improve the health or reduce the risk of death or disability of a customer (defined for purposes of this subsection as policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured or applicant); or
 - (IX) Assist in the administration of the employee or retiree benefit insurance coverage.
- (iii) The cost to the insurer or producer offering the product or service to any given customer must be reasonable in comparison to that customer's premiums or insurance coverage for the policy class.
 - (iv) If the insurer or producer is providing the product or service offered, the insurer or producer must ensure that the customer is provided with contact information to assist the customer with questions regarding the product or service.
 - (v) The commissioner may adopt regulations when implementing the permitted practices set forth in this statute to ensure consumer protection. Such regulations, consistent with applicable law, may address, among other issues, consumer data protections and privacy, consumer disclosure and unfair discrimination.
 - (vi) The availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory. The documented criteria must be maintained by the insurer or producer and produced upon request by the Department.

Drafting Note: States may wish to consider alternative language based on their filing requirements.

- (vii) If an insurer or producer does not have sufficient evidence but has a good-faith belief that the product or service meets the criteria in H(2)(e)(ii), the insurer or producer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing

program for no more than one year. An insurer or producer must notify the Department of such a pilot or testing program offered to consumers in this state prior to launching and may proceed with the program unless the Department objects within twenty-one days of notice.

Drafting Note: This Section is not intended to limit or curtail existing value-added services in the marketplace. It is intended to promote innovation in connection with the offering of value-added services while maintaining strong consumer protections.

- (f) An insurer or a producer may:
 - (i) Offer or give non-cash gifts, items, or services, including meals to or charitable donations on behalf of a customer, in connection with the marketing, sale, purchase, or retention of contracts of insurance, as long as the cost does not exceed an amount determined to be reasonable by the commissioner per policy year per term. The offer must be made in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.
 - (ii) Offer or give non-cash gifts, items, or services including meals to or charitable donations on behalf of a customer, to commercial or institutional customers in connection with the marketing, sale, purchase, or retention of contracts of insurance, as long as the cost is reasonable in comparison to 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. The offer must be made in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.
 - (iii) Conduct raffles or drawings to the extent permitted by state law, as long as there is no financial cost to entrants to participate, 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 manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.

Drafting Note: If a state wishes to limit (f) to a stated monetary limit 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 governed by the Real Estate Settlement Procedures Act of 1974 and the laws and regulations governing the Federal Crop Insurance Corporation Risk Management Agency. States may want to consider a limit for commercial or institutional customers.

- (3) An insurer, producer or representative of either may not offer or provide insurance as an inducement to the purchase of another policy or otherwise use the words “free”, “no cost” or words of similar import, in an advertisement.

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(q) 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.

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 may be expanded to cover all lines of insurance.

- J. Prohibited Group Enrollments. No insurer shall offer more than one group policy of insurance through any person unless such person is licensed, at a minimum, as a limited insurance representative. However, this prohibition shall not apply to employer/employee relationships, nor to any such enrollments.
- K. Failure to Maintain Marketing and Performance Records. Failure to maintain its books, records, documents and other business records, including any recordings, when applicable, in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two (2) preceding years (or insert state requirement) shall be maintained.
- L. Failure to Maintain Complaint Handling Procedures. Failure of any insurer to maintain a complete record of all the complaints it received since the date of its last examination under Section [insert applicable section]. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this subsection, “complaint” shall mean any written communication primarily expressing a grievance.
- M. Misrepresentation in Insurance Applications. Making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money or other benefit from any provider or individual person.
- N. Unfair Financial Planning Practices. An insurance producer:
 - (1) Holding himself or herself out, directly or indirectly, to the public as a “financial planner,” “investment adviser,” “consultant,” “financial counselor,” or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters or trust and estate matters when such person is in fact engaged only in the sale of policies. This provision does not preclude persons who hold some form of formal recognized financial planning or consultant certification or designation from using this certification or designation when they are only selling insurance. This does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

- (2) (a) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in Paragraph 3, or solicitation of the sale of a product or service that
 - (i) He or she is also an insurance salesperson, and
 - (ii) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case.
- (b) The disclosure requirement under this subsection may be met by including it in any disclosure required by federal or state securities law.
- (3) (a) Charging fees other than commissions for financial planning by insurance producer, unless such fees are based upon a written agreement, signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the party to be charged at the time the agreement is signed by the party.
 - (i) The services for which the fee is to be charged must be specifically stated in the agreement.
 - (ii) The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement.
 - (iii) The agreement must state that the client is under no obligation to purchase any insurance product through the insurance producer or consultant.

Drafting Note: This subsection is intended to apply only to persons engaged in personal financial planning.

- (b) The insurance producer shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the commissioner upon request.
- O. Failure to file or to certify information regarding the endorsement or sale of long-term care insurance. Failure of any insurer to:
- (1) File with the insurance department the following material:
 - (a) The policy and certificate;
 - (b) A corresponding outline of coverage; and
 - (c) All advertisements requested by the insurance department; or
 - (2) Certify annually that the association has complied with the responsibilities for disclosure, advertising, compensation arrangements, or other information required by the commissioner, as set forth by regulation.
- P. Failure to Provide Claims History

- (1) Loss Information—Property and Casualty. Failure of a company issuing property and casualty insurance to provide the following loss information for the three (3) previous policy years to the first named insured within thirty (30) days of receipt of the first named insured’s written request:
 - (a) On all claims, date and description of occurrence, and total amount of payments; and
 - (b) For any occurrence not included in Subparagraph (a) of this paragraph, the date and description of occurrence.
- (2) Should the first named insured be requested by a prospective insurer to provide detailed loss information in addition to that required under Paragraph (1), the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than reasonably required to underwrite the same line or class of insurance. The insurer shall provide information under this subparagraph to the first named insured as soon as possible, but in no event later than twenty (20) days of receipt of the written request. Notwithstanding any other provision of this section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information.
- (3) The commissioner may promulgate regulations to exclude the providing of the loss information as outlined in Paragraph (1) for any line or class of insurance where it can be shown that the information is not needed for that line or class of insurance, or where the provision of loss information otherwise is required by law.

Drafting Note: Loss information on workers’ compensation is an example in some states of loss information otherwise required by law.

- (4) Information provided under Paragraph (2) shall not be subject to discovery by any party other than the insured, the insurer and the prospective insurer.

Drafting Note: This provision may not be required in states that have a privacy act that governs consumer access to this information. Those states considering applying this requirement to life, accident and health lines of insurance should first review their state privacy act related to issues of confidentiality of individual insured information.

Q. Violating any one of Sections [insert applicable sections].

Drafting Note: Insert section numbers of any other sections of the state’s insurance laws deemed desirable or necessary to include as an unfair trade practice, such as cancellation and nonrenewal laws.

Section 5. Favored Agent or Insurer; Coercion of Debtors

- A. No person or depository institution, or affiliate of a depository institution may require as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such money or credit is extended or whose obligation a creditor is to acquire or finance, negotiate any policy or renewal thereof through a particular insurer or group of insurers or agent or broker or group of agents or brokers. Further, no person or depository institution, or affiliate of a depository institution, may reject an insurance policy solely because the policy has been issued or underwritten by a person who is not associated with the depository institution or affiliate when insurance is required in connection with a loan or extension of credit.
- B. No person or depository institution, or affiliate of a depository institution, who lends money or extends credit may:
- (1) As a condition for extending credit or offering any product or service that is equivalent to an extension of credit, require that a customer obtain insurance from a depository institution or an affiliate of a depository institution, or a particular insurer or producer. However, this provision does not prohibit a person or depository institution, or affiliate of a depository institution, from informing a customer or prospective customer that insurance is required in order to obtain a loan or credit, or that loan or credit approval is contingent upon the procurement by the customer of acceptable insurance, or that insurance is available from the person or depository institution, or affiliate of a depository institution;
 - (2) Unreasonably reject a policy furnished by the customer or borrower for the protection of the property securing the credit or lien. A rejection shall not be deemed unreasonable if it is based on reasonable standards, uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for rejection of a policy because it contains coverage in addition to that required in the credit transaction;
 - (3) Require that any customer, borrower, mortgagor, purchaser, insurer, broker or agent pay a separate charge, in connection with the handling of any policy required as security for a loan on real estate or pay a separate charge to substitute the policy of one insurer for that of another. This paragraph does not include the interest that may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document. Further, this paragraph does not apply to charges that would be required when the person or depository institution or affiliate of a depository institution is the licensed producer providing the insurance;
 - (4) Require any procedures or conditions of duly licensed producers or insurers not customarily required of those producers or insurers affiliated or in any way connected with the person who lends money or extends credit;
 - (4) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state is responsible for the insurance sales activity of, or stands behind the credit of, the person, depository institution or its affiliate;

- (6) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state guarantees any returns on insurance products or is a source of payment on any insurance obligation of or sold by the person, depository institution or its affiliate;
- (7) Act as a producer unless properly licensed in accordance with [insert appropriate statutory provisions for producer licensing];
- (8) Pay or receive any commission, brokerage fee or other compensation as a producer, unless the person holds a valid producer's license for the applicable class of insurance. However, an unlicensed person may make a referral to a licensed producer provided that the person does not discuss specific insurance policy terms and conditions. The unlicensed person may be compensated for the referral; however, in the case of a referral of a customer, the unlicensed person may be compensated only if the compensation is a fixed dollar amount for each referral that does not depend on whether the customer purchases the insurance product from the licensed producer. Furthermore, any person who accepts deposits from the public in an area where such transactions are routinely conducted in the depository institution may receive for each customer referral no more than a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a transaction;

Drafting Note: The last sentence of this paragraph further limits the referral for customers of personal, family and household insurance products as a result of Section 305 of the Gramm-Leach-Bliley Act and the subsequent adoption of regulations by the federal banking regulators at 12 C.F.R. 14.50, 208.85, 343.50 and 536.50. By including this language the paragraph will be consistent with the Gramm-Leach-Bliley Act and the federal regulations while maintaining the integrity of Section 104(d)(2)(B)(iv) and (v) of the Gramm-Leach-Bliley Act.

- (9) Solicit or sell insurance, other than credit insurance or flood insurance, unless the solicitation or sale is completed through documents separate from any credit transactions;
- (10) Include the expense of insurance premiums, other than credit insurance premiums or flood insurance premiums, in the primary credit transaction without the express written consent of the customer;
- (11) Solicit or sell insurance unless its insurance sales activities are, to the extent practicable, physically separated from areas where retail deposits are routinely accepted by depository institutions; or
- (12) Solicit or sell insurance unless it maintains separate and distinct books and records relating to the insurance transactions, including all files relating to and reflecting consumer complaints.

Drafting Note: The Gramm-Leach-Bliley Act contains two "safe harbors" that relate to information sharing. Section 104(d)(2)(B)(vi) describes the circumstances surrounding the release of a customer's insurance information. Section 104(d)(2)(B)(vii) describes the circumstances surrounding the use of a customer's health information obtained from the insurance records of the customer. If a state has adopted the NAIC's Privacy of Consumer Financial and Health Information Model Regulation, no further action is needed. If not, language implementing the two safe harbors should be considered. It should be noted, however, that during the drafting process, there were concerns expressed about the application of the preemption provisions of the Fair Credit

Reporting Act (FCRA) in circumstances involving the sharing of information with affiliates. Nothing in this Act shall be construed to modify, limit or supersede the operation of the FCRA (15 U.S.C. 1681 *et seq.*). In addition, no inference shall be drawn on the basis of the provisions of this Act regarding whether information is transaction or experience information under Section 603 of FCRA.

- C. Every person or depository institution, or affiliate of a depository institution that lends money or extends credit and who solicits insurance primarily for personal, family or household purposes shall disclose to the customer in writing that the insurance related to the credit extension may be purchased from an insurer or producer of the customer's choice, subject only to the lender's right to reject a given insurer or agent as provided in Subsection B(2). Further, the disclosure shall inform the customer that the customer's choice of insurer or producer will not affect the credit decision or credit terms in any way, except that the depository institution may impose reasonable requirements concerning the creditworthiness of the insurer and the scope of coverage chosen as provided in Subsection B(2).

- D. (1) A depository institution that solicits, sells, advertises or offers insurance, and any person who solicits, sells, advertises or offers insurance on behalf of a depository institution or on the premises of a depository institution shall disclose to the customer in writing, where practicable and in a clear and conspicuous manner, prior to a sale, that the insurance:
 - (a) Is not a deposit;
 - (b) Is not insured by the Federal Deposit Insurance Corporation or any other federal government agency;
 - (c) Is not guaranteed by the depository institution, its affiliate (if applicable) or any person that is soliciting, selling, advertising or offering insurance (if applicable); and
 - (d) Where appropriate, involves investment risk, including the possible loss of value.

- (2) For purposes of these requirements, an affiliate of a depository institution is subject to these requirements only to the extent that it sells, solicits, advertises, or offers insurance products or annuities at an office of a depository institution or on behalf of a depository institution. These requirements apply only when an individual purchases, applies to purchase, or is solicited to purchase insurance products or annuities primarily for personal, family or household purposes and only to the extent that the disclosure would be accurate.

Drafting Note: The requirements of this provision are meant to apply only when the consumer may have a reasonable belief that the product is a deposit; that it is insured by the Federal Deposit Insurance Corporation; that it is guaranteed by the person or depository institution; and that, where appropriate, it involves investment risk, including the possible loss of value. This provision is not intended to require every entity or person in a financial holding company to provide the disclosure as a result of having both solicitation of insurance and extending of credit or lending of money occurring within an entity in the financial holding company group.

- (3) A depository institution that solicits, sells, advertises, or offers insurance, and any person who solicits, sells, advertises or offers insurance on behalf of a depository institution or on the premises of a depository institution shall obtain written acknowledgement of the receipt of the disclosure from the customer at the time the customer receives the disclosure or at the time of the initial purchase of the insurance policy. If the solicitation is conducted by telephone, the person or depository institution shall obtain an oral acknowledgement of receipt of the disclosure, maintain sufficient documentation to show that the acknowledgment was given by the customer, and make reasonable efforts to obtain a written acknowledgment from the customer. If a customer affirmatively consents to receiving the disclosures electronically and if the disclosures are provided in a format that the customer may retain or obtain later, the person or depository institution may provide the disclosure and obtain acknowledgement of the receipt of the disclosure from the customer using electronic media.
 - (4) For the purposes of Paragraph (1), a person is selling, soliciting, advertising or offering insurance on behalf of a depository institution, whether at an office of the depository institution or another location, if at least one of the following applies:
 - (a) The person represents to the customer that the sale, solicitation, advertisement or offer of the insurance is by or on behalf of the depository institution;
 - (b) The depository institution refers a customer to the person who sells insurance, and the depository institution has a contractual arrangement to receive commissions or fees derived from the sale of insurance resulting from the referral; or
 - (c) Documents evidencing the sale, solicitation, advertisement or offer of insurance identify or refer to the depository institution.
- E. The commissioner shall have the power to examine and investigate those insurance activities of any person, depository institution, affiliate of a depository institution or insurer that the commissioner believes may be in violation of this section. The person, depository institution, affiliate of a depository institution or insurer shall make its insurance books and records available to the commissioner and the commissioner's staff for inspection upon reasonable notice. An affected person may submit to the commissioner a complaint or material pertinent to the enforcement of this section.
- F. Nothing herein shall prevent a person or depository institution, or affiliate of a depository institution, who lends money or extends credit from placing insurance on real or personal property in the event the mortgagor, borrower or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.
- G. Nothing contained in this section shall apply to credit related insurance.

Drafting Note: The consumer protection rules promulgated by the banking regulatory agencies pursuant to Section 305 of the Gramm-Leach-Bliley Act apply to retail sales practices, solicitations, advertising or offers of any insurance product or annuity. If a state has adopted the NAIC's Consumer Credit Insurance Model Act and Consumer Credit Insurance Model Regulation, no further action is needed. If not, the state should consider eliminating Subsection G.

Section 6. Power of Commissioner

The commissioner shall have power to examine and investigate the affairs of every person or insurer or health insurance lead generator in this state in order to determine whether such person, insurer, or health insurance lead generator has been or is engaged in any unfair trade practice prohibited by this Act. However, in the case of depository institutions, the commissioner shall have the power to examine and investigate the insurance activities of depository institutions, in order to determine whether the depository institution has been or is engaged in any unfair trade practice prohibited by this Act. The commissioner shall notify the appropriate federal banking agency of the commissioner's intent to examine or investigate a depository institution and advise the appropriate federal banking agency of the suspected violations of state law prior to commencing the examination or investigation.

Section 7. Hearings, Witnesses, Appearances, Production of Books, and Service of Process

- A. Whenever the commissioner shall have reason to believe that any insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution has been engaged or is engaging in this state in any unfair trade practice whether or not defined in this Act, and that a proceeding by the commissioner in respect thereto would be in the interest of the public, the commissioner shall issue and serve upon such insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution, a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than [insert number] days after the date of the service thereof. With respect to a depository institution, the commissioner's authority to call a hearing is limited to the depository institution's insurance underwriting, sales, solicitation and cross marketing activities. The commissioner shall provide a copy of the notice of hearing to the appropriate federal banking agency when a depository institution is involved.
- B. At the time and place fixed for the hearing, the insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner requiring the insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution to cease and desist from the acts, methods or practices so complained of. Upon good cause shown, the commissioner shall permit any person to intervene, appear and be heard at the hearing by counsel or in person.
- C. Nothing contained in this Act shall require the observance at the hearing of formal rules of pleading or evidence.
- D. The commissioner, at the hearing, may administer oaths, examine and cross examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence or other documents the commissioner deems relevant to the inquiry, provided, however, that in the case of depository institutions, the commissioner shall have the power to require the production of books, papers, records, correspondence or other documents that the commissioner deems relevant to the inquiry only on the insurance activities of the depository institution. The commissioner, may, and upon the request of any party, shall cause to be made a stenographic record of all the evidence and all the proceedings at the hearing. If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person

to comply with any subpoena or to testify with respect to any matter concerning which he may be lawfully interrogated, the [insert title] Court of [insert county] County or the county where the person resides, on application of the commissioner, may issue an order requiring such person to comply with the subpoena and to testify; and any failure to obey any order of the court may be punished by the court as contempt.

- E. Statements of charges, notices, orders and other processes of the commissioner under this Act may be served by anyone duly authorized by the commissioner, either in the manner provided by law for service of process in civil actions, or by registering and mailing a copy thereof to the person affected by the statement, notice, order or other process at the person's residence or principal office or place of business. The verified return by the person so serving the statement, notice, order, or other process, setting forth the manner of service, shall be proof of the same, and the return postcard receipt for the statement, notice, order or other process, registered and mailed as specified, shall be proof of the service of the same.

Section 8. Cease and Desist and Penalty Orders

- A. If, after a hearing, the commissioner finds that an insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution has engaged in an unfair trade practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution charged with the violation, a copy of the findings in an order requiring the insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution to cease and desist from engaging in the act or practice and the commissioner may, at the commissioner's discretion order:
 - (1) Payment of a monetary penalty of not more than \$1,000 for each violation, but not to exceed an aggregate penalty of \$100,000, unless the violation was committed flagrantly in a conscious disregard of this Act, in which case the penalty shall not be more than \$25,000 for each violation not to exceed an aggregate penalty of \$250,000; and/or
 - (2) Suspension or revocation of the insurer's license if the insurer knew or reasonably should have known that it was in violation of this Act.
- B. In the case of a depository institution, the commissioner shall, if practicable, notify the appropriate federal regulator before imposing a monetary penalty on a depository institution or suspending or revoking the depository institution's insurer's license, and provide to the federal regulator a copy of the findings.

Section 9. Judicial Review of Orders

- A. An insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution subject to an order of the commissioner under Section 8 or Section 11 may obtain a review of the order by filing in the [insert title] Court of [insert county] County, within [insert number] days from the date of the service of the order, a written petition praying that the order of the commissioner be set aside. A copy of the petition shall be served upon the commissioner, and thereupon the commissioner shall certify and file in the court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the commissioner. Upon filing of the petition and transcript, the court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of

the petition shall operate as a stay of the order of the commissioner, and shall have power to make and enter upon the pleadings, evidence and proceedings set forth in the transcript a decree modifying, affirming or reversing the order of the commissioner, in whole or in part. The findings of the commissioner as to the facts, if supported by [insert type] evidence, shall be conclusive.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination.

- B. To the extent that the order of the commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of the order of the commissioner. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that the additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as the court may deem proper. The commissioner may modify the findings of fact, or make new findings by reason of the additional evidence so taken, and shall file the modified or new findings that are supported by [insert type] evidence with a recommendation if any, for the modification or setting aside of the original order, with the return of the additional evidence.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination. In a state where final judgment, order or decree would not be subject to review by an appellate court provision therefor should be inserted here.

- C. An order issued by the commissioner under Section 8 shall become final:
 - (1) Upon the expiration of the time allowed for filing a petition for review if no such petition has been duly filed within such time; except that the commissioner may thereafter modify or set aside the order to the extent provided in Section 9B; or
 - (2) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for review dismissed.
- D. No order of the commissioner under this Act or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

Section 10. Judicial Review by Intervenor

If after any hearing under Section 7 or Section 11, the report of the commissioner does not charge a violation of this Act, then any intervenor in the proceedings may within [insert number] days after the service of the report, cause a petition [notice of appeal] [petition for writ of certiorari] to be filed in the [insert title] Court of [insert county] County for a review of the report. Upon review, the court shall have authority to issue appropriate orders and decrees in connection therewith, including, if the court finds that it is to the interest of the public, orders enjoining and restraining the continuance of any method of competition, act or practice which it finds, notwithstanding the report of the commissioner, constitutes a violation of this Act, and containing penalties pursuant to Section 8.

Drafting Note: The type of procedure should conform to state procedure. See also note to Section 9 concerning review by appellate courts.

Section 11. Penalty for Violation of Cease and Desist Orders

Any insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution that violates a cease and desist order of the commissioner and while such order is in effect, may after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to:

- A. A monetary penalty of not more than \$25,000 for each and every act or violation not to exceed an aggregate of \$250,000 pursuant to any such hearing; and/or
- B. Suspension or revocation of the insurer's license.

Section 12. Regulations

The commissioner may, after notice and hearing, promulgate reasonable rules, regulations and orders as are necessary or proper to carry out and effectuate the provisions of this Act. Such regulations shall be subject to review in accordance with Section [insert applicable section].

Drafting Note: Insert section number providing for review of administrative orders.

Section 13. Provisions of Act Additional to Existing Law

The powers vested in the commissioner by this Act shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

Section 14. Immunity from Prosecution

If any person shall ask to be excused from attending and testifying or from producing any books, papers, records, correspondence or other documents at any hearing on the ground that the testimony or evidence required may tend to incriminate or subject the person to a penalty or forfeiture, and shall notwithstanding be directed to give testimony or produce evidence, the person shall nonetheless comply with the direction, but shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which the person may testify or produce evidence thereto, and no testimony so given or evidence produced shall be received against the person upon any criminal action, investigation or proceeding; provided, however, that no person so testifying shall be exempt from prosecution or punishment for any perjury committed while so testifying and the testimony or evidence so given or produced shall be admissible against the person upon any criminal action, investigation or proceeding concerning such perjury, nor shall the person be exempt from the refusal, revocation or suspension of any license, permission or authority conferred, or to be conferred, pursuant to the Insurance Law of this state. Any such person may execute, acknowledge and file in the office of the commissioner a statement expressly waiving immunity or privilege in respect to any transaction, matter or thing specified in the statement and thereupon the testimony of the person or evidence in relation to the transaction, matter or thing may be received or produced before any judge or justice, court, tribunal, grand jury or otherwise, and if so received or produced the person shall not be entitled to any immunity or privilege on account of any testimony the person may give or evidence produced.

Section 15. Separability Provision

If any provision of this Act, or the application of the provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of the provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1947 Proc. 383, 392-400, 413 (adopted).

1960 Proc. II 485-487, 509-515, 516 (reprinted).

1972 Proc. I 15, 16, 443-444, 491, 493-501 (amended and reprinted).

1977 Proc. I 26, 28, 211, 226-227 (amended).

1979 Proc. II 31, 34, 38, 39, 525 (amended).

1985 Proc. I 19, 39, 85-86 (amended).

1989 Proc. II 13, 21, 129-130, 132, 133-140 (amended and reprinted).

1990 Proc. I 6, 25, 122, 146 (changed name of model).

1990 Proc. II 7, 13-14, 160, 169-177 (amended and reprinted).

1991 Proc. I 9, 16, 192-193, 196-203 (amended and reprinted).

1993 Proc. I 8, 136, 242, 246-254 (amended and reprinted).

1993 Proc. 1st Quarter 3, 34, 267, 274, 276 (amended).

2001 Proc. 2nd Quarter 7, 9, 836, 843-853 (amended and reprinted).

2021 Spring National Meeting (amended).

Draft: Mar 5, 2024

PROJECT HISTORY

AMENDMENTS TO THE *UNFAIR TRADE PRACTICES MODEL ACT* (#880)

1. Description of the project, issues addressed, etc.

In July 2021, the Market Regulation and Consumer Affairs (D) Committee adopted a new charge and appointed the Improper Marketing of Health Insurance (D) Working Group under the Antifraud (D) Task Force. The Working Group was assigned two charges:

- A. Coordinate with regulators, both on a state and federal level, to provide assistance and guidance on monitoring the improper marketing of health plans and coordinate appropriate enforcement actions, as needed, with other NAIC committees, task forces, and working groups.
- B. Review existing NAIC models and guidelines that address the use of lead generators for sales of health insurance products and identify models and guidelines that need to be updated or developed to address current marketplace activities.

As a result of the Working Group's discussions in 2021 regarding current marketplace practices and enforcement actions concerning the improper marketing of health plans, the Working Group adopted amendments to the *Unfair Trade Practices Act* (#880):

- Section 2: Definitions. This section was amended to include a definition of health insurance lead generator and lead-generating device.
- Section 3: Unfair Practices Prohibited. This section was amended to specify it is unfair trade practice for any insurer, health insurance lead generator, or person engaged in the business of insurance to commit any practices defined in Section 4 of Model #880.
- Section 4: Unfair Trade Practices Defined. Subsection 4.B (false information and advertising) was amended to encompass the use of email, internet advertisement, or electronic posting of any kind via the internet or other electronic means.

2. Name of group responsible for drafting the model and states participating.

The Improper Marketing of Health Insurance (D) Working Group of the Antifraud (D) Task Force was responsible for drafting the revisions.

3. Project authorized by what charge and date first given to the group.

The project was authorized in 2021 by the following charge: Review existing NAIC models and guidelines that address the use of lead generators for sales of health insurance products and identify models and guidelines that need to be updated or developed to address current marketplace activities.

The Executive (EX) Committee unanimously adopted the Request for NAIC Model Law Development for revising Model #880 at the 2023 Spring National Meeting.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

In the fall of 2021, the Improper Marketing of Health Insurance (D) Working Group began its work to address its charge to review existing models and guidelines that need to be updated or developed to address the use of lead generators for the sale of health insurance products. The first draft of amendments to Model #880 was distributed to interested regulators and interested parties for review and comment in August 2022. The second draft of amendments to Model #880 was distributed in November 2022.

During the 2023 Spring National Meeting, the Working Group reviewed the second draft and the comments received. Following the Spring National Meeting, a small group of subject matter experts (SMEs) completed the drafting of amendments, and the Working Group circulated a third draft of the model in July 2023.

All drafts were posted on the NAIC website. Written regulator comments were received from Hawaii, Maine, Missouri, Ohio, and Rhode Island. Written industry comments were received from the American Council of Life Insurers (ACLI), the American Health Insurance Policies (AHIP), The Health Benefits Institute, and the National Association of Health Underwriters (NAHU). NAIC consumer representatives also submitted a joint comment letter.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers, and legislators was solicited).

The first draft of the proposed amendments was exposed on Aug. 31, 2022, for a 30-day public comment period that ended Sept. 30, 2022. The Working Group met on Nov. 3, 2022, to adopt the model law development request and review the comments received. The second draft was exposed on Nov. 8, 2022, for a public comment period that ended Nov. 18, 2022. The comment period was then extended until March 10, 2023. The Working Group met on March 23, 2023, during the Spring National Meeting to discuss the comments received. The Working Group continued to meet through virtual meetings to discuss comments received, and a third draft was exposed on June 29, 2023, for a public comment period that ended July 21, 2023.

The Improper Marketing of Health Insurance (D) Working Group adopted revisions to Model #880 on Aug. 14, 2023, during the Summer National Meeting. The Antifraud (D) Task Force made technical edits to the model and adopted revisions to the model on Dec. 2, 2023, during the Fall National Meeting. The Market Regulation and Consumer Affairs (D) Committee adopted revisions to the model on Dec. 3, 2023, during the Fall National Meeting.

6. A discussion of the significant issues (items of some controversy raised during the due process and the group's response).

The Improper Marketing of Health Insurance (D) Working Group decided that Model #880 should be the first model for review and amendment to provide greater regulatory oversight for entities that are improperly marketing health insurance. The Working Group believed amending Model #880 would provide states with a quicker legislative option than amending other NAIC models, and amending Model #880 would not preclude future discussions of possible amendments to other NAIC models.

The Working Group discussed the review of the following models for possible amendment in addition to Model #880: *Producer Licensing Model Act* (#218), *Advertisements of Accident and Sickness Insurance Model Regulation* (#40), and *NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines* (#660).

7. Any other important information (e.g., amending an accreditation standard).

Addressing the improper marketing in health insurance is a strategic priority for the NAIC. This strategy includes modifying NAIC model laws to grant regulatory power over health insurance lead generators.

The amendments do not impact any accreditation standards.

Adopted by Market Regulation and Consumer Affairs (D) Committee, Dec. 3, 2023
Adopted by Market Conduct Annual Statement Blanks (D) Working Group, Oct. 10, 2023

Market Conduct Annual Statement Data Element Revision Process

The following establishes the procedures of the Market Regulation and Consumer Affairs (D) Committee's Market Conduct Annual Statement Blanks (D) Working Group ([MCAS Blanks WG](#)) for the a) development of new Market Conduct Annual Statement (MCAS) interrogatories, data elements, and definitions for the collection of data for new approved lines of business; and b) proposed changes to the MCAS data elements for existing lines of business. ~~The procedures are for substantive changes only—such as the addition of data elements or significant (non-technical) changes to their definitions.~~

The following best practices are encouraged to ensure the timelines for adoption are successfully met

- A minimum of five Working Group jurisdictions should volunteer and participate in subject matter expert (SME) group meetings during the creation of reporting for new MCAS line of business or blank changes to an existing line of business.
 - SME group draft documents and a summary of progress should be exposed to Working Group members, interested regulators and interested parties monthly.
 - Weekly (SME) meetings should be encouraged from the beginning of SME work.
 - A formal meeting should be held after the conclusion of the SME group meetings and prior to the voting deadline to present the draft document to the Working Group members, interested state insurance regulators, and interested parties to increase exposure, facilitate discussion, and proactively identify any concerns.
1. The MCAS Blanks WG may consider relevant changes to the annual statement blank and instructions at any scheduled Working Group conference call or meeting. The MCAS Blanks WG chair will determine which suggested changes are considered.
 2. Suggested changes and amendments to the MCAS data elements or definitions may be submitted ([using the MCAS Proposal Submission Form located on the Working Group's web page](#)) to the NAIC support staff for the MCAS Blanks WG at any time during the year.
 3. All recommended changes shall include all of the following:
 - A concise statement of the proposed change.
 - The statement type of the suggested change (Life and Annuity, Property and Casualty, Long Term Care, Health, etc.).
 - The reason for the change.
 - Any supporting information relating to the change.
 4. Changes that have been adopted by the MCAS Blanks WG prior to June 1 and subsequently adopted by the Market Regulation and Consumer Affairs (D) Committee by August 1 and by the NAIC Plenary by December 31 of the same year will become effective for the following year's experience reporting.

Additional information for drafts to be considered by the Working Group:

- To provide sufficient time for the Working Group to review, discuss, and consider MCAS reporting data call and definitions for new lines of business, substantial additions, and/or changes to existing lines of business, drafts should be provided to the Working Group by April 1.
 - All other draft MCAS edits/changes should be provided to the Working Group by May 1.
 - If these new drafts are provided to the Working Group later than the suggested April 1 or May 1 dates, the Working Group can determine on a case-by-case basis if there is group consensus to adopt prior to June 1 for use in the following data year or if additional time is needed for revisions prior to adoption.
5. If the MCAS Blanks WG or the Market Regulation and Consumer Affairs (D) Committee do not adopt a recommended change by their respective date (June 1 or August 1), any adopted change will be effective the second calendar year after the adoption of the change. (For example, if MCAS Blanks WG adopts a change during July ~~2017~~2024 and the D-Committee adopts it in September ~~2017~~2024, the change will be effective January 1, ~~2019~~2026 and would be reported in the data filed in ~~2020~~2027).
 6. All suggested changes will be made available for comment at least 30 days prior to adoption by the Market Regulation and Consumer Affairs (D) Committee.

Date: 2/26/2024

State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Amendments to the ***Unfair Trade Practices Act (#880)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. Fourteen jurisdictions have adopted revisions to this model.

Life Insurance and Annuities (A) Committee

- Amendments to the ***Annuity Disclosure Model Regulation (#245)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Summer National Meeting. Two jurisdictions have adopted revisions to this model.
- Amendments to the ***Standard Nonforfeiture Law for Individual Deferred Annuities (#805)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Twenty-four jurisdictions have adopted revisions to this model.

Health Insurance and Managed Care (B) Committee

- Amendments to the ***Health Maintenance Organization Model Act (#430)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. One jurisdiction has adopted revisions to this model.
- Amendments to the ***Insurance Holding Company System Regulatory Act (#440)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Fourteen jurisdictions have adopted revisions to this model.
- Amendments to the ***Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Seven jurisdictions have adopted revisions to this model.

Property and Casualty Insurance (C) Committee

- Adoption of the ***Real Property Lender-Placed Insurance Model Act (#631)***—This model was adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. One jurisdiction has adopted this model.
- Adoption of the ***Pet Insurance Model Act (#633)***—This model was adopted by the Executive (EX) Committee and Plenary at the 2022 Summer National Meeting. Six jurisdictions have adopted this model.
- Adoption of the ***Nonadmitted Insurance Model Act (#870)***—This model was adopted by the Executive (EX) Committee and Plenary at the 2023 Summer National Meeting. NAIC staff are not aware of adoption by any jurisdiction.

Financial Condition (E) Committee

- Adoption of the ***Property and Casualty Insurance Guaranty Association Model Act (#540)*** — This model was adopted by the Executive (EX) Committee and Plenary at the 2023 Fall National Meeting. NAIC staff are not aware of adoption by any jurisdiction.
- Adoption of the ***Mortgage Guaranty Insurance Model Act (#630)*** — This model was adopted by the Executive (EX) Committee and Plenary at the 2023 Summer National Meeting. NAIC staff are not aware of adoption by any jurisdiction.