MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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The Market Regulation and Consumer Affairs (D) Committee met in Austin, TX, Dec. 9, 2019. The following Committee members participated: Chlora Lindley-Myers, Chair (MO); Allen W. Kerr, Vice Chair, and Russ Galbraith (AR); Trinidad Navarro represented by Frank Pyle (DE); John F. King represented by Martin Sullivan (GA); Colin M. Hayashida represented by Paul Yuen (HI); Stephen W. Robertson represented by Holly Williams-Lambert (IN); Vicki Schmidt (KS); Anita G. Fox represented by Michele Riddering (MI); Mike Causey represented by Tracy Biehn (NC); Barbara D. Richardson (NV); Kent Sullivan and Ignatius Wheeler (TX); Todd E. Kiser (UT); and Mike Kreidler and John Haworth (WA). Also participating were: Maria Ailor (AZ); Cynthia Amann (MO); Timothy Schott (ME); Bruce R. Ramge (NE); Jessica Altman (PA) and Larry Deiter (SD).

1. **Adopted its Oct. 1 Minutes**

The Committee met Oct. 1 and took the following action: 1) adopted its Summer National Meeting minutes; and 2) appointed the Privacy Protections (D) Working Group.

Commissioner Kerr made a motion, seconded by Mr. Haworth, to adopt the Committee’s Oct. 1 minutes (Attachment One). The motion passed unanimously.

2. **Adopted its 2020 Proposed Charges**

Director Lindley-Myers said the Committee’s 2020 proposed charges are similar to its 2019 charges, except for some revisions to the charges of the Market Conduct Annual Statement Blanks (D) Working Group. She said the first charge of Working Group was changed to reflect that the review of Market Conduct Annual Statement (MCAS) data elements should be for the lines of business in effect longer than three years, rather than for all lines. Additionally, the reference to completing work by June 1 was deleted to reflect that the Working Group's tasks are completed as necessary and appropriate.

Commissioner Kerr made a motion, seconded by Mr. Haworth, to adopt the Committee’s 2020 proposed charges. The motion passed unanimously.

3. **Adopted the Workers’ Compensation Standardized Request and the P/C Travel Insurance Examination Standards**

Director Ramge said the Market Conduct Examination Standards (D) Working Group met on Aug. 29 and adopted a new workers’ compensation in-force standardized data request (SDR) (Attachment Two) that will be incorporated into the reference documents of the NAIC Market Regulation Handbook.

Director Ramge said the Working Group also met on Oct. 9 and adopted new travel insurance examination standards (Attachment Three) for inclusion in the NAIC Market Regulation Handbook. He said the examination standards were discussed during the Working Group’s May 30, June 18, July 18, Aug. 29 and Oct. 9 conference calls. He said the Working Group’s revisions to the exposure draft were drafted with input from the U.S. Travel Insurance Association (UStiA) and the American Property Casualty Insurance Association (APCIA).

Commissioner Richardson made a motion, seconded by Commissioner Schmidt, to adopt the workers’ compensation in-force SDR and the new travel insurance examination standards. The motion passed unanimously.

4. **Adopted Revisions to the NAIC State Licensing Handbook and the 2019 Continuing Education Reciprocity (CER) Agreement**

Director Deiter said the Producer Licensing (D) Task Force met Dec. 7 and adopted revisions to the NAIC State Licensing Handbook (Attachment Four), which was revised to be consistent with established NAIC policy on producer licensing. He said the Producer Licensing Uniformity (D) Working Group began its review of the Handbook in April 2019. He said the Working Group met six times from August through October and adopted the final revisions to the Handbook on Oct. 30. He said the more significant changes are as follows: 1) exact language from the Producer Licensing Model Act (#218) was added where appropriate; 2) the appendix to the Handbook will be removed from future hard copy versions and will be posted as a separate electronic appendix on the NAIC website; 3) the Handbook was updated to provide a link to the NAIC web page where the
most current information about the National Association of Registered Agents and Brokers (NARAB) is posted because of ongoing uncertainty about when NARAB will be formed; and 4) additional clarification was added to the licensing reciprocity examples in Chapter 4 of the Handbook.

Director Deiter said the Task Force also adopted the 2019 Continuing Education Reciprocity (CER) Agreement (Attachment Five). He said the Uniform Education (D) Working Group drafted the agreement throughout 2019 and adopted the agreement on Oct. 31. He said the agreement supports the use of the Uniform Continuing Education Reciprocity Course Filing Form (CER Form). He said continuing education (CE) providers may use the CER Form to streamline the course-approval process in multiple states. He noted that through the reciprocal approval process, the CE provider’s home state conducts a substantive review of the CE course; therefore, non-resident states do not need to perform a similar review for a course previously approved by the home state.

Commissioner Schmidt made a motion, seconded by Commissioner Kerr, to adopt the revisions to the NAIC State Licensing Handbook and the 2019 CER Agreement. The motion passed unanimously.

5. Adopted its Task Force and Working Group Reports

Director Lindley-Myers said the reports of the Committee’s task forces and working groups were circulated for this meeting. She said the Market Actions (D) Working Group met Dec. 7 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. She asked if any of the chairs of the task forces or working groups, committee members, or interested parties would like to make any comments on the reports.

a. Advisory Organization Examination Oversight (D) Working Group

Mr. Schott said the Advisory Organization Examination Oversight (D) Working Group issued a survey to Collaborative Action Designees (CADs), Market Analysis Chiefs (MACs) and Market Chief Examiners (MCEs) concerning whether to add three new advisory organizations to be overseen by the Working Group for regularly scheduled examinations. He encouraged any state that has not yet responded to do so.

b. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met Dec. 8 and adopted its Nov. 21 minutes. He said during the Nov. 21 conference call the Working Group agreed to not include fraternals in the MCAS until a formal proposal is received for their inclusion and the adopted “other health” as a line of business in the MCAS.

Mr. Haworth said that during the Working Group’s meeting on Dec. 8, it continued discussion of adding “other health” to the MCAS and assured all interested parties that the development of the blank will be done by the Market Conduct Annual Statement Blanks (D) Working Group, and it will include state insurance regulators, carriers and consumer representatives. The goal, as always, will be to develop a blank with all the parameters and data elements fully and clearly defined.

Mr. Haworth said the Working Group also heard an update on the short-term limited duration (STLD) data call. He said a reminder letter was sent to all companies on Dec. 5 reminding them of the Dec. 13 due date. He said only one filing has been received as of Dec. 7. He said the Working Group encouraged companies to complete their filings or notify NAIC staff that they do not write STLD.

Mr. Haworth said the Working Group also began work revising the MCAS Best Practices Guide and other MCAS materials in order to build consistency in how the states handle extension and waiver requests.

Finally, Mr. Haworth said the Working Group discussed its plans for meeting its 2020 proposed charges.

Samantha Burns (America’s Health Insurance Plans—AHIP) said the development of the Other Health MCAS blank will be a significant undertaking. She said AHIP has concerns about the scope of the blank and the definitions. She said even though the Market Conduct Annual Statement Blanks (D) Working Group is charged with developing the blank, it is the purview of the Market Analysis Procedures (D) Working Group to adopt the line of business before it is created. She said the Working Group should better define what is expected to be included as “other health.” By not being specific, the Working Group is setting a bad precedent. Ms. Burns said the discussion about the other health line of business was tabled in 2018 and the Working Group focused on STLD. When discussions were renewed in November, the line of business was adopted without any discussion about what products are included in “other health.” Ms. Burns noted that packaged indemnity products were mentioned as...
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being included in other health, but they are not packaged or sold at the carrier level. She said the MCAS would not be the best avenue for obtaining data on packaged indemnity plans.

Ms. Burns said more discussion is needed, and she asked the Committee to not adopt other health as the next line of business and instruct the Working Group to continue its discussions about what is included in the line of business. Chuck Piacentini (American Council of Life Insurers—ACLI) agreed with Ms. Burns. He said other health is not a common term, and if the intent is to obtain information on plans other than major medical plans, the Working Group should be more specific. There may be better methods for getting data for different types of products.

Birny Birnbaum (Center for Economic Justice—CEJ) said there was an extended discussion during the Working Group’s Dec. 8 meeting about the process for developing an MCAS blank. He said the Market Analysis Procedures (D) Working Group is charged with identifying the need for a new MCAS line of business. The Working Group did that. He said the Market Conduct Annual Statement Blanks (D) Working Group will then consider the coverages and data that will be collected in the MCAS blank. He said if the Market Conduct Annual Statement Blanks (D) Working Group decides that packaged indemnity products should not be collected in an MCAS blank, it can decide not to include them. As an example, he said the Market Conduct Annual Statement Blanks (D) Working Group eliminated coverages from both the flood insurance and lender-placed insurance MCAS blanks. He said the industry is encouraged to take part in the development of the MCAS blanks.

Commissioner Kerr agreed with Mr. Birnbaum. He said state insurance regulators need to know what is being sold in the marketplace. Commissioner Altman also agreed and said the Working Groups should move forward with the creation of the Other Health MCAS blank.

Commissioner Richardson made a motion, seconded by Commissioner Kerr, to adopt the Market Analysis Procedures (D) Working Group’s report, including the adoption of other health as the next line of business in the MCAS. The motion passed unanimously.

c. Market Conduct Annual Statement Blanks (D) Working Group

Ms. Ailor said the Market Conduct Annual Statement Blanks (D) Working Group did not meet at the Fall National Meeting. She said the Working Group met Oct. 23 and Nov. 21.

Ms. Ailor said that during its Oct. 23 conference call, the Working Group heard an update on the Life and Annuity MCAS Data Element Review Project, and it decided to issue a survey to the states to determine if any data elements need to be added, deleted or revised for the Homeowner and Auto lines of business in the MCAS.

Ms. Ailor said that during its Nov. 21 call, the Working Group made two changes to due dates. She said the first change involves situations where the MCAS due date occurs on a weekend or federal holiday. She said that in that instance, the Working Group agreed that the due date will be moved to the next business day.

Ms. Ailor said the second change is the due date for the health MCAS. She said the Working Group extended the health MCAS filing due date to June 30 for data to be reported in 2020, 2021 and 2022. She said that after three years, the due date will automatically revert to April 30 unless health companies request a re-evaluation. She said that because this is an extension of the April 30 due date, the Working Group received assurances from industry that companies would not request extensions beyond the June 30 due date except for extraordinary circumstances.

Joe Zolecki (Blue Cross Blue Shield Association—BCBSA) thanked Ms. Ailor, Ms. Dingus and the Working Group for overseeing a collaborative process to address issues raised by the health insurance industry regarding its MCAS filings.

d. Privacy Protections (D) Working Group

Ms. Amann said the Privacy Protections (D) Working Group met Dec. 8. She said the Working Group was formed on Oct. 1 and the vice-chair is Ron Kreiter, the Deputy General Counsel of the Oklahoma Insurance Department. She said the Working Group is in the process of building the membership, as well as the distribution lists for interested state insurance regulators and interested parties. She said the Working Group will work closely with the other working groups in this arena, such as the Artificial Intelligence (EX) Working Group and the Accelerated Underwriting (A) Working Group. She noted that each of these working groups has its unique set of issues that, nevertheless, require coordination.
Ms. Amann said that during the Dec. 8 meeting, the Working Group discussed its proposed workplan to meet every six weeks via conference call to keep on track so it can accomplish its charges by the deadline established. She said the Working Group also heard a presentation by Jennifer McAdam (NAIC) in which she reviewed: 1) the NAIC Insurance Information and Privacy Protection Model Act (#670); 2) the Privacy of Consumer Financial and Health Information Regulation (#672); 3) the General Data Protection Regulation (GDPR); 4) the California Consumer Privacy Act (CCPA); and 5) the State Data Privacy Legislation.

Ms. Amann said the Working Group also received an update from Kendall Cotton, the Montana State Auditor, on current legislative activities in Montana. Additionally, the Working Group discussed comments received from the CEJ, the National Association of Mutual Insurance Companies (NAMIC), and the APCIA.

David Snyder (APCIA) said the Antifraud (D) Task Force summary report in the Committee materials references a Buzzfeed article bringing awareness to a potential threat claiming that an alliance between insurers and law enforcement is working against innocent consumers. He said the report says the Task Force decided to review and provide an additional update at the 2020 Spring National Meeting. He said the APCIA challenges the validity of the article and asked to participate in the review of the allegations in the article. He noted that the insurer antifraud efforts and law enforcement have cooperated to effectively protect consumers, not harm them. Mr. Pyle said he is a member of the Task Force, and though he cannot speak for the chair, he is certain the APCIA’s participation would be welcomed by the Task Force. Mr. Birnbaum said the CEJ is responsible for forwarding the article to the Task Force and the Market Regulation and Consumer Affairs (D) Committee chairs to illustrate the need to review the algorithms being used in antifraud efforts to be sure that they are not biased in some way. He said it was not meant to cast any aspersion of the work of the antifraud entities.

Commissioner Kerr made a motion, seconded by Commissioner Kreidler, to adopt the reports of the Committee’s task forces and working groups: the Antifraud (D) Task Force, the Market Information Systems (D) Task Force; the Producer Licensing (D) Task Force; the Advisory Organization Examination Oversight (D) Working Group; the Market Actions (D) Working Group; the Market Analysis Procedures (D) Working Group (Attachment Six); the Market Conduct Annual Statement Blanks (D) Working Group (Attachment Seven); the Market Conduct Examination Standards (D) Working Group (Attachment Eight); the Market Regulation Certification (D) Working Group (Attachment Nine); and the Privacy Protections (D) Working Group (Attachment Ten). The motion passed unanimously.

6. Discussed Updates to Best Practices and Guidelines for Consumer Information Disclosures

Director Lindley-Myers said the review of the Best Practices and Guidelines for Consumer Information Disclosures is in response to a request from the NAIC funded consumer representatives for the NAIC membership to consider best practices for consumer information disclosures. She said that in response to requests for comments prior to the Summer National Meeting and again in October, the Committee received extensive, suggested revisions from the NAIC funded consumer representatives. She said no state insurance regulators or other interested parties submitted comments.

Mr. Birnbaum said the consumer representatives provided proposed revisions to the Best Practices and Guidelines for Consumer Information Disclosures to incorporate new information on how consumers learn to make consumers disclosures more effective. He said it also highlights the work of state insurance regulators to get consumer engagement, notably Commissioner Sullivan and the Texas Department of Insurance. He said the consumer representative asks that the proposed revisions be exposed for another comment period to add additional information.

7. Heard a Presentation on Mental Health Parity Examinations

Joel Ario (Manatt Health), Daniel Blaney-Koen (American Medical Association—AMA) and Tim Clement (American Psychiatric Association—APA) gave a presentation to the Committee on the urgency of the state insurance departments to use their mental health and substance use disorder (MH/SUD) parity oversight authority to address the opioid epidemic in the U.S.

Mr. Blaney-Koen provided recommendations including: 1) removing prior authorization regulations for medication-assisted treatment (MAT); 2) increased oversight and enforcement of MH/SUD parity laws; 3) ensuring network adequacy for those needing treatment for opioid use disorder; 4) enhancing access to comprehensive, multi-disciplinary multimodal pain care; 5) expanding access to naloxone; and 6) evaluating the results to identify what is working, and building on the most successful efforts.

Mr. Clement said when conducting a market conduct examination regarding MH/SUD parity, examiners should not assume that a company is necessarily complying with the easiest parts of the Mental Health Parity and Addiction Equity Act.
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(MHPAEA), such as defining MH/SUD, classifying benefits, or using quantitative treatment limitations and financial requirements. He also said many carriers are setting non-quantitative treatment limitations, such as requiring prior authorizations on all formulations of naloxone, all inpatient MH/SUD benefits, and blanket exclusions on benefits. He also said examiners should look to see if the carrier has more stringent written processes, evidentiary standards, and triggers for utilization review. Finally, he encouraged examiners to look closely at claims to see if the company’s utilization review approvals for MH/SUD are more limited, whether MH/SUD requests are more often sent for peer review, and whether the peer reviewers are adhering to medical necessity criteria and level of care guidelines.

Commissioner Kreidler asked whether the use of blanket prior authorizations is more of an issue when a consumer changes carriers or plans rather than when a consumer has a continuity of coverage. Mr. Blaney-Koen said it is more common when switching plans, but it occurs in both instances. Commissioner Kreidler also recommended that a review of the thorough study being conducted by the Washington Department of Insurance to evaluate consumer access to services for MH/SUD in state-regulated individual, small group, and large group health insurance plans.

Commissioner Sullivan asked if there are tools available to consumers to help them inquire of a company about their MH/SUD parity and compare companies. Mr. Clement said there are some resources, but they are written at too high a level. He asked Commissioner Sullivan and other members of the Committee to contact him for more information on consumer tools that are available. Mr. Ario said some of the state insurance department websites contain very useful consumer assistance.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
The Market Regulation and Consumer Affairs (D) Committee met via conference call Oct. 1, 2019. The following Committee members participated: Chlora Lindley-Myers, Chair (MO); Allen W. Kerr, Vice Chair (AR); Trinidad Navarro represented by Frank Pyle (DE); Stephen W. Robertson represented by Holly Lambert (IN); Vicki Schmidt (KS); Anita G. Fox represented by Michele Riddering (MI); Barbara D. Richardson represented by Nick Stosic (NV); Mike Causey represented by Tracy Biehn (NC); Kent Sullivan represented by Ignatius Wheeler (TX); Todd E. Kiser represented by Tanji Northrup (UT); Michael S. Pleskiak represented by Christina Rouleau (VT); and Mike Kreidler and John Haworth (WA). Also participating were: Pam O’Connell (CA); Damion Hughes (CO); Kurt Swan (CT); Scott Woods (FL); Lindsay Bates and Kim Cross (IA); Ron Henderson and Jeff Zewe (LA); Timothy Schott (ME); Paul Hanson (MN); Cynthia Amann (MO); Jeannie Keller (MT); Edwin Pugsley (NH); Mark McLeod (NY); Angela Dingus and Don Layson (OH); Ron Kreiter and Joel Sander (OK); Rebecca Nichols (VA); Tom Whitener (WV); and Sue Ezalarab and Jo LeDuc (WI).

1. Adopted its Summer National Meeting Minutes

Commissioner Kerr made a motion, seconded by Ms. Biehn, to adopt the Committee’s Aug. 5 minutes (see NAIC Proceedings – Summer 2019, Market Regulation and Consumer Affairs (D) Committee). The motion passed unanimously.

2. Discussed the New Charge on State Insurance Privacy Protections and Appointed a New Working Group

Director Lindley-Myers said the Innovation and Technology (EX) Task Force has a charge to monitor developments in the area of cybersecurity. During the Summer National Meeting, the Task Force received an update on cybersecurity and data privacy. Director Lindley-Myers said that cybersecurity is focused on information technology (IT) system security and that data privacy is about what insurance companies do with consumer data and how they communicate their activities to consumers. After receiving updates from NAIC staff regarding federal activity on data privacy and NAIC model laws addressing data privacy, Director Lindley-Myers said the Task Force decided it would be appropriate for the Market Regulation and Consumer Affairs (D) Committee to pursue further investigation into state insurance privacy protections and to evaluate where there may be gaps or omissions that may require some type of additional work. The Task Force referred the following charge to the Committee: “Review state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions, and make recommended changes, as needed, to certain NAIC models, such as the NAIC Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Regulation (#672), by the 2020 Summer National Meeting.” Director Lindley-Myers said the Executive (EX) Committee and Plenary adopted this charge at the Summer National Meeting.

Director Lindley-Myers asked Jennifer McAdam (NAIC) to provide an update on the research NAIC legal staff have completed on state data privacy initiatives and the NAIC models that govern data privacy. Ms. McAdam said the NAIC has three model laws governing data privacy: 1) the Health Information Privacy Model Act (#55); 2) the NAIC Insurance Information and Privacy Protection Model Act (#670); and 3) the Privacy of Consumer Financial and Health Information Regulation (#672).

Ms. McAdam said Model #670 was the first NAIC model and was adopted in 1980. To put this into historical context, she said the federal Fair Credit Reporting Act was enacted in 1970, and this Act addresses the fairness, accuracy and privacy of the personal information contained in the files of the credit reporting agencies. Then the federal Privacy Act was enacted in 1974. This Act governs the collection, maintenance, use and dissemination of personally identifiable information about individuals that is maintained in records of federal agencies. The NAIC drafted this model when those two federal laws were in place. Ms. McAdam said Model #670 sets standards for the collection, use and disclosure of information gathered in connection with insurance transactions. It requires insurers to provide notice that alerts the individual of the insurer’s information practices. It gives consumers the right to request that an insurer: 1) give access to recorded personal information; 2) disclose the identity of the third parties to whom the insurance disclosed the information; 3) provide the source of the collected information; 4) correct and amend the collected information; 5) amend the personal information; and 6) delete the collected personal information. Seventeen jurisdictions have adopted the model.

Ms. McAdam said the NAIC adopted Model #55 following the federal enactment of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Model #55 sets standards to protect health information from unauthorized collection, use and disclosure by requiring carriers to establish procedures for the treatment of all health information.

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Following HIPAA, Ms. McAdam said the federal Gramm-Leach-Bliley Act (GLBA) was enacted in 1999. The GLBA imposes privacy and security standards on financial institutions and directs state insurance commissioners to adopt certain data privacy and data security regulations. In response to this, Ms. McAdam said the NAIC adopted both Model #672 and the Standards for Safeguarding Customer Information Model Regulation (#673). Model #672 is about consumer privacy, and Model #673 is about data security and was used as the basis for drafting the Insurance Data Security Model Law (#668).

Ms. McAdam said data privacy and data security are often conflated, but the focus of the regulations is different. Data security regulations focus on how the information that a business collects is protected from unauthorized access once it is in the possession of the business. On the other hand, data privacy regulations focus on the consumer’s right to privacy and how companies are allowed to collect and then disclose the personal information of a consumer.

Ms. McAdam said Model #672 was intended to be enforced via a state’s unfair trade practices law. Model #672: 1) requires that insurers provide notice to consumers about its privacy policies and practices; 2) describes the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and 3) provides methods for individuals to prevent a licensee from disclosing that information—“opt out” for financial info and “opt in” for health info. The provisions governing protection of health information were taken directly from Model #55 and the health information privacy regulations promulgated by the U.S. Department of Health and Human Services (HHS) pursuant to HIPAA. The provisions governing protection of financial information are based on privacy regulations promulgated by federal banking agencies. Ms. McAdam said the key difference between the treatment of financial information and health information is that insurers must give consumers the right to “opt out” of the disclosure or sharing of their financial information, but insurers must obtain explicit consumer authorization to “opt in” prior to sharing health information. Every state has a version of this model regulation, with 19 jurisdictions having only adopted the provision regarding financial information and not the one regarding health information.

Ms. McAdam said data privacy started receiving more attention when the European Union’s (EU) General Data Protection Regulation (GDPR) became effective in May 2018. Although it is an EU law, Ms. McAdam said it affects many U.S. companies if they collect data from citizens of the EU over the internet. It requires companies to obtain explicit consent from consumers to collect their data (“opt in”), with an explanation of how the data will be used. It also contains standards for safeguarding the data. Ms. McAdam said California then became the first U.S. state to adopt an “omnibus” privacy law, which imposes broad obligations on businesses to provide consumers with transparency and control of their personal data. The California Consumer Privacy Act (CCPA) was signed into law in June 2018, amended in September 2018 and will become effective in 2020. The CCPA gives consumers the right to request that a business: 1) disclose the categories and specific pieces of personal information collected; 2) disclose categories of sources the information was collected from; 3) disclose the business purpose for collecting the information; 4) disclose the categories of third parties with whom the information is shared and the specific pieces of personal information that were shared; and 4) delete any personal information. Ms. McAdam said the CCPA also gives consumers the right to opt-out of their information being disclosed to third parties and has separate opt-in requirements for minors. In addition, there is a nondiscrimination provision that prohibits companies from discriminating against consumers who exercise their rights under the law. Finally, there is a full exemption for protected health information governed by HIPAA and a partial exemption for information subject to the GLBA.

Ms. McAdam said several states introduced similar data privacy bills during the 2019 legislative session. There were 24 states considering some type of data privacy legislation, but only three states enacted laws: Illinois, Maine and Nevada. Illinois’ law bans insurers from using genetic testing information to set health or accident rates. Maine’s law bans internet providers from selling personal information without consent. Nevada’s law requires businesses to allow consumers to opt out of any sale of their personal information. There are exemptions for entities subject to the GLBA and HIPAA. Ms. McAdam said NAIC legal staff created a chart listing general state data privacy laws applicable to all businesses and not specific to insurers. The chart lists: 1) the entity responsible for enforcing the law; 2) what exemptions there are, if any; 3) whether it is “opt-in” or “opt-out”; and 4) what consumer notice requirements there are.

Director Lindley-Myers asked for the circulation of the research to the Market Regulation and Consumer Affairs (D) Committee and interested parties. She asked if the Committee should address the charge or if a new Privacy Protections (D) Working Group should be appointed. Mr. Haworth questioned if the discussion would include the use of electronic disclosures. Director Lindley-Myers said this would be included but provided an example of Missouri consumers wanting hard copies of insurance documents. Because of this, she suggested the models should address both the use of the electronic and hard copy disclosures. Mr. Haworth said he supports the formation of a Working Group and suggested a more detailed list of issues to be addressed. Peter Kochenburger (University of Connecticut School of Law) suggested the working group discuss best practices for disclosures and the limitations of disclosures for consumer protection.
Commissioner Schmidt made a motion, seconded by Ms. Northrup, to appoint a Privacy Protections (D) Working Group. The motion passed. Director Lindley-Myers said Cynthia Amann (MO) would chair the Working Group unless there is interest from another state.

Birny Birnbaum (Center for Economic Justice—CEJ) said insurers are relying more on consumer, nonfinancial data from third-party vendors. In addition, Mr. Birnbaum said insurers are using consumer data generated through telematics and health monitoring devices. Mr. Birnbaum said the NAIC models should address the concept of consumer digital rights, such as whether a consumer has provided insurers the permission to have access and use this type of data.

Director Lindley-Myers said NAIC research would be shared with all parties by the end of the week and asked Mr. Birnbaum to submit written comments for consideration of the workplan. Director Lindley-Myers asked state insurance regulators to contact Tim Mullen (NAIC) if they want to be a member of the Privacy Protections (D) Working Group and asked all parties to submit comments regarding the issues that should be addressed. Director Lindley-Myers said a workplan would then be shared with the Committee by Oct. 25 for its review.

3. Discussed Other Matters

Director Lindley-Myers said the Committee will consider the adoption of its 2020 proposed charges in November. Draft charges will be circulated to Committee members in October and then circulated to all interested parties.

Director Lindley-Myers said the Committee will discuss the proposed revisions to the *Best Practices and Guidelines for Consumer Information Disclosures*, which were adopted in 2012. The NAIC consumer representatives provided a document with extensive revisions at the Summer National Meeting. Director Lindley-Myers asked for the submission of additional comments by Oct. 15 and said she would work with NAIC staff to revise the document for further discussion by the Committee in November.

Director Lindley-Myers said the Committee will also consider the adoption of Market Conduct Annual Statement (MCAS) disability ratios and the workers’ compensation in force standardized data request during its November conference call.

Director Lindley-Myers said Mr. Birnbaum submitted an Aug. 15, 2019, BuzzFeed article titled “Insurance Companies Are Paying Cops to Investigate Their Own Customers.” She said the article sets forth allegations of insurers’ unfair and abusive anti-fraud investigations against consumers in the settlement of homeowners and automobile claims. Mr. Birnbaum asked the Committee to review the role of third-party databases and algorithms use for claim settlement and antifraud and the revised antifraud model proposed by the Coalition Against Insurance Fraud (CAIF), which was recently adopted by National Council of Insurance Legislators (NCOIL). Director Lindley-Myers said that the Antifraud (D) Task Force would review these issues and that some preliminary thoughts would likely be shared with the Committee during its November conference call.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
POLICY IN FORCE STANDARDIZED DATA REQUEST  
Property & Casualty Line of Business  
Workers Compensation

**Contents:** This file should be downloaded from company system(s) and contain one record for each workers compensation policy issued in [applicable state] which was in force at any time during the examination period.

For any fields where there are multiple entries, please repeat field as necessary.

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or termination of workers compensation policies in [applicable state] within the scope of the examination.

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<td></td>
<td>Policy suffix <strong>Repeat field as necessary for each additional covered class (Blank if NONE)</strong></td>
</tr>
<tr>
<td>PolStTyp</td>
<td>32</td>
<td>3</td>
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<td></td>
<td>Policy status type for the record (i.e., new or renewal) <strong>Please provide a list to explain any codes used</strong></td>
</tr>
<tr>
<td>PolTyp</td>
<td>35</td>
<td>25</td>
<td>A</td>
<td></td>
<td>Type of policy (i.e., large deductible, small deductible, retrospective, guaranteed cost/first dollar, etc.) <strong>Please provide a list to explain any codes used</strong></td>
</tr>
<tr>
<td>PolForm</td>
<td>60</td>
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<td></td>
<td>Policy form number as filed with the insurance department</td>
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<tr>
<td>EndrNum</td>
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<td>Form number of endorsement(s) added to policy <strong>Repeat field as necessary</strong></td>
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<tr>
<td>Endr</td>
<td>80</td>
<td>20</td>
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<td>Name of endorsement(s) Repeat field as necessary</td>
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<td>FormNum</td>
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<td>Form</td>
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<td>PremEndr</td>
<td>130</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Total endorsement premium</td>
</tr>
<tr>
<td>PrCode</td>
<td>140</td>
<td>6</td>
<td>A</td>
<td></td>
<td>Company internal producer, CSR, or business entity producer identification code <strong>Please provide a list to explain any codes used</strong></td>
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<tr>
<td>NPN</td>
<td>146</td>
<td>6</td>
<td>A</td>
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<tr>
<td>InsName</td>
<td>152</td>
<td>15</td>
<td>A</td>
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<td>Insured/employer name</td>
</tr>
<tr>
<td>InsFEIN</td>
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<td>9</td>
<td>A</td>
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<td>Insured/employer Federal Employer Identification Number</td>
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<tr>
<td>InsAddr</td>
<td>176</td>
<td>25</td>
<td>A</td>
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<td>Insured street address</td>
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<tr>
<td>InsCity</td>
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<td>IssSt</td>
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<td>A</td>
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<td>State abbreviation where policy was issued</td>
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<tr>
<td>InsZip</td>
<td>223</td>
<td>5</td>
<td>A</td>
<td></td>
<td>Insured ZIP code</td>
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<td>Field Name</td>
<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
</tr>
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<td>Date application received [MM/DD/YYYY]</td>
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<td>AppProDt</td>
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<td>D</td>
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<td>Anniversary rating date of policy [MM/DD/YYYY]</td>
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<td>ExpDt</td>
<td>290</td>
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<td>GovClsCd</td>
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<td>InClDes</td>
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<td>Initial classification description for 1st covered class <strong>Repeat field as necessary for each additional covered class</strong></td>
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<tr>
<td>InLC</td>
<td>350</td>
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<td>N</td>
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<td>Initial loss cost for 1st covered class <strong>Repeat field as necessary for each additional covered class</strong></td>
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<td>InPayrl</td>
<td>365</td>
<td>15</td>
<td>N</td>
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<td>Initial remuneration payroll for 1st covered class <strong>Repeat field as necessary for each additional covered class</strong></td>
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<tr>
<td>LCM</td>
<td>380</td>
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<td>Loss cost multiplier</td>
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<td>Policy issued as gross (G) or net (N) plan</td>
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<tr>
<td>LossRep</td>
<td>382</td>
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<td>A</td>
<td></td>
<td>Losses reported on gross (G) or net (N) basis</td>
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<tr>
<td>EaAccLmt</td>
<td>392</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Employers liability limit for bodily injury by accident – each accident</td>
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<tr>
<td>EaEmpLmt</td>
<td>402</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Employers liability limit for bodily injury by accident – each employee</td>
</tr>
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<td>PolLmt</td>
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<td>N</td>
<td>2</td>
<td>Limit for bodily injury by disease – policy</td>
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<td>DedAmt</td>
<td>422</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Deductible limit amount chosen by policyholder if applicable</td>
</tr>
<tr>
<td>SrAdm</td>
<td>432</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Administrative surcharge factor</td>
</tr>
<tr>
<td>SrAdmAmt</td>
<td>442</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Initial administrative surcharge premium</td>
</tr>
<tr>
<td>SrSIF</td>
<td>452</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Second injury fund surcharge rate</td>
</tr>
<tr>
<td>SrSIFAmt</td>
<td>462</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Initial amount of second injury fund surcharge</td>
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<td>FAuDt</td>
<td>472</td>
<td>10</td>
<td>D</td>
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<td>Date first audit completed [MM/DD/YYYY]</td>
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<td>LAuDt</td>
<td>482</td>
<td>10</td>
<td>D</td>
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<td>Date last audit completed [MM/DD/YYYY]</td>
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<td>AuBilDt</td>
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<td>10</td>
<td>D</td>
<td></td>
<td>Audit billing statement date [MM/DD/YYYY]</td>
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<td>AuClsCd</td>
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<td>Audit class code for 1st covered class <strong>Repeat field as necessary for each additional covered class</strong></td>
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<td>Class code changed at audit – Added (A), Removed (R), No change (NC)</td>
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<tr>
<td>AuLC</td>
<td>522</td>
<td>10</td>
<td>N</td>
<td>4</td>
<td>Audit loss cost for 1st covered class <strong>Repeat field as necessary for each additional covered class</strong></td>
</tr>
<tr>
<td>AuPay</td>
<td>532</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Audit remuneration payroll for 1st covered class <strong>Repeat field as necessary for each additional covered class</strong></td>
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<tr>
<td>Field Name</td>
<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
</tr>
<tr>
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</tr>
<tr>
<td>AuAdm</td>
<td>542</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Final administrative surcharge amount due to audit</td>
</tr>
<tr>
<td>AuSIF</td>
<td>552</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Final second injury fund amount due to audit</td>
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<tr>
<td>AuDel</td>
<td>562</td>
<td>10</td>
<td>A</td>
<td></td>
<td>Reason for exceeding the required deadline to complete the audit Please provide a list of codes and their descriptions</td>
</tr>
<tr>
<td>AuTyp</td>
<td>572</td>
<td>10</td>
<td>A</td>
<td></td>
<td>Type of audit (i.e., physical, mail, phone, etc.) Please provide a list of codes and their descriptions</td>
</tr>
<tr>
<td>FPremAmr</td>
<td>582</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Final premium for [examination state] after audit, prior to second injury fund and administrative surcharges</td>
</tr>
<tr>
<td>PremMo</td>
<td>592</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Policy premium, including second injury fund and administrative surcharges, for [examination state] only</td>
</tr>
<tr>
<td>Par</td>
<td>593</td>
<td>1</td>
<td>A</td>
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<td>Is the policy participating in a dividend plan? (Y/N)</td>
</tr>
<tr>
<td>DPlanCd</td>
<td>603</td>
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<td>A</td>
<td></td>
<td>Dividend plan code If codes are used, provide a list of dividend plan codes and their descriptions</td>
</tr>
<tr>
<td>DivAmt</td>
<td>613</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Dividend amount paid</td>
</tr>
<tr>
<td>CanReqDt</td>
<td>623</td>
<td>10</td>
<td>D</td>
<td></td>
<td>Date cancellation requested, if applicable [MM/DD/YYYY]</td>
</tr>
<tr>
<td>CanTerRs</td>
<td>687</td>
<td>64</td>
<td>A</td>
<td></td>
<td>Reason for cancellation/termination of coverage (i.e., lapse, insured request, company cancellation) If codes are used, please provide a list of codes and their descriptions</td>
</tr>
<tr>
<td>CanTer</td>
<td>688</td>
<td>1</td>
<td>A</td>
<td></td>
<td>Who cancelled the coverage C=Consumer or I=Insurer</td>
</tr>
<tr>
<td>CanTerDt</td>
<td>698</td>
<td>10</td>
<td>D</td>
<td></td>
<td>Date policy cancelled/terminated [MM/DD/YYYY]</td>
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<tr>
<td>CanTerNt</td>
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<td>D</td>
<td></td>
<td>Date the cancellation/termination notice was mailed [MM/DD/YYYY]</td>
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<tr>
<td>PremRef</td>
<td>719</td>
<td>11</td>
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<td>2</td>
<td>Amount of premium refunded to the insured</td>
</tr>
<tr>
<td>RfndDt</td>
<td>729</td>
<td>10</td>
<td>D</td>
<td></td>
<td>Date premium refund mailed [MM/DD/YYYY]</td>
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<tr>
<td>RefMthd</td>
<td>754</td>
<td>25</td>
<td>A</td>
<td></td>
<td>Refund method (i.e., 90%, pro rata, etc) If codes are used, please provide a list of codes and their descriptions</td>
</tr>
<tr>
<td>IndLgDed</td>
<td>755</td>
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<td>A</td>
<td></td>
<td>Is the individual risk large deductible account on file with the department? (Y/N)</td>
</tr>
<tr>
<td>DedLDP</td>
<td>756</td>
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<td>A</td>
<td></td>
<td>Is the large deductible rating plan (including rates) on file with the department? (Y/N)</td>
</tr>
<tr>
<td>DfIndFil</td>
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<td>D</td>
<td></td>
<td>Date individual risk large deductible account was filed [MM/DD/YYYY]</td>
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<td>DfLDPFil</td>
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<td>D</td>
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<td>Date large deductible rating plan was filed [MM/DD/YYYY]</td>
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<td>SERFFNo</td>
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<td>SERFF tracking number for large deductible rating plan (or filing number if not filed in SERFF)</td>
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<td>SERFFNum2</td>
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<td>A</td>
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<td>SERFF tracking number for individual large deductible account (or filing number if not filed in SERFF)</td>
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<td>Field Name</td>
<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
</tr>
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<tr>
<td>PremM</td>
<td>815</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Manual premium = [(payroll/100) * rate]</td>
</tr>
<tr>
<td>SpDs</td>
<td>825</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Supplementary disease factor</td>
</tr>
<tr>
<td>SpDsPprm</td>
<td>835</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Supplementary disease premium = [(subject payroll/100) * disease rate]</td>
</tr>
<tr>
<td>USLH</td>
<td>845</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>US Longshore and Harbor Workers (USL&amp;H) exposure non-F class codes factor</td>
</tr>
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<td>USLHPrm</td>
<td>855</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>USL&amp;H exposure non-F class codes premium = [(subject payroll/100) * (rate*USL&amp;H factor)]</td>
</tr>
<tr>
<td>TManPrrm</td>
<td>865</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Total manual premium including supplementary disease and USL&amp;H exposures</td>
</tr>
<tr>
<td>WSub</td>
<td>875</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Waiver of subrogation factor = [% applied to portion of total manual premium where waiver is applicable]</td>
</tr>
<tr>
<td>WSubPrrm</td>
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<td>N</td>
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<td>Waiver of subrogation premium</td>
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<tr>
<td>ELILF</td>
<td>895</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Employers liability increased limits factor = [% applied to total manual premium]</td>
</tr>
<tr>
<td>ELILCh</td>
<td>905</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Employers liability increased limits charge</td>
</tr>
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<td>ELAdmF</td>
<td>915</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Employers liability increased limits factor (Admiralty, FELA) = [Factor applied to the portion of the manual premium where Admiralty/FELA coverage is applicable]</td>
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<tr>
<td>ELAdmCh</td>
<td>925</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Employers liability increased limits (Admiralty, FELA) charge</td>
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<tr>
<td>ELVCmpCh</td>
<td>935</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Employers liability (liability/voluntary compensation flat charge = [Coverage in monopolistic state funds])</td>
</tr>
<tr>
<td>SmDedCr</td>
<td>945</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Small deductible credit = [% applied to total manual premium]</td>
</tr>
<tr>
<td>SmDedPrrm</td>
<td>955</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Small deductible credit amount of premium</td>
</tr>
<tr>
<td>LgDedCr</td>
<td>965</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Large deductible credit = [% applied to total manual premium]</td>
</tr>
<tr>
<td>LgDedPrrm</td>
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<td>10</td>
<td>N</td>
<td>2</td>
<td>Large deductible credit amount of premium</td>
</tr>
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<td>Total subject premium</td>
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<td>Experience modification factor</td>
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<td>2</td>
<td>Experience modification premium amount (debit/credit)</td>
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<td>Total modified premium</td>
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<td>CCPAP</td>
<td>1025</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Contracting class premium adjustment program factor = [1-CCPAP credit %]</td>
</tr>
<tr>
<td>CCPAPPrrm</td>
<td>1035</td>
<td>10</td>
<td>N</td>
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<td>Contracting class premium adjustment program premium</td>
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<td>SRtFact</td>
<td>1045</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Schedule rating factor = (1 - SR credit %) or (1 + SR debit %)</td>
</tr>
<tr>
<td>SRtPrrm</td>
<td>1055</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Schedule rating premium (debit/credit)</td>
</tr>
<tr>
<td>SpDsExp</td>
<td>1065</td>
<td>10</td>
<td>N</td>
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<td>Supplemental disease exposure charge (asbestos, NOC)</td>
</tr>
<tr>
<td>AERadExp</td>
<td>1075</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Atomic energy radiation exposure charge – NOC</td>
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<td>CatLoad</td>
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<td>N</td>
<td>2</td>
<td>Charge for non-ratable catastrophe loading</td>
</tr>
<tr>
<td>AirStch</td>
<td>1095</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Aircraft seat surcharge</td>
</tr>
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<td>MPrmSt</td>
<td>1105</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Balance to minimum premium (State Act) = [Balance to minimum premium at standard limits]</td>
</tr>
<tr>
<td>MPrmAdmF</td>
<td>1115</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Balance to minimum premium (Admiralty, FELA)</td>
</tr>
<tr>
<td>TStdPrrm</td>
<td>1125</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Total standard premium for [examination state]</td>
</tr>
<tr>
<td>Field Name</td>
<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
<td>--------</td>
<td>------</td>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>StdPrmR</td>
<td>1135</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Standard premium for the entire policy (risk), including other states</td>
</tr>
<tr>
<td>PrmDisc</td>
<td>1145</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Premium discount factor = % applied to standard premium</td>
</tr>
<tr>
<td>PrmDisAm</td>
<td>1155</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Premium discount amounts</td>
</tr>
<tr>
<td>CMineChg</td>
<td>1165</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Coal mine disease charge = [underground, surface, surface auger]</td>
</tr>
<tr>
<td>ExpCons</td>
<td>1175</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Expense constant charge</td>
</tr>
<tr>
<td>TerFact</td>
<td>1185</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Terrorism premium factor</td>
</tr>
<tr>
<td>TerPrm</td>
<td>1195</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Terrorism premium amount = [(Payroll/100) * [____ terrorism value]</td>
</tr>
<tr>
<td>RtDev</td>
<td>1205</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Additional deviation factor (outside class code exposure or schedule rating plan)</td>
</tr>
<tr>
<td>RtDevTyp</td>
<td>1215</td>
<td>10</td>
<td>A</td>
<td></td>
<td>Type or name of deviation description (outside class code exposure or schedule rating plan)</td>
</tr>
<tr>
<td>EstAnPrm</td>
<td>1225</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Estimated annual premium as per the NCCI algorithm</td>
</tr>
<tr>
<td>EndRec</td>
<td>1226</td>
<td>1</td>
<td>A</td>
<td></td>
<td>End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.</td>
</tr>
</tbody>
</table>

Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.
Chapter 21A—Conducting the Property and Casualty Travel Insurance Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state’s own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a format for conducting travel insurance company examinations. Procedures for conducting property/casualty insurance company examinations and other types of specialized examinations—such as third-party administrators and surplus lines brokers—may be found in separate chapters.

The examination of travel insurance operations may involve any review of one or a combination of the following business areas:

A. Marketing and Sales
B. Producer Licensing
C. Policyholder Service
D. Underwriting and Rating
E. Claims

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.
A. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, Chapter 21—Conducting the Property and Casualty Examination, and the standards set forth below.

1. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.
STANDARDS
MARKETING AND SALES

Standard 1
Ensure the advertising and/or sales materials being utilized by the limited lines travel insurance producer and travel insurer (i) provide the information required by Section 4(C) of the model law [or state equivalent], (ii) are consistent with the travel protection plan being offered, (iii) are not deceptive or misleading, and (iv) otherwise comply with state law.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ The travel insurer’s approved brochures or other written materials used in offering or disseminating travel insurance to prospective purchasers.

_____ Policy forms and fulfillment materials are accurately represented in advertising and sales materials

_____ Producers’ own advertising and sales materials, including travel retailers under the direction of a limited lines travel insurance producer

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Examiners should request a listing of all marketing materials and select a sample according to the jurisdiction’s sampling protocols. If the examiner is unable to obtain the requested information from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.

Review specimen or actual copies of all of the brochures or other written materials in conjunction with the appropriate policy forms, endorsements, policies, rate filings, and certificates of insurance.

Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous; and
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization

Materials should:

- Clearly disclose name and address of insurer;
- If using a trade name, disclose the name of the insurer, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer, or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Clearly describe the type of policy being advertised;
- Indicate that the travel protection plan being marketed is insurance; and
• Comply with applicable statutes, rules and regulations.

Determine if the travel insurer approves producer sales materials and advertising.
## STANDARDS
### MARKETING AND SALES

<table>
<thead>
<tr>
<th>Standard 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The disclosures combinations of travel insurance, non-insurance travel assistance services, and cancellation fee waivers are compliant with applicable statutes, rules, and regulations.</td>
</tr>
</tbody>
</table>

**Apply to:** All property and casualty travel insurance products  
**Priority:** Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations  
- Policy forms and fulfillment materials are accurately represented in advertising and sales materials  
- Producers’ own advertising and sales materials and travel retailers acting under the direction of a Limited lines travel insurance producer

### NAIC Model References

- *Travel Insurance Model Act (#632)*  
- *Unfair Trade Practices Act (#880)*

### Review Procedures and Criteria

Examiners should request information from the travel insurer or limited lines travel insurance producer that is sufficient to determine compliance with this standard. If the examiner is unable to obtain the information from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.
### STANDARDS
#### MARKETING AND SALES

<table>
<thead>
<tr>
<th>Standard 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>The limited lines travel insurance producer has established and maintains a register of each travel retailer that offers travel insurance on the producer’s behalf.</td>
</tr>
</tbody>
</table>

**Apply to:** All property and casualty travel insurance products

**Priority:** Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations

**Others Reviewed**

- 

**NAIC Model References**

- Travel Insurance Model Act (#632)

**Review Procedures and Criteria**
STANDARDS
MARKETING AND SALES

Standard 4
The limited lines travel insurance producer has documentation sufficient to demonstrate compliance that the travel retailers (acting under the limited lines travel insurance producer’s license) comply with 18 USC § 1033.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ __________________________________________________________________________

_____ __________________________________________________________________________

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria
STANDARDS
MARKETING AND SALES

Standard 5
Determine that consumers were provided with information and an opportunity to learn more about the pre-existing condition exclusions (i) at any time prior to the purchase and (ii) in the fulfillment materials.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy form, fulfillment materials, advertising/sales materials, and disclosures

Others Reviewed

_____ __________________________

_____ __________________________

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Determine that information about pre-existing condition exclusions is provided prior to the time of purchase, including whether the purchaser of travel insurance (i) has the ability to waive the pre-existing condition exclusion, (ii) under what circumstances it can be waived; and (iii) the purchaser of travel insurance has been advised that the coverage for pre-existing conditions can be purchased, if applicable.

Determine that the fulfillment materials provide information about pre-existing condition exclusions

Determine that the policies or certificates and fulfillment materials clearly define pre-existing conditions as intended in the exclusions
### Standard 6
Determine that descriptions of the following are provided to the purchasers of travel insurance: (i) material or actual terms of the insurance coverage, (ii) process for filing a claim, (iii) review or cancellation process for the travel insurance policy, and (iv) the identity and contact information of the travel insurer and limited lines travel insurance producer.

**Apply to:** All property and casualty travel insurance products  

**Priority:** Essential

### Documents to be Reviewed
- Applicable statutes, rules and regulations

### NAIC Model References
- *Travel Insurance Model Act* (#632)  
- *Unfair Trade Practices Act* (#880)

### Review Procedures and Criteria
Examiners should request information from the travel insurer or limited lines travel insurance producer that is sufficient to determine compliance with this standard. If the examiner is unable to obtain the information from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.
STANDARDS
MARKETING AND SALES

Standard 7
The limited lines travel insurance producer has an adequate training program in place, containing instructions on the types of insurance offered, ethical sales practices, and required consumer disclosures, that is required of each employee and authorized representative of the travel retailer whose duties shall include offering and disseminating travel insurance.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

- Applicable statutes, rules and regulations
- Limited lines travel insurance producer’s policies and procedures, including the standards for product training
- Limited lines travel insurance producer’s instruction/training files and training materials for travel retailer employees and authorized representatives offering or disseminating travel insurance

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Review policies and procedures to ensure that the limited lines travel insurance producer has adequate procedures in place to provide instruction and training that is appropriate for and consistent with the type(s) of travel insurance being offered. Review the limited lines travel insurance producer’s procedures used to inform travel retailers of the regulated entity’s standards for travel insurance product training and of applicable state statutes, rules or regulations regarding the solicitation and sale of travel insurance products.

Determine that the limited lines travel insurance producer has adequate procedures in place to verify that the employees and authorized representatives of a travel retailer have completed necessary training, as required by applicable state statutes, rules and regulations, before allowing the employees and authorized representatives to sell travel insurance for that insurer.

Contact other regulators that may have conducted a recent review of the training standards.

Determine if the training materials are appropriate and accurately reflect the coverage provided by the travel insurance product.

Review regulated entity’s records to determine if, when and how training occurred prior to the employees or authorized representatives of a travel retailer’s recommendation of a travel insurance product.
STANDARDS
MARKETING AND SALES

Standard 8
The Limited lines travel insurance producer has designated a “Designated Responsible Producer.”

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

*Travel Insurance Model Act (#632)*

Review Procedures and Criteria
STANDARD
MARKETING AND SALES

Standard 9
Sales practices do not include “negative option or opt out”.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sales and marketing

Others Reviewed

_____ _________________________________

_____ _________________________________

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Review a sampling of marketing materials and policies to confirm that customers were not offered or sold a policy through negative option or opt out.
STANDARDS
MARKETING AND SALES

<table>
<thead>
<tr>
<th>Standard 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blanket coverage is not marketed or described as “free” coverage.</td>
</tr>
</tbody>
</table>

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Review the use of the words/phrases “free,” “no cost,” “without cost,” “no additional cost,” “at no extra cost” or words/phrases of similar import. Such words/phrases should not be used with respect to any benefit or service being made available with a policy, unless true.
### STANDARD MARKETING AND SALES

**Standard 11**

If the aggregator’s website provides a short summary of the coverage, determine that the consumer has access to the full provisions of the policy by electronic means.

**Apply to:** All property and casualty travel insurance products  
**Priority:** Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations

**Others Reviewed**

- _________________________________________
- _________________________________________

**NAIC Model References**

*Travel Insurance Model Act (#632)*

**Review Procedures and Criteria**
B. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, Chapter 21—Conducting the Property and Casualty Examination, and the standards set forth below.
STANDARD
PRODUCER LICENSING

<table>
<thead>
<tr>
<th>Standard 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine that the travel insurer or limited lines travel insurance producer has provided the information required in Section 4(B)(1) [or state equivalent] to the purchasers of travel insurance.</td>
</tr>
</tbody>
</table>

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

- Applicable statutes, rules and regulations

Others Reviewed

- _________________________________________
- _________________________________________

NAIC Model References

- Travel Insurance Model Act (#632)
- Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Determine if the requested coverage is issued.

Examiners should request proof from the travel insurer or limited lines travel insurance producer sufficient to demonstrate that the actual information was provided. If the examiner is unable to obtain proof from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.
C. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, Chapter 21—Conducting the Property and Casualty Examination, and the standards set forth below.
STANDARD
POLICYHOLDER SERVICE

<table>
<thead>
<tr>
<th>Standard 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fulfillment materials were provided to the policyholder or certificateholder as required.</td>
</tr>
</tbody>
</table>

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All applications

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Examiners should request documentation from the travel insurer or limited lines travel insurance producer that is sufficient to demonstrate that the fulfillment documents were provided to the purchasers of travel insurance.
STANDARD
POLICYHOLDER SERVICE

<table>
<thead>
<tr>
<th>Standard 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The policy documents disclosed whether the travel insurance was primary or secondary to other coverage.</td>
</tr>
</tbody>
</table>

**Apply to:** All property and casualty travel insurance products

**Priority:** Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations
- All applications

**Others Reviewed**

- ________________________________
- ________________________________

**NAIC Model References**

*Travel Insurance Model Act (#632)*

**Review Procedures and Criteria**

Examiners should request documentation from the travel insurer or limited lines travel insurance producer that is sufficient to demonstrate that the policy documents state whether the coverage provided is primary or secondary to other coverage.
D. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, Chapter 21—Conducting the Property and Casualty Examination, and the standards set forth below.
STANDARD
UNDERWRITING AND RATING

Standard 1
Minimum data collection standards to ensure proper allocation for payment of premium tax have been established.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All applications

Others Reviewed

____ __________________________________________________________________________

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria
E. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, Chapter 21—Conducting the Property and Casualty Examination, and the standards set forth below.
STANDARD
CLAIMS

Standard 1
The policies issued contain benefits for which a claim and claim payment could have been made.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations
_____ Review policy forms and endorsements
_____ Claim files
_____ Claim complaint records
_____ Claim procedure/underwriting manuals

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)
Unfair Property/Casualty Claim Settlement Practices Act (#902)

Review Procedures and Criteria

To determine compliance with this requirement, examiners will (i) review a sample set of policies to confirm that benefits are being offered under the policies issued and a payment for a claim could have been made; and (ii) review a sample of denied claims to confirm that the denials were appropriate based on the policy language.

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Chapter 1

Modern Producer Licensing

The process for licensing insurance producers has had numerous phases. The first NAIC model on this subject was the NAIC Agent and Broker Model. The next phase was the NAIC Single License Procedure Model. Although development of the newest model began in the late 1990s, it was Congress’ passage of the GLBA in 1999 that caused the NAIC to speed the development of the PLMA Producer Licensing Model Act.

Uniformity Provisions of the Gramm Leach Bliley Act Adopted in 1999

In order to achieve the licensing uniformity standards of GLBA, a majority of states had to satisfy all five of the following requirements:

1. Adoption of uniform criteria regarding a producer’s integrity, personal qualifications, education, training and experience, which must include qualification and training on suitability of products for a prospective customer.
2. Adoption of uniform continuing education (CE) requirements.
3. Adoption of uniform ethics course requirements in conjunction with other CE requirements.
4. Adoption of uniform suitability requirements based on financial information submitted by the customer.
5. Elimination of nonresident requirements posing any limitation or condition because of the place of the producer’s residence or business, except for countersignature requirements.

One of the major provisions of the GLBA was a provision to create NARAB. While much progress was made to improve uniformity and streamline nonresident producer licensing, the NAIC endorsed the provisions of Terrorism Risk Insurance Program Reauthorization Act of 2015 (Public Law 107-297), which modified NARAB. These provisions, commonly referred to as NARAB II, were signed by President Barack Obama on Jan. 12, 2015. At the time of the publication of this handbook NARAB has not been completed for additional updated information please see the NAIC link.

NARAB II is intended to streamline the nonresident producer licensing process while preserving the states’ ability to protect consumers and regulate producer conduct. NARAB II does not create a federal insurance regulator but establishes a nonprofit corporation, known as NARAB, controlled by its board of directors. The stated purpose of the legislation is to provide “a mechanism through which licensing, CE, and other nonresident insurance producer qualification requirements and conditions may be adopted and applied on a multistate basis without affecting the laws, rules and regulations, and preserving the rights of a state pertaining to certain specific producer-related conduct.”

NARAB is to be governed by a 13-member governing board comprised of eight state insurance commissioners and five insurance industry representatives subject to presidential appointment and Senate confirmation. NARAB, acting through its board of directors, will establish membership criteria through which producers can obtain nonresident authority to sell, solicit or negotiate insurance. Satisfaction of membership criteria means a producer can sell, solicit or negotiate insurance (and perform incidental activities) in any state for which the producer is licensed in the home state. NARAB membership is not mandatory for producers.

The law preserves the rights of a state pertaining to resident licensing and CE, supervision and enforcement of conduct, and disciplinary actions for nonresident producers, and leaves intact a state’s full range of authorities for resident producers. The PLMA also includes important disclosures to the states, addresses business entity licensing and protects state revenues.

Through the efforts of the Producer Licensing (DEX) Task Force and the its Producer Licensing (EX) Working Group, the NAIC monitors state compliance with reciprocity guidelines. The NAIC also set a goal to create uniform licensing practices. The Producer Licensing (DEX) Working Group Task Force has adopted a number of Uniform Licensing Standards and guidelines, and continues to strive toward a more efficient licensing system among the states.
National Insurance Producer Registry

The NAIC has long advocated for increased use of technology to streamline licensing processes. In 1996, the NAIC collaborated with industry to create the Insurance Regulatory Information Network (IRIN) as a nonprofit affiliate of the NAIC. In 1999, the organization changed its name to the National Insurance Producer Registry (NIPR). The purpose of the NIPR is to work with the states and the NAIC to re-engineer, streamline and make more uniform the producer licensing process for the benefit of insurance regulators, the insurance industry and consumers. The NIPR worked with the NAIC to develop and implement: 1) the Producer Database (PDB), which includes licensing information from 50 states, the District of Columbia and three U.S. territories, utilized by the industry for licensing and appointment information; and 2) the State Producer Licensing Database (SPLD) for use by insurance regulators.

States use the NIPR to link state insurance departments with the entities they regulate. Applicants and licensees can transmit licensing applications, insurers can transmit appointments and terminations, and both can transmit other information to insurance regulators in multiple states, thereby creating electronic solutions that are easy and efficient to use by the states and industry.

Additionally, using the subsequent launch of the Attachment Warehouse, an applicant who answers “yes” to any background question on the NAIC Uniform application can submit the required supporting documentation at the time he or she is applying for or renewing a license. The submission of a document to the Attachment Warehouse will trigger an email alert to the appropriate state(s) notifying the state(s) that supporting documentation has been submitted to fulfill document requirements pertaining to the “yes” answer on the background. The advantage to the producer and the state(s) is that the documentation can be sent to the Attachment Warehouse once, and all appropriate states will be notified and have the ability to view, download or print the document. The Attachment Warehouse also allows a producer to meet the requirement from the states to report and submit documentation related to any regulatory action taken against him/her/them. This enables the producer to meet this regulatory obligation quickly in order to comply with the typical state requirement for producers to report an action within 30 days. Through the use of the Attachment Warehouse, all states in which the producer is licensed are notified with an email alert and have access to the document.

A complete list of jurisdictions using NIPR products and services is available at www.nipr.com. The website has an updated list of the states that are making active use of NIPR electronic processing. (Product List by State)
Chapter 2

Producers Licensing Model Act
Uniformity Provisions of the Producer Licensing Model Act

Through the PLMA, the NAIC created a system of reciprocity for producer licensing and also established uniform standards in key areas of producer licensing. The PLMA was initially adopted in January 2000. It was subsequently amended in October 2000 and in January 2005.

In December 2002, the Producer Licensing (EX) Working Group adopted a set of Uniform Resident Licensing Standards (URLS). In December 2008, the standards were revised and updated to incorporate standardization and uniformity for both resident and nonresident licensing. The standards were, therefore, renamed the ULS. The PLMA and the ULS are designed to complement each other and assist the states in creating a uniform system of producer licensing. In 2008, the Producer Licensing (EX) Working Group was charged with reviewing the ULS. Subsequent revisions were made to the ULS in August 2010 (limited lines definitions) and in August 2011 (definitions for certain non-core limited lines). The revised standards are included in the Appendix, and updates can be found on the Producer Licensing (EX) Working Group’s State Licensing Handbook web page on the NAIC website. (https://content.naic.org/state_licensing_handbook.htm)

The key uniformity provisions of the PLMA are:

1. Definitions for “negotiate,” “sell” and “solicit,” and uniform exceptions to licensing requirements.
2. An application process for both resident and nonresident producer license applications that uses the NAIC Uniform Application for resident and nonresident producers.
3. Definitions for the six major lines of insurance: Life, Accident and Health or Sickness, Property, Casualty, Personal Lines, and Variable Life or Annuity Products.
4. Exemptions from completing prelicensing education and examinations for licensed producers who apply for nonresident licenses.
5. Standards for license denials, non-renewals and revocations.
6. Standards regarding which individual producers and business entities may receive a commission related to the sale of an insurance policy.
7. Standards for producer appointments for states that have an appointment system.
8. Procedures for insurance regulators, companies and producers to report and administratively resolve “not for cause” and “for cause” appointment terminations.
9. A definition for limited lines insurance. The Producer Licensing (EX) Working Group has adopted a recommended list of limited lines licenses, as set forth in the ULS, and has encouraged states to eliminate licensing categories for other lines of insurance.

Other Key Provisions of the Producer Licensing Model Act

The PLMA also contains a number of provisions that promote simplified licensing procedures.

Home State

The intent of the PLMA is for a producer to have one state of residence. Section 2(B) of the PLMA defines this concept as the home state:

“Home state” means the District of Columbia and any state or territory of the United States in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer."

A producer is permitted to designate either the actual state of residence or the principal place of business as the home state. The PLMA does not specifically prohibit the existence of two home state licenses. The producer may select either the resident state or the principal place of business. This option was intended to accommodate a producer who lives in one state but maintains his/her business in another state. However, it was the intent of the drafters for one state to be designated as the home state to prevent forum shopping. The Producer Licensing (DEX) Working Group Task Force has discouraged any state from adopting a stance that a producer can maintain two home states.

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Change of Home State

Under the PLMA, there is now a simplified process for producers who move from state to state and were in good standing prior to the change of residence.

Section 9 of the PLMA provides a mechanism for licensed producers to maintain an active license when changing the state of residence. Section 9(A) creates an exemption from prelicensing education or examination for a producer who moves into a state who was previously licensed for the same lines of authority in another state. In this scenario, the producer receives a new resident license for the same lines of authority, so long as the producer applies for a resident license within 90 days of the cancellation of the producer’s previous license and the producer was in good standing in the prior state.

Section 9(B) creates an exemption from prelicensing education or examination for a line of authority held by a former nonresident producer who moves into a state and becomes a resident of that state. In practice, when a nonresident becomes a resident, that producer is to be granted the same lines of authority previously held, so long as the producer applies for a resident license within 90 days of establishing legal residence. States are not to impose prelicensing education or an examination on a nonresident producer who subsequently moves into another state and declares it to be the home state, unless “the commissioner has determined otherwise by regulation.”

Under the PLMA, letters of certification were eliminated as a prerequisite to granting a nonresident license. The SPLD provides verification of good standing in the producer’s home state.

One unresolved issue is the long-established practice of requiring a letter of clearance for producers changing their resident state. Despite the fact that the PLMA does not contain any reference to a letter of clearance, some states still require the producer to provide a letter of clearance from the former state before the new state will grant the producer an active resident status. Other states grant the new nonresident license but continue to monitor the producer’s record to make sure that the prior resident license changes in status from resident to nonresident. This is done to prevent the producer from holding two active resident licenses.

The Producer Licensing (EX) Working Group and NIPR have identified this as an issue that could best be resolved by the establishment of an electronic method for the producer to communicate the desired changes to all affected states in one transaction. NIPR’s launch of the Contact Change Request (CCR) service allows producers for many states to change their physical addresses, email addresses, phone numbers and fax numbers. The Producer Licensing (EX) Working Group will turn its attention to solving the issues surrounding a change of resident state once all states have fully implemented the CCR service.

Commissioner Discretion

The PLMA contains language that allows a state to adopt regulations to cover a state-specific situation. States should carefully consider the impact that deviation from the PLMA might have on NAIC uniformity and reciprocity initiatives.

Section-by-Section Summary of the Producer Licensing Model Act

The full text of the PLMA is in the Appendices.

Section 1: Purpose and Scope

• To promote efficiency and uniformity in producer licensing.

Section 2: Definitions

• Defines the terms “home state,” “limited lines insurance,” “sell,” “solicit,” “negotiate” and other pertinent terms.

Section 3: License Required

Section 4: Exceptions to Licensing

• Lists the persons and entities that do not need licenses, even though they participate in the insurance industry.
Section 5: Application for Examination

- Requires that producers must pass an examination in the lines of authority for which application is made.
- Allows use of outside testing services to administer examinations.

Section 6: Application for License

- Sets forth the qualifications for licensure as an individual or business entity.
- Provides that limited line credit insurers must provide instruction to individuals who will sell credit insurance.

Section 7: License

- Sets forth the six major lines of authority, the limited line of credit insurance and any other line of insurance permitted under state laws or regulations.
- Provides guidelines for license continuation and reinstatement.
- Provides for hardship exemptions for failure to comply with renewal procedures.
- Lists the information the license should contain.
- Requires licensees to notify the insurance commissioner of a legal change of name or address within thirty (30) days of the change.

Section 8: Nonresident Licensing

- Requires states to grant nonresident licenses to persons from reciprocal states for all lines of authority held, including limited lines and surplus lines insurance, if those persons are currently licensed and in good standing in their home states.
- Requires a nonresident licensee who moves from one state to another to file a change of address and certification from the new resident state within thirty (30) days with no fee or application.

Section 9: Exemption from Examination

- Exempts licensed individuals who change their home state from prelicensing and examination.
- Requires a licensed nonresident who becomes a resident to register in the new home state within ninety (90) days of establishing legal residence, unless “the commissioner determines otherwise by regulation.”

Section 10: Assumed Names

- Requires a producer to notify the insurance commissioner prior to using an assumed name.

Section 11: Temporary Licensing

- Allows temporary licensure for up to 180 days without requiring an exam when the insurance commissioner deems that the temporary license is necessary for the servicing of an insurance business in specific cases.

Section 12: License Denial, Non-renewal or Revocation

- Lists 14 grounds for denial, non-renewal or revocation of a producer license.
Provides that a business entity license may be revoked if an individual licensee’s violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation, and the violation was not reported to the insurance commissioner nor was corrective action taken.

Section 13: Commissions

- Prohibits payment of commissions or other compensation to or acceptance by an unlicensed person for “selling, soliciting or negotiating” insurance.
- Allows payment of renewal commissions to an unlicensed person if the person was licensed at the time of the sale, solicitation or negotiation.
- Permits payment or assignment of commissions or other compensation to an insurance agency or to persons who do not sell, solicit or negotiate, unless the payment would violate rebate provisions.

Section 14: Appointments (optional)

- Prohibits a producer from acting as a producer for an insurer unless appointed. The insurer appoints the producer either within 15 days from the date the agency contract is executed or within 15 days from the date that the first insurance application is submitted.
- Sets forth processes for initial and renewal appointments.

Section 15: Notification to the Insurance Commissioner of Termination

- Requires the insurer to notify the insurance commissioner within 30 days following the effective date of termination of a producer’s appointment, if the termination is for cause. The insurer also has a duty to promptly notify the insurance commissioner of any new facts learned after the termination. When requested by the insurance commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.
- If termination of a producer is not for cause, the insurer must notify the insurance commissioner within 30 days following the effective date of termination.
- Sets forth a detailed process for notifying the producer and for a producer to submit comments to the state.
- Provides that in the absence of actual malice, insurers have immunity from any actions that result from providing information required by or provided pursuant to this section.
- Contains penalties for insurers who fail to report or who report with actual malice.
- Requires that documents furnished to the insurance commissioner pursuant to this section shall be confidential and privileged.

Section 16: Reciprocity

- A state cannot impose additional requirements on nonresident license applicants who are licensed in good standing in their home state other than the requirements imposed by Section 8 of the PLMA, if the applicant’s home state grants nonresident producer licenses on the same basis.

   A nonresident’s satisfaction of CE in the producer’s home state shall constitute satisfaction of all CE requirements in the nonresident state, if the home state practices CE reciprocity. A nonresident producer’s satisfaction of his or her home state’s continuing education requirements for licensed insurance producers shall constitute satisfaction of this state’s continuing education requirements if the non-resident producer’s home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis”.

Section 17: Reporting of Actions (By Producers)

- A producer must report any administrative actions taken in another jurisdiction or by another government agency in the home jurisdiction within thirty (30) days of the final disposition of the matter.
• A producer shall report any criminal prosecution taken in any jurisdiction within 30 days of the initial pretrial hearing date. The report must include the legal order, relevant court documents and the original complaint.

Section 18: Compensation Disclosure

• In any instance when a producer will receive compensation from a customer for placing an insurance policy and also will receive compensation from an insurer for that placement, prior to placing that policy, the producer is required to disclose to the customer the amount and sources of compensation the producer will receive, if the customer makes an insurance purchase.

Section 19: Regulations

• The insurance commissioner may promulgate reasonable regulations to carry out the purposes of the PLMA.

Section 20: Severability

Section 21: Effective Date

Frequently Asked Questions

The Producer Licensing (EX) Working Group has created several documents that answer frequently asked questions (FAQ) about reciprocity, uniformity and how to administer the PLMA. The current version of the FAQ as of the publication date appears below. The latest version of these documents can be found on the State Licensing Handbook webpage under the appendix section. (https://content.naic.org/state_licensing_handbook.htm) The latest version of these documents can be found on the Producer Licensing (EX) Working Group’s web page on the NAIC website.

PLMA Implementation - FAQ

This document has been prepared by the NAIC’s Producer Licensing (D) Working Group for informational purposes only. The following questions and answers are based upon the language of the PLMA. This document is not intended as legislative history or to replace a state insurance department’s independent review and analysis of these questions. The contents of this document should not be interpreted as representing the views or opinions of the NAIC or of any individual NAIC member or state insurance department.

Question 1: Is Section 14 of the PLMA regarding appointments, which is labeled “optional,” intended to be optional for adoption by a state that requires insurer appointments of producers?

Answer 1: No. If a state requires appointments, it should adopt Section 14. It was labeled “optional” only to accommodate those states that do not require appointments—e.g., Colorado.

Question 2: PLMA Section 14B starts a clock of 15 days for insurer compliance by providing that “the appointing insurer shall file … within 15 days from the date the agency contract is executed or the first insurance application is submitted” (emphasis added). When is an application deemed “submitted”?

Answer 2: An application is submitted when it is dated received by the insurer. The use of any other event will undermine the ability of the states and insurers to achieve uniform national practice for regulatory notifications. This is because any other temporal event is unknown to the insurer, which has the compliance responsibility. That is, “submitted” should not mean when a producer mails an application, since different producers might use different means of communicating applications; different producers will mail applications at different times; mail pick-up and delivery varies among localities, etc. The one certain time of submission is when the application is dated received by the insurer.

Question 3: If a state adopts PLMA Section 14, is there an option for the state to require an insurer to execute an agency contract with a producer prior to accepting the first insurance application from a producer that has not yet been appointed?

Answer 3: No. PLMA Section 14B provides that “the appointing insurer shall file, in a format approved by the insurance commissioner, a notice of appointment within 15 days from the date the agency contract is executed or the first insurance application is submitted” (emphasis added). The use of the word “or” in the model act clearly allows an insurer to notice
appointment upon the earliest of the two events. Pennsylvania has adopted modified language and is not in complete agreement with this answer.

**Question 4:** Since the PLMA works toward uniform national procedures by eliminating the traditional distinctions between agents and brokers for purposes of licensure, is it appropriate to require appointments of producers acting as brokers?

**Answer 4:** No. PLMA Section 14A makes clear that an insurer need only appoint producers “acting as agents on behalf of the insurer.” Inasmuch as brokers are not appointed, notification of appointments of brokers is not required.

**Question 5:** Must a business entity reside in a state to obtain a producer license?

**Answer 5:** No. Section 8 outlines the requirements that a person must fulfill in order to obtain a nonresident license, and the definition of “person” (see PLMA §2L) makes clear that this section applies to the licensing of both individuals and business entities. Section 8 is devoid of any residency requirement, and a nonresident business entity should be able to obtain a nonresident producer license if business entities are required to be licensed by the insurance department at all. In addition, states that impose residency requirements on business entities are likely not compliant with National Archives and Records Administration (NARA) provisions of the GLBA.

**Question 6:** Should the record of producer qualifications obtainable from the NIPR SPLD satisfy all certification requirements for state licensing?

**Answer 6:** Yes. PLMA Section 7G, Section 8B and Section 9 make clear that states should adopt and use the SPLD record for all regulatory purposes.

**Question 7:** Should a state require that a resident be licensed as a producer if he or she is entitled to renewal or other deferred commissions produced in another state?

**Answer 7:** No. PLMA Section 3 and Section 13C indicate that a producer license is required to sell, solicit or negotiate the sale of insurance, but do not suggest that a license is needed after such activity has ceased. The person’s receipt of renewal or other deferred commissions does not result in any licensing requirement.

**Question 8:** Are insurers alone responsible for educating those persons who sell limited lines credit insurance products?

**Answer 8:** Yes. PLMA Section 6D requires such insurers to furnish the program of instruction to those who sell limited lines insurance. The program is filed with the insurance commissioner in most states.

**Question 9:** Does reciprocity pursuant to Section 8 of the PLMA require recognition of a nonresident line of authority when the state in which the nonresident license is sought does not recognize a line of authority for resident producers?

**Answer 9:** Yes. For example, the reciprocity mandates of Section 8E should be respected for a limited line of authority, as is the case with any other line of authority. Consequently, states should be prepared to recognize the authority on a nonresident basis.

**Question 10:** What process is to be followed by a producer in identifying a new “home state” without the loss of his or her license to do business in the prior home state?

**Answer 10:** The producer should notify the prior home state of his or her change of address and intent to apply for a resident license in the new home state. The producer must apply for resident license in his or her new home state. Pursuant to Section 9 of the PLMA, the producer or applicant is not required to complete any prelicensing education or examination in order to secure the new resident license.

**Question 11:** What process is to be followed by the new home state insurance regulator with regard to a producer changing his or her state of residency?

**Answer 11:** The new home state should process the producer’s application, issue a resident license if warranted and, if issued, notify the SPLD of the producer’s new status as a resident licensee.
Question 12: What is the process to be followed by the prior home state insurance regulator?

Answer 12: At the time the producer notifies the prior home state insurance regulator of a change of address, the prior home state insurance regulator should send to the SPLD a report of “active with notice of transfer of residency to [the new home state],” identifying the new state of residency. Upon PDB notification of the new resident state licensure, the prior home state resident license is replaced with a nonresident license for the duration of its term. It is noted that time frames for notice to the states of a change in address are stated in the PLMA.

Question 13: If a commission is paid to enroll a customer in a group credit insurance policy, must the enroller be licensed?

Answer 13: Yes. An individual who enrolls customers under a group insurance policy must obtain a limited lines license if a commission is paid. PLMA Section 4B(2) provides an exception from licensing if no commission is paid to the enroller and the enroller does not engage in selling, soliciting or negotiating.

Question 14: May an individual sell, solicit or negotiate group credit insurance coverage without a license?

Answer 14: No. An individual must have a limited lines license before he or she can sell, solicit or negotiate the purchase of group insurance. While PLMA Section 4B(2) provides an exception for securing and furnishing information in connection with group insurance coverage, there is no such exception from licensing for selling, soliciting or negotiating group insurance coverage.

Question 15: Can a person enrolling someone in a group insurance policy secure and furnish information about the policy to a customer and still be exempt from licensure?

Answer 15: Yes. As set forth in Section 4B(2) of the PLMA, there is an exception that allows a group enroller to secure and furnish information about the group insurance policy to a customer, provided no commission is paid or there is no selling, solicitation or negotiation. However, Section 4B(2) generally recognizes an exception for purposes of enrolling individuals under plans, issuing certificates under plans, assisting with the administration of plans, and performing administrative services related to the mass marketing of property/casualty (P/C) insurance.

Note: It is important to note that individual state laws and factual circumstances will control in determining whether an activity involves selling, solicitation or negotiation. Likewise, the states will have discretion in interpreting what activities constitute the “securing or furnishing” of information.

Question 16: With regard to products sold by life insurers, does the qualification in the PLMA that a person shall not sell, solicit or negotiate insurance “in this state” without a license mean that the producer must be licensed in the state(s) where the: 1) sale, solicitation or negotiation occurs; or 2) policyholder principally resides?

Answer 16: In those states that have adopted the PLMA, licensure should be based upon where a producer “sells, solicits or negotiates” insurance, as specifically stated in the PLMA. In traditional insurance sales transactions, licensure should be determined solely by this PLMA standard without reference to the state of residence of the insured. Application of the “sells, solicits or negotiates” standard where an insurance transaction takes place purely by electronic or telephonic means is more complex. In such transactions, application of the PLMA licensure standard should turn on the state of residence of the customer.

Question 17: Section 14B of the PLMA states: “To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the insurance commissioner, a notice of appointment within 15 days from the date the agency contract is executed or the first insurance application is submitted.” In a situation where a producer is not currently appointed by an insurer, but was previously appointed by and submitted an application to that insurer, must that producer now obtain a new appointment before submitting a new application to that insurer because it would not be the first application the producer ever submitted to that insurer?
**Answer 17:** No. Section 14B of the PLMA requires appointment within 15 days of the date an insurer receives the first application submitted by a producer who is not currently appointed, even if that producer was previously appointed by that insurer and submitted business in the past. Reference to the agency contract or the first application is based on the current time period. If a producer’s prior appointment with the insurer was terminated, each jurisdiction would consider the time period to start again with the new contract execution or the time period when the agent submits his first insurance application following the prior termination.
Chapter 3

Uniform Licensing Standards

In 2002, the Producer Licensing (EX) Working Group adopted the Uniform Resident Licensing Standards (URLS). The standards were revised and updated to incorporate standardization and uniformity for both resident and nonresident licensing. The standards were renamed to the ULS in 2008. These standards will be referenced throughout this Handbook. The full text of the ULS is in the Appendices. The latest version of the appendix can be found on the State Licensing Handbook webpage (https://content.naic.org/state_licensing_handbook.htm). The latest information can be found on the Producer Licensing (EX) Working Group’s web page on the NAIC website.

These standards establish an important baseline to assure insurance regulators that all states are applying the same standards to resident applicants. The Producer Licensing (DEX) Working Group Task Force and its Working Groups monitors compliance with the uniform standards. Since the adoption of the ULS, the Producer Licensing (EX) Working Group Task Force has adopted interpretative guidelines and clarifications to further explain the proper implementation of the ULS.

The ULS contain guidelines in the following categories:

1. Licensing qualifications.
2. Prelicensing education training.
3. Producer licensing test.
4. Integrity/personal qualifications/background checks.
5. Application for licensure/license structure.
6. Appointment process.
7. CE Requirements.
8. Limited lines uniformity.
9. Surplus lines standards.
11. Commission sharing.

Initial and Renewal Producer License Applications

The Producer Licensing (EXD) Working Group Task Force has adopted initial and renewal NAIC Uniform Applications for resident and nonresident individuals and business entities. Under the ULS, states are directed to use the Uniform Applications rather than state-specific applications. The Producer Licensing (EXD) Working Group Task Force has established a schedule for review and update of the applications. States are encouraged to use the most current form of the Uniform Applications. The forms are available on the NAIC website. All NIPR online applications use the most recent approved uniform initial and renewal application forms.
### Recommended Best Practices for Insurance Regulators

- Conduct a regular review of state business rules, as well as any state-specific requirements for paper and electronic applications that are posted on NIPR’s website, with the NIPR or other vendor to maintain compliance with reciprocity and the ULS.
- Consider whether existing business rules are statutorily required. To the extent they are not statutorily required, they should be removed. To the extent they are statutorily required, the state licensing director should consider whether they are necessary. To the extent they are not necessary for consumer protection, the insurance commissioner should take steps to attempt to have such statutory requirements repealed (e.g., sponsor legislation).
- Carefully consider whether licensing staff should be given authority to change internal business rules or to give direction to a vendor without the licensing director’s approval. A change in procedure that may seem to be appropriate could cause problems with reciprocity or the ULS.
- If a state uses an outside vendor to receive and process license applications, monitor the vendor to ensure that applicants are provided only the most current NAIC uniform application, whether the applicant applies or renews online or via paper application.
- Adapt the department website to direct applicants to a single electronic location to obtain the most current version of the NAIC uniform forms, or specifically to the link for the electronic process.
- Departments should encourage the use of electronic processes, when available, rather than paper processes to expedite the licensing process.
- Eliminate all state-specific application forms, and use only the most recent version of the NAIC uniform forms.
• Develop a procedure manual, and cross-train staff so that several personnel can perform all licensing tasks.
• Provide adequate notice of changes to licensing and appointment fee structures, as well as changes to applications and other forms required to be submitted by applicants. With regard to the transition from an old application form to a new form, states should continue to accept original, signed applications up to a reasonable transition period beyond the inception date for the new form. Prior to the effective revision date, the state should provide adequate notice by way of email, website updates and any other appropriate communication device to interested parties.
Chapter 4

Nonresident Licensing

The previous reciprocity provisions of the GLBA adopted in 1999 required that barriers to nonresident producer licensing be eliminated. The PLMA contains specific guidance on this issue. A producer licensed in good standing in the home state must be granted a nonresident license unless good cause for denial exists under Section 12 of the PLMA.

There are four key components to licensing reciprocity:

1. Administrative procedures.
2. CE requirements.
3. Elimination of any limitations on nonresident.
4. Reciprocity with other States.

Administrative Procedures

Under the previous administrative procedures for reciprocal licensing mandated by the GLBA, a nonresident person received a nonresident producer license if:

1. The person was currently licensed as a resident and is in good standing in the person’s home state.
2. The person submitted the proper request for licensure and paid the fees required by the nonresident state’s law or regulation.
3. The person submitted or transmitted to the insurance commissioner the application for licensure that the person submitted to the person’s home state or, in lieu of that, a completed NAIC Uniform Application.
4. The person’s home state awarded nonresident producer licenses on the same basis to residents of the state in which the applicant is seeking a nonresident license.

States were required to license nonresident applicants for at least the line of authority held in the home state. This was true even if the line of authority held in the applicant’s home state may not have precisely aligned with the major or limited lines of authority in the other state. States were not allowed to charge a licensing fee to a nonresident that was so different from the fee charged a resident so as to be considered a barrier to nonresident licensure. States also were not allowed to collect fingerprints from nonresident applicants.

Section 8(C) of the PLMA makes it clear that a licensed nonresident producer who changes residency is not required to surrender the license and submit a new application. All that is required is a change of address within thirty (30) days of the change of legal residence. The model provides that a state should not charge a fee for processing this change of address.

The reciprocity provisions of the PLMA also extend to surplus lines producers. A majority of states treat surplus lines as a distinct license type. Persons holding surplus lines producer licenses in their home states shall receive nonresident surplus lines producer licenses, unless some other reason for disqualification exists.

A producer holding a limited line of insurance is eligible for a nonresident limited lines producer license for the same scope of authority as granted under the license issued by the producer’s home state. The nonresident state may require only what is permitted under Section 8 of the PLMA for limited lines applicants. A limited line is any authority that restricts the authority of the licensee to less than the total authority prescribed in the associated major line.

Continuing Education Requirements

Pursuant to the PLMA, a nonresident state must accept the producer’s proof of the completion of the home state’s CE requirements as satisfaction of the nonresident state’s CE requirements, if the nonresident producer’s home state recognizes the satisfaction of its CE requirements imposed upon producers from the nonresident state on the same basis.
Limitations on Nonresidents

States had to eliminate licensing restrictions that required a nonresident producer to maintain a residence or office in the nonresident state so long as the nonresident’s license was from one of the United States, the District of Columbia or the U.S. territories. The NARAB Working Group stated it was not a violation of GLBA reciprocity requirements if a state required nonresidents to provide proof of citizenship; however, under the ULS, it is the responsibility of the resident state to verify an applicant’s citizenship status.

Reciprocal Reciprocity

To comply with the reciprocal reciprocity provisions of the GLBA, a majority of the states had to meet all three of the above components and grant reciprocity to all residents of the other states who have met those components.

Reciprocity Examples

The PLMA contains specific guidance on the proper reciprocal treatment that a state licensing director should grant. This chapter contains illustrative examples of these provisions. Unless otherwise specified, these examples assume that the applicant is in good standing in the home state and has not requested a change in line of authority (LOA). There are some states that did not adopt all the reciprocity standards previously required by the GLBA in 1999 and currently reflected in the PLMA. The answers to the following examples will vary when a nonreciprocal state is involved. Examples also can be found in the Producer Licensing (EX) Working Group Frequently Asked Questions contained in Chapter 1.

- **Example A**

A producer whose home state is State A has a nonresident license from State B and State C and moves to State D as the producer’s new home state.

What should happen: The producer timely files a change of address in State A, State B and State C. State A places the producer’s resident license on inactive status. Within 90 days of cancelling the resident state license in State A, the producer applies for a resident license in State D. Using the SPLD, State D confirms the producer was in good standing in State A and is apply for the same line of authority the producer held in State A. State D issues the producer a resident license. State A confirms the producer’s new resident license in State D and converts the producer’s inactive resident license to an active non-resident license. State B and State C also confirm the producer now holds a resident license in State D and record the producer’s change of address. Because the producer held the same line of authority in State A that the producer applied for in State D, the producer should not be required to take and pass a license examination or complete prelicensing education.

- **Example B**

A producer holds a line of authority for surety in State A, and applies for a nonresident license in State B. However, State B does not have a separate surety line of authority.

What should happen: State B issues license that includes surety (which may have additional authority) but the producer is limited to the surety LOA held in the producer’s resident state.

- **Example C**

A producer’s home state is State A. State A does not have a prelicensing education requirement for the life LOA. The producer holds a license with the life LOA in State A. The producer applies for a nonresident license in State B. State B has a resident license prelicensing education requirement.

What should happen: State B issues a nonresident license with the life LOA and does not require any prelicensing education.

- **Example D**

A producer’s home state is State A. State A does not have a prelicensing education requirement for any LOA. The producer holds a license with the life insurance LOA. The producer holds a nonresident license from State B. State B has a resident license prelicensing education requirement. The producer moves to State B.
What should happen: State B should issue a resident license to the producer with the life LOA. State B should not require prelicensing education or completion of an examination before issuance, “except where the commissioner determined otherwise by regulation.” (See PLMA Section 9B.)

• Example E

A producer’s home state is State A. Both State A’s resident prelicensing education and CE requirements are less than the ULS. The producer holds a resident license with the life insurance LOA in State A. The producer applies for a nonresident license in State B. State B has both prelicensing and CE requirements that match or exceed the ULS.

What should happen: State B issues the nonresident license with the life LOA and does not require the completion of either additional prelicensing education or additional CE.

• Example F

A producer’s home state is State B. The producer applies for a nonresident license with the variable products LOA in State A. A check of the PDB reveals that the applicant is not licensed for the variable products LOA in State B. Upon investigation, it is learned that State B either issues life or variable as a combined LOA or has a requirement for variable products licensing, but it is not specifically tracked by the Department of Insurance (DOI).

What should happen: This is a challenge, as State B has failed to adopt the variable products line of authority as defined in the PLMA. A second challenge is that the records on the SPLD and/or the NIPR may not accurately reflect the home state business rule. In this example, the nonresident state will have to pend the application and contact the home state to verify if the applicant is in compliance with the home state law on variable products. The nonresident state must then decide if the applicant should be granted a license.

• Example A

A producer whose home state is State A has a nonresident license from State B and State C and moves to State D as the producer’s new home state.

What should happen: The producer timely files a change of address in State A, State B and State C. State A changes the license from resident to nonresident. State B and State C record a change of address. The producer should apply for a license with State D within 90 days. State D should issue the license and may not require the producer to complete either an examination or prelicensing education; State D should verify that the license was in good standing in State A via the SPLD.

• Example B

A producer who holds a line of authority for surety in the home state, State A, applies for a nonresident license in State B, which does not have a separate surety line of authority.

What should happen: State B issues a license that has multiple LOAs, including surety LOA, that the producer holds in the home state, but the producer is limited to the surety LOA held in his or her home state.

• Example C

A producer’s home state, State A, does not have a prelicensing education requirement for any LOA, and the producer holds a life insurance LOA. The producer applies for a nonresident license in a state that has a prelicensing education requirement.

What should happen: State B issues a nonresident license with the life LOA and does not require any prelicensing education before issuance.

• Example D

A producer’s home state, State A, does not have a prelicensing education requirement for any LOA, and the producer holds a life insurance LOA. The producer holds a nonresident license from State B that has a prelicensing education requirement. The producer moves into that state.
What should happen: State B should issue a resident license to the producer with a life LOA and does not require prelicensing education or completion of an examination before issuance, “except where the commissioner determined otherwise by regulation.” (See PLMA Section 9B.)

Example E

A producer’s home state, State A, has a prelicensing education requirement and a CE requirement that is less than the ULS, and the producer holds a life insurance LOA. The producer applies for a nonresident license in State B, which has a prelicensing requirement that matches or exceeds the ULS and a CE requirement that matches the ULS.

What should happen: State B issues the nonresident license with the life LOA and does not require the completion of either additional prelicensing education or additional CE.

Example F

A nonresident producer applies for the variable products LOA in State A. A check of the SPLD reveals that the applicant is not licensed for variable products in the home state, State B. Upon investigation, it is learned that State B either issues life or variable as a combined LOA or has a requirement for variable products licensing, but it is not specifically tracked by the Department of Insurance (DOI).

What should happen: This is a challenge, as State B has failed to adopt the variable products line of authority as defined in the PLMA. A second challenge is that the records on the SPLD and/or the NIPR may not accurately reflect the home state business rule. In this example, the nonresident state will have to pend the application and contact the home state to verify if the applicant is in compliance with the home state law on variable products. The nonresident state must then decide if the applicant should be granted a license.
Chapter 5

Activities Requiring Licensure

License Required to Sell, Solicit and Negotiate

The PLMA uses three key words to determine when a person is required to have an insurance producer license:

“Sell” means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

“Solicit” means attempting to sell insurance, or asking or urging a person to apply for a particular kind of insurance, from a particular company.

“Negotiate” means the act of conferring directly with, or offering advice directly to, a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

The specific requirement to hold a license is found in Section 3 of the PLMA and reads as follows:

A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance, unless the person is licensed for that line of authority in accordance with this Act.

The Producer Licensing (EX) Working Group clarified in 2006 that in traditional life insurance sales transactions, licensure should be determined solely by the PLMA’s “sells, solicits or negotiates” standard, without reference to the insured’s state of residence. The key is to determine if the producer was properly licensed in the state in which the activity requiring a license took place. See also FAQ Number 16 in Chapter 2.

During the drafting of the PLMA, there was considerable discussion about who should be required to hold an insurance producer license. Prior to the adoption of the PLMA, the Producer Licensing (EX) Working Group discussed guidelines for “licensable” and “non-licensable” activities. The main thrust of that effort was to distinguish acts that constitute the sale, solicitation or negotiation of insurance from administrative or clerical acts. The guidelines document gives numerous examples of “Agent” activities that do require an insurance producer license and “Clerical” activities that do not. The document is included in the Appendices. The latest version of these documents can be found on the State Licensing Handbook webpage under the appendix section. Check the Producer Licensing (EX) Working Group’s webpage for any updates.

Commissions

Section 13 of the PLMA provides guidance regarding the relationship between being licensed and receiving commissions. Section 13(A) prohibits the payment of commission to a person who is required to be licensed. Section 13(B) prohibits a person from receiving a commission if that person was unlicensed and was required to hold a license under the Act.

Section 13(C) of the PLMA states that it is not necessary nor should any state require a producer to maintain an active license solely to continue to receive renewal or deferred commissions.

Section 13(D) of the PLMA provides that an insurer or a producer licensed in a state may assign commissions, services fees, brokerages or similar compensation to an insurance agency (business entity) or to persons (individuals) who are not selling, soliciting or negotiating in that state and who are not licensed in that state, unless the payment would violate a state’s antifreezing statutes. For example, if a regional manager in State A is, by contract with an insurer, to receive an override commission on all sales activities from subagents located in States B and State C, but the manager does not engage in any activity that would require licensure under Section 3 of the PLMA, no license should be required by State B or State C in order for the manager to receive commission payments.

Another example: A trade association with members in all states is headquartered in State A. An insurer pays a fee to the association for each member who purchases insurance from that insurer through an affinity marketing program. The association does not have to be licensed in any state because the association does not sell, solicit or negotiate insurance.
In 2008, the Producer Licensing (EX) Working Group provided guidance on uniform interpretation of the commission sharing provision in PLMA and recommended that adoption of Section 13 be included in the ULS. The Commission Sharing guidance document is included in the Appendix of this Handbook.

**Exceptions to Licensing**

The PLMA contains two key sections that clarify when a license is not required. When considering whether to require a license, states should carefully review Section 4 and Section 13 of the PLMA.

Section 4 of the PLMA contains a specific list of exceptions from the licensing requirement. States should take special note of Section 4(B)(6), which provides an exception for producers placing commercial insurance for a multistate risk with an incidental exposure in several states. As the section provides, in this situation a license is only required in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state.

The following is a summary of types of persons and entities that are exempted from licensing:

1. An officer, director or employee of an insurer or insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in the state.
2. A person who secures and furnishes information for, or enrolls individuals in, group life insurance, group P/C insurance, group annuities or group, or blanket accident and health insurance; where no commissioner is paid to the person for the service.
3. An employer or association; its officers, directors, employees; or the trustees of an employee trust plan, not in any manner compensated, directly or indirectly, by the company issuing the contracts.
4. Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks.
5. A person whose activities in a state are limited to advertising without the intent to solicit insurance in that state.
6. A person who is not a resident of a state who sells, solicits or negotiates a contract of insurance for commercial P/C risks to an insured with risks located in more than one state insured under that contract.
7. A salaried, full-time employee who counsels or advises the employer relative to the insurance interests of the employer who does not receive commission.

**Recommended Best Practice for Insurance Regulators**

- For uniformity purposes, states that still use a “transaction-based licensure” approach should eliminate that standard and change to the PLMA standard.
Chapter 6

Prelicensing Education

Prelicensing education is required in some states as a condition of licensure for resident insurance producers. Neither the PLMA nor the ULS suggests that a state must have a requirement for prelicensing education. States that have a prelicensing education requirement should follow the uniform standards as adopted by the Producer Licensing (EX) Working Group.

The ULS set a minimum credit hour requirement for prelicensing education. In 2010, the Producer Licensing (EX) Working Group was charged with reviewing this standard. Updated information, if there are any changes to this standard, can be found on the Producer Licensing (EX) Working Group’s web page.

States that require prelicensing education shall require 20 credit hours of prelicensing education per major line of authority. States must accept both classroom study and verifiable self-study, which includes both text and online courses. The ULS does not have a limit on the number of credits that can be obtained by self-study. States shall independently determine the content requirements for prelicensing education. The ULS require that a state have a method to verify completion of prelicensing education, but they do not prescribe a method.

The ULS provide that a person who has completed a college degree in insurance shall be granted a waiver from all prelicensing education requirements. The ULS also provide that individuals holding certain professional designations approved by the insurance department should be granted a waiver from the prelicensing education requirement. In 2008, the ULS were updated to indicate the following list of designations be provided as guidance for designations that would waive prelicensing education, but the list is not exhaustive:

Life:  CEBS, ChFC, CIC, CFP, CLU, FLMI, LUTCF

Health:  RHU, CEBS, REBC, HIA

P/C:  AAI, ARM, CIC, CPCU

Under both reciprocity standards and the ULS, no state shall require prelicensing education for nonresident applicants or nonresident producers who change their state of residency.
Chapter 7

Application Review for Initial Licenses

Individual Application Forms

The Producer Licensing (EX) Working Group adopted a uniform application, and the ULS require its use for all producer applicants. Section 6 of the PLMA outlines the process a state is to follow in reviewing the application and in making the determination as to whether to grant a resident producer license.

Before issuing a resident producer license to an applicant, the state must find that an applicant for a resident license:

1. Is at least 18 years of age.
2. Has not committed any act that is a ground for denial, suspension or revocation set forth in the PLMA Section 12.
3. Where required by the insurance commissioner, has completed a prelicensing course of study for the lines of authority for which the person has applied.
4. Has paid the appropriate fees.
5. Has successfully passed the examinations for the lines of authority for which the person has applied. Note that the ULS provide that examinations are not generally required for limited lines, but that it is acceptable for examinations for areas such as crop and surety.

Business Entity Applications

The following requirements are optional and would apply only to those states that have a business entity license requirement.

The Producer Licensing (EX) Working Group adopted a uniform application form for business entities, and the ULS require its use. Section 6 of the PLMA requires that before approving an application for a resident business entity, the state shall find that:

1. The business entity has paid the appropriate fees.
2. The business entity has designated a licensed producer responsible for the business entity’s compliance with the insurance laws, rules and regulations of the state.

Section 6 also gives the insurance commissioner authority to require any documents necessary to verify the information contained in an application. In 2010, the Producer Licensing (EX) Task Force considered methods to expedite and streamline business entity licensing. Updated proposals can be found on the Producer Licensing (EX) Working Group’s web page.

Background Checks

The GLBA allows states to perform criminal background checks on resident applicants. The ULS contain guidelines on how to perform background checks, including the following three-step process for background checks:

A. States will ask and review the answers to the standard background questions contained on the Uniform Applications;

B. States will run a check against the NAIC Regulatory Information Retrieval System (RIRS)/SPLD and 1033 State Decision Repository (SDR) – Data Entry Tool; and

C(1) States will fingerprint their resident producer applicants and conduct state and federal criminal background checks on new resident producer applicants; or

C(2) If a state lacks the authority or resources to accept and receive data from the Federal Bureau of Investigation (FBI), it shall conduct a statewide criminal history background check through the appropriate governmental agency for new resident producer applicants until such time as it obtains the appropriate authority.
Fingerprints

Under the ULS, the goal is that all states will electronically fingerprint their resident producers as part of the initial resident producer licensing process. States that lack the authority to run criminal history background checks through the FBI are encouraged to at least run a statewide background check until such time that state and national fingerprinting is implemented.

The Producer Licensing (EX) Working Group adopted model language that will allow a state to access federal databases. (See the Authorization for Criminal History Record Check Model [#222].) States are encouraged to adopt this language. The Model #222 can be found on the State Licensing Handbook web page on the NAIC website. (https://content.naic.org/state_licensing_handbook.htm)

1033 Consent Waivers

The Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. §§ 1033 and 1034, commonly referred to as “1033,” establishes a ban on individuals who have been convicted of certain felony crimes involving dishonesty or breach of trust from working in the insurance business. The law provides that a banned person can apply to the state insurance commissioner for a written consent to work in the insurance business. If an individual with a felony involving dishonesty or breach of trust obtains a 1033 consent waiver from that person’s resident state, the person cannot be prosecuted for engaging in the business of insurance in violation of 18 U.S.C. §§1033 and 1034.

When one state grants a written consent waiver to an individual pursuant to 18 U.S.C. §1033, the consensus of legal opinion is that this written consent waiver is effective nationwide.

The Producer Licensing (EX) Working Group determined that the resident state bears responsibility for consideration of applications for consent waivers. Nonresident applicants should not be subject to additional procedures, nor should producers seeking nonresident licenses have to go through the 1033 process in all states after the producer’s resident state has issued a waiver. However, producers who have received waivers are required to attach them to applications for nonresident licenses. To assist these applicants, states should include a specific reference to 18 U.S.C §1033 within the text of the document that grants a waiver. States may exercise their discretion to deny licenses based on the types of criminal convictions disclosed in consent waivers. The NAIC Antifraud (D) Task Force adopted guidelines for review and granting of these consent waivers. Under the guidelines, states are to report all activity on these consent waivers to the (1033 SDR – Data Entry Tool). The full text of the guidelines are included State Licensing Handbook web page on the NAIC website. (https://content.naic.org/state_licensing_handbook.htm) is available through I-Site.

NAIC Databases Relevant to Initial Application Review

The NAIC maintains three databases that should be consulted as part of application review.

1. The Complaint Database System (CDS) contains information on closed complaints as reported by the states.
2. The RIRS contains any action taken by a state insurance department where the action is against an entity and where the disposition is public information. All final adjudicated actions taken and submitted by a state insurance department are reflected in the RIRS. The information typically includes: administrative complaints, cease and desist orders, settlement agreements and consent orders, receiverships, license suspensions or revocations, corrective action plans, restitutions, closing letters, and letter agreements. The RIRS does not include exam report adoption orders without regulatory actions.
3. A record of 1033 actions is maintained in 1033 SDR – Data Entry Tool. The 1033 State Decision Repository (SDR) application allows regulators to enter and search for 1033 decisions (approved or denied), which state regulators have made for individuals who requested to work in the business of insurance but who have been prohibited to do so by section 1033 of the Violent Crime Control and Law Enforcement Act of 1994.

Review of Applications When Criminal History is Disclosed

As part of the 2009 charges for the Producer Licensing (EX) Working Group, the Producer Licensing (EX) Task Force asked the Producer Licensing (EX) Working Group to develop uniform guidelines for background check reviews of producers. For all jurisdictions to have a comfort level with licensing determinations made by a resident state when the applicant has a criminal
history, a uniform process of review is warranted. If all jurisdictions implement these guidelines, in most situations, nonresident states will be able to defer to the resident state’s licensing decision. A copy of the Uniform Criminal History and Regulatory Actions Background Review Guidelines is included in the Appendix of this Handbook.
When an application contains a disclosure with a “yes” answer to a criminal history question, in determining whether to issue a license, states should consider the following factors:

- **Resident vs. Nonresident**

  If the application is for a resident producer license, it is incumbent upon the resident state to scrutinize all “yes” answers on the application and to request and obtain documentation and a detailed explanation for all criminal charges. Nonresident applicants’ criminal histories also should be documented and explained with consideration given the fact that the resident state already has issued a license to the applicant.

- **Severity and Nature of the Offense**

  Felony convictions should always be considered in determining whether to issue a license to an individual and may require the applicant to apply for a 1033 consent waiver prior to application. (See the section on 1033 consent waivers.)

  A criminal conviction is only relevant to the licensing decision if the crime is related to the qualifications, functions or duties of an insurance producer. Examples include theft; burglary; robbery; dishonesty; fraud; breach of trust or breach of fiduciary duties; any conviction arising out of acts performed in the business of insurance; or any actions not consistent with public health, safety and welfare. Special scrutiny should be given to financial and violent crimes.

- **Frequency of Offenses**

  While a producer’s past criminal history is a red flag and may be a predictor of future behavior, the frequency of offenses should be considered, with more weight given to a pattern of illegal behavior than to a one-time minor indiscretion.

- **Date of the Offense**

  The application form requires the applicant to disclose all criminal charges, except minor traffic offenses. A reviewer should consider when the offenses occurred and the age of the applicant at the time of the offense.

- **Completion of Terms of Sentencing**

  Applicants should provide evidence that they have completed all the terms of their sentences, including paying restitution, or completing any probationary periods or community service.

- **Evidence of Rehabilitation**

  The applicant should be required to provide evidence of rehabilitation. Completion of the terms of sentencing alone does not demonstrate rehabilitation. A state may request a statement from the applicant’s probation officer or other appropriate official.

### Statutory Obligations and Discretion

Insurance regulators should review state law to determine guidelines for approval or denial of the application. After consideration of the above factors, the insurance regulator has several options:

1. Request additional information or documentation.
2. If the producer failed to report an action, contact the producer and request an explanation from the producer. (Technical violations, such as bad address or failure to timely report, generally do not merit formal action. However, the failure to report an action in itself can be cause for administrative penalty or a warning letter, depending on the particular state’s law).
3. Approve the application with no conditions.
4. Approve the application with conditions.
5. Deny the application.

In some cases, it may be appropriate to grant a conditional license. This option may not be available in all states and may be limited by state law or regulation. Some options include:
1. Issue a probationary license that will expire after six months or a year, or that will coincide with the applicant’s criminal probationary period. At the end of the probationary period, and prior to consideration of full licensure, the insurance regulator should confirm that the applicant successfully completed all terms of the sentence and probation. This option also can be used for a producer with a record of prior administrative action.

2. Enter into a supervisory agreement, whereby another established licensed producer agrees to be responsible for the applicant during a certain period of time of the applicant’s license term. This is a good option for producers who have criminal records in another state or some other evidence of past bad conduct. The supervisory agreement should include a requirement that the supervising producer report to the insurance regulator any inappropriate behavior that is relevant to the agreement and to the applicant’s license status.

3. Issue only a limited or restricted license for a particular product, such as credit life insurance. The theory of this option is that some types of products present individuals with less opportunity to commit bad acts.

4. Issue the license along with a requirement that the producer must report all complaints received against the producer and under the condition that there will be an immediate suspension for any bad act.

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Recommended Best Practices for Insurance Regulators

- Work with state officials to adopt a fingerprint program that allows your state criminal justice agency to receive electronic prints, as well as electronically submit the reports back to the state DOI.
- If no fingerprint program is in place, inquire of the state criminal investigation department to determine if an alternative system for meaningful state background checks can be arranged.
- Allow pre-exam and post-exam fingerprinting.
- Make electronic fingerprinting available at test sites.
- Allow re-fingerprinting, if necessary, on a walk-in basis with no additional cost.
- Include registration for fingerprinting with registration for the exam, or link the online websites to allow for electronic registration.
- Streamline the background check process to avoid delay in the overall licensing process such as allowing for a temporary work authority pending receipt of the background check results.
- Check with other state agencies to determine what vendor(s) are used for the submission of electronic fingerprints (agencies that oversee programs such as teachers, bus drivers, social workers, foster parents, etc.)
- Adopt the NAIC’s Authorization for Criminal History Record Check Model Act (#222) for all license classes. (Allow some lag time before the effective date to provide sufficient time to establish procedures.) Note that ULS 14 has since been updated to fingerprint new resident producers and that fingerprints are no longer required for additional lines of authority under an existing home state license.
- The PLMA allows a producer to reinstate a lapsed license within 12 months of expiration, so only resident producers who are reinstating a license lapsed over 12 months should be required to submit fingerprints.
- Work with your state district attorney official to coordinate review and approval of the enabling statute, which must be approved by the U.S. attorney general to access the Criminal Justice Information Services (CJIS) division of the FBI criminal history record information.
- Establish a set number of times an applicant should be re-fingerprinted. (At times, fingerprints are rejected.) If re-fingerprinting is required, and the fingerprints are still rejected, establish a process to perform a state and federal NAME check.
- If your state is unable to use a vendor to electronically collect the cost of the criminal history background check from applicants, work with NiPR to collect this fee from new resident producer applicants during the electronic resident licensing application.
- Work with state officials to establish a reimbursement services agreement (RSA) for the payment of fingerprint or background checks.
- If your jurisdiction is just implementing fingerprinting, reach out to other jurisdictions for suggestions and best practices.
- Develop a system for review of 1033 consent waiver applications and post relevant information on the department website.
- Post all information regarding 1033 consent waiver requests, approvals and denials on the 1033 SDR – Data Entry Tool.
- Accommodate applicants to the greatest extent possible with flexible hours of operation.
- Allow payment by check, credit card or debit card.
Chapter 8

Testing Programs

Introduction

The states have a responsibility to ensure that licensing examinations are fair, sound, valid and secure. Directors must consider how an exam is developed, who is involved in the development process, how the exam is offered and how security is maintained. Nearly every state has contracted with an outside vendor to assist in examination development and administration. These testing vendors employ test development experts and psychometricians to construct and evaluate examinations.

The primary purpose of a state examination and licensing program is to protect consumers. Examinations should be consistent across the states in difficulty level, content and subject matter. They should be uniformly administered and scored. Examinations should be psychometrically sound, using methods for setting and maintaining passing standards (i.e., cut scores) that are in accordance with testing industry best practices. They should use resources such as: 1) the Standards for Educational and Psychological Testing, developed jointly by the American Educational Research Association (AERA), American Psychological Association (APA) and National Council on Measurement in Education (NCME); and 2) the U.S. Equal Employment Opportunity Commission’s (EEOC) Uniform Guidelines on Employee Selection Procedures (29 CFR 1607).

Through valid, reliable and legally defensible test development practices, candidates will have a fair and equitable opportunity to pass an exam, regardless of which state exam they take. Ideally, pass rates should be consistent throughout the states; however, statistics from national examination administration have shown that the pass rates for examinations for the same line of insurance vary significantly among the states. Other variables may contribute to pass rates, such as state education systems, demographics, the existence of a prelicensing education requirement and the quality of such prelicensing education, but the states should work with their test vendors to be sure that they eliminate any practices that do not measure the entry-level knowledge, duties and responsibilities of an insurance producer.

Different states take different approaches to the development and administration of producer license examinations. Some of the states exercise significant control over test development and review. Other states rely almost entirely on outside experts. In most of the states, the state does not pay any fee to a testing vendor, and the cost of test development and administration is passed through to the test-takers. Most of the states reserve the right to preapprove any fees charged by testing vendors.

With the state licensing system increasingly built on reciprocity, it is in the best interest of consumers, insurance regulators, industry, producers and prospective producers for state licensing directors to establish guidelines that promote efficiency and consistency throughout the licensing process. Directors also should reduce or eliminate artificial barriers that impede qualified applicants from obtaining a license.

The purpose of this chapter is to recommend best practices for states in testing administration in the following areas:

1. Test development and review.
2. Test administration.
3. Test results.
4. Expectations for test vendors.

This chapter was developed with assistance from insurance test vendors, industry representatives, education providers and insurance regulators.

PLMA Guidelines on Examinations

Section 5 of the PLMA contains guidance for administering licensing examinations. Under Section 5, all residents are expected to complete a written examination, which should include the following:

1. The entry-level knowledge required for an individual concerning the lines of authority for which the application is made.
2. The duties and responsibilities of an insurance producer.
3. The applicable insurance laws and regulations of the state.

Section 5 grants the insurance commissioner authority to hire an outside testing service to administer examinations and impose nonrefundable examination fees.
The PLMA contains several exemptions from prelicensing education and examination requirements. An individual who is licensed as a nonresident in a state and who moves into that state, or an individual who moves from his or her home state to another state and seeks a resident license, is not required to complete an examination for the line(s) of authority previously actively held in the prior resident state as long as application is made within 90 days of the change in residence and the prior resident state indicates the producer was licensed in good standing. In this situation, a nonresident state should never impose prelicensing education or examination requirements.

The ULS provide that examinations are not generally required for limited lines, but that it is acceptable to require examinations for areas such as crop and surety.

The PLMA leaves test development and administration to the discretion of the individual states. Section 5(A) of the PLMA requires that “[a] resident individual applying for an insurance producer license shall pass a written examination” and requires that the examination must test the knowledge of the individual in three areas:

1. The specific lines of authority for which the application is made.
2. The entry-level duties and responsibilities of an insurance producer.
3. The applicable insurance laws and regulations of the state.

Beyond these broad subject matter categories, Section 5 states that tests “shall be developed and conducted under rules and regulations prescribed by the insurance commissioner.”

In order to provide more uniformity in state licensing practices, the 2012 revised ULS for Exam Content or Subject Area and Testing Administration Standards establishes implementation of the “Exam Content and Testing Administration Recommended Best Practices found in Chapter 8 of the NAIC State Licensing Handbook” as the uniform standard.

**Test Development and Review**

Test development experts believe that licensing examinations should measure the minimum competency required for a candidate to perform at an entry level. Therefore, test content and curriculum development should be focused on assessing whether a candidate demonstrates sufficient knowledge to pass an examination that is appropriately targeted to an entry-level producer.

The examination should not dictate the curriculum that an entry-level insurance producer should master. Instead, the test content should be developed using the steps outlined below. Examinations and curriculums should be updated to reflect any changes in insurance laws, regulations or industry practice. An online candidate guide should be available and should provide detailed testing and licensing procedures, as well as content outlines with cross-references to the curriculum.

Input from trainers who conduct test preparation courses may assist in the development of the curriculum and the exam content outline; however, some insurance regulators believe it is not appropriate to invite these trainers to participate in reviewing final examination questions. Education providers who do not offer prelicensing education courses (such as CE providers) sometimes are used during test development. There are generally two approaches to examination construction. A bank-based test generates individual examinations from a large bank of items. A form-based examination will consist of a specified set of predesigned test forms that are rotated. The states use both methods, and both are psychometrically acceptable. Although contracted outside experts play a major role in test development in most jurisdictions, the state should have a regular process and procedures for developing and reviewing licensing examinations to ensure that those examinations are properly focused on the minimum competencies required of an entry-level producer. Some items that should be included in the plan include:

1. Procedures to ensure that a job analysis survey that includes input from insurance regulators and the industry is conducted at regular intervals to determine the requirements and work performed by an entry-level insurance producer.
2. Regular, ongoing review and assessment of producer licensing examinations in the event of legislative or regulatory changes that could affect the accuracy of exam content.
3. An annual review of the examination development process conducted with the state and the testing vendor.
4. Depending on test volume, test performance and the need for content changes, either an annual (or at least biannual) substantive review of the examination and the psychometric properties of the test. These efforts should include the involvement of content or test development professionals, department personnel and industry representatives, including recent, entry-level producers. More experienced producers should include a mix of both recently licensed and more experienced producers.
5. A fair and valid state-based test should incorporate knowledge, skills and abilities that measure state-specific and national expertise. This balance will shift depending on the subject matter. For example, life insurance laws and regulations tend to be more similar among the states, while health insurance standards can vary widely.

6. If the state collects demographic data, it should be reviewed annually.

Developing the Questions

Developing a valid and sound bank of test questions, often called “items,” is perhaps the most critical piece of any testing program. The items need to be at the appropriate level of difficulty. Items should be relevant to the profession and should be effective in evaluating whether the person taking the exam possesses the knowledge, skills and abilities critical to competently performing the job and safely practicing in the profession. To create this balance, most of the states use a combination of local subject-matter experts (SMEs) and content or test development professionals. The local panel should include new and experienced producers to help establish such a balance.

Using multiple item writers to develop test content is a common practice, but it can lead to variation in test item style, format and difficulty. Developing a style guide with templates, development standards and rules can go a long way in improving item consistency, format and variety. Content development training can ensure that writers have the tools they need to develop credible, legally defensible items and templates that can be leveraged to create multiple variations of the same question.

Passing Score vs. Pass Rate

A passing score, sometimes called a “cut score,” is the minimum score one needs to achieve in order to pass the exam. The “pass rate” is the percentage of candidates who actually pass the exam. The test development process will consider data from actual tests and data from reviewers rating the items and exams in evaluating the cut score.

In some of the states, the cut scores are arbitrarily established by rule or regulation. This is not a valid testing practice. Cut scores should be based on data collected through the test-development process. Regulatory licensing exams typically target a level referred to as “minimum” competency rather than “average” competency. Licensing examinations try to determine who has the minimum competency to safely practice in a profession without compromising the health and safety of the public. An arbitrary cut score, which is the practice in some of the states, tends to focus on the average, rather than minimum, competency. Thus, qualified candidates could be cut because they fall below the average, not because their competency is unacceptable.

Exam Scoring

Some of the states administer a one-part or one-score exam, while others administer two-part exams. In the one-part exam, general product knowledge and state-specific content are scored together. In the states with a two-part exam, the candidate must separately pass both the general product knowledge exam and the state-specific exam in order to be eligible to apply for a license for the line of authority requested. A third variation is to require the first-time test-taker to pass an exam on state-specific insurance laws and regulations once. All additional lines of authority are tested on general product knowledge only.

Preliminary review of pass rates indicates a tendency for more candidates to fail in the states that require two-part exams. There is no evidence that two-part exams increase consumer protections or that the states that administer one-part exams license producers who do not know applicable state law. The states are encouraged to move to one-part exams to allow for more success among candidates without jeopardizing consumer protections.

Exam Content

As of May 2013, the states have no standard exam curriculum. The NAIC is encouraging more uniform approaches by considering the best practices for testing programs listed at the end of this chapter to be standards for all jurisdictions to work toward. The Producer Licensing (EX) Task Force formed a subgroup of five states to develop a draft national content outline using the life and annuity line of authority as a pilot. The national content outline provides guidance for entry-level subject matter that the states should test for, as well as information that will assist candidates in identifying relevant knowledge to study in preparation for the exam.

Some experts have recommended that examinations should be constructed with the following considerations in mind:

1. The states should not target examinations to an artificially set passing score. A state should determine whether its test is focused on assessing the knowledge needed by potential new producers, and only applicants who lack that
level of knowledge should fail. The states should use legally defensible, recognized methodology when establishing a cut score.

2. Prior to releasing items into an exam form, the editing and review process employed is critical. This editing process should include the psychometric evaluation of the cognitive level of the items and the reading level of the items, as well as such editorial issues as grammar, sensitivity and style. Psychometric editing is best performed by test development professionals, not state SMEs or item writers. Individuals trained in the complexity of psychometric editing evaluate items in a different, critical light than SMEs or item writers. It is critical, however, to have all final items reviewed and approved by state and national SMEs in the given field for accuracy and relevancy.

3. Each examination should consist of pre-test questions that are being evaluated for performance and questions that previously have been evaluated (pre-tested) and determined to be statistically effective. Each candidate’s score should be based only on the previously pre-tested and approved questions. Any time used to respond to pre-test items should not be counted against the test-takers, and responses to pre-test items should not be calculated in the test-taker’s score. Pre-test items should not be used as scored items until they have been statistically proven to be effective. The test questions for any new examination should be chosen from the pool of test questions to properly represent the subject-matter outline of the examination.

4. Reports regarding exam pass rates, candidate demographics when collected and number of exams administered should be made available to the public. Reports should include first-time pass success by subject area. Whenever possible, this information should be tracked by, and be made available to, each education provider so they may evaluate their programs and instructors, and be provided with data needed for course development. The states may ask for, but generally cannot require, information on candidate population, gender, ethnicity, education level and income level. When candidate demographics are collected, reports should include the percentage and number of examinees who passed the examination by race, ethnicity, gender, education level and native language. This information is necessary for the selection of future test questions, and will aid in making testing transparent and assessing whether differences in test scores are correlated with relevant demographic factors.

5. A state advisory committee consisting of insurance regulators and the industry—including, where possible, recently licensed producers—should annually (or, if changes are not needed every year, at least biannually) work with the testing vendor to review the questions on each examination form or bank of items for substantive and psychometric requirements. Adjustments should be made to the examination to eliminate any questions that might be inaccurate or unclear, that might test subject matter that is beyond what a new producer should know or that exhibit unsatisfactory psychometric properties.

6. Licensing examinations should be reviewed at least annually, but if, during any rolling 12-month period, a licensing examination exhibits uncharacteristically high or low pass rates (such as less than 60% or more than 80%), unexplained fluctuations in testing volume or other significant deviations, that examination should be reviewed immediately.

A state testing program should include statistical analysis of test items in the field and gather feedback on the candidate performance on the individual items. The most obvious and critical use of this information is to ensure that exams are equivalent, and to evaluate the accuracy with which items differentiate between candidates who are minimally qualified and candidates who are not. The psychometric review can result in the continued use of items, the modification of items or the deletion of items from the bank.

A professional test vendor should use a comprehensive strategy for developing test items and ensuring measurement of the knowledge, skills and abilities necessary for initial insurance licensees to perform their jobs effectively. The steps may include:

1. Conducting a committee-based job analysis.
2. Developing content specifications and weightings.
3. Developing items.
4. Editing and reviewing items with SMEs to ensure items meet the required criteria.
5. Obtaining item difficulty (e.g., Angoff method) estimates to establish a passing score.
6. Developing item sampling groups to structure each examination.
7. Creating equivalent forms.
Test Development Deliverables

A state licensing director should expect to receive the following items to ensure that the testing vendor has provided all items necessary to administer a successful testing program:

1. Finalized task and knowledge statements reflecting the requirements of each licensed insurance position.
2. Content specifications for each licensing examination.
3. A set of approved, relevant and important items for use on each licensing examination.
4. A list of references used to develop the test items.
5. Candidate Information Bulletins (CIBs).
6. A technical report describing the procedures used and results obtained from the test development process for each licensing examination.

Candidate Information Bulletin

A CIB should describe the examinations, examination policies and procedures, and the consequences of violating security procedures. A testing vendor should be capable of making changes to the information contained within the CIB during any contract year at the state’s request.

The CIB should be available at no charge to candidates, trainers and insurers in hard copy or in electronic format via the Internet. The state licensing director should consider including the following topics in the CIB:

1. How to contact the testing vendor.
2. Requirements for taking an examination.
3. How to apply for an examination, including receiving authorization of eligibility from the state, prelicensing education and background checks.
4. Links to current application forms.
5. How to obtain current forms in hard copy (if available in hard copy).
6. Examination fees.
7. Scheduling procedures.
8. The content outline and format of the examination.
9. Supplies provided at the test center.
10. The time limit for the examination.
11. The scoring system.
13. Examination process and procedures.
14. Appropriate examination-taking strategies (e.g., “There is no penalty for incorrect answers, so be sure to answer every question.”).
15. Appropriate use of scratch paper, calculators and/or other support material.
16. Sample questions.
17. Specific information about taking the test on the computer.
19. List of test centers, alternative test centers and driving directions to each.
20. Procedures for requesting special accommodation.
21. Examination registration forms.
22. Licensing requirements and procedures.
23. Refund policies.
24. Holiday or weather-related test center closures.
25. Instructions about how to contact the state insurance department.

A state should approve each CIB before it is published. The licensing director should work with the vendor to set a timeline that will allow for final publication of an updated CIB in advance of the expiration of the prior edition of the CIB. The new edition should be provided to test preparation trainers at least six weeks in advance of implementation so that training materials can be updated.

Technology Issues

A licensing director should consult with the state’s information technology (IT) staff to ensure that the testing vendor can deliver data to the state insurance department. This is critical when a state changes testing vendors. This also is critical if the
state directs a vendor to send data to a different location than the state insurance department. Any transition should include a testing phase for hardware, software and state insurance department staff.

The state and the testing vendor should jointly agree on a timeline for introducing new or updated examinations. State IT staff also should be consulted.

**Legal Defensibility**

Items developed also must be legally defensible to protect the state in the event of a legal challenge. To protect the state from liability, each exam should be critically reviewed from a content and psychometric perspective to ensure that the exam was developed according to recognized standards. Validation procedures for licensing examinations should be designed to comply with content validation requirements of the EEOC’s Uniform Guidelines on Employee Selection Procedures (29 CFR 1607).

The states should require testing vendors to follow and document standardized methods. This should include appropriate test development personnel in the process. Using the appropriate, credentialed professionals is critical, as there are multiple steps involved in the test development process and various methodologies that can be used for each step. State licensing directors should discuss all options with qualified professionals.

**Vendor Responsibilities**

Test vendors should be able to meet minimum guidelines for sufficient availability, facilities, personnel and openness in terms of providing information related to their operations.

The states, and not the test vendors, must be responsible for all examination content and content outlines. The vendor should provide accessible information regarding the registration system through the Internet, toll-free telephone numbers, interactive voice response, fax and other available technologies. The available information should include permitting candidates to view exam test dates and to access forms and content guidelines without requiring prior payment and scheduling of an exam.

The vendor should promptly provide the state with all pertinent information, including prompt notification of any candidate complaints, changes to test administration, conflicts at examination test sites or other information requested or required by the state.

The vendor should provide quality, accessible facilities, with an established system of examination site supervision that ensures that competent site administrators consistently provide accurate information to applicants.

Where a vendor operates test sites in multiple states, the vendor should permit any applicant to take a state’s examination in another state, under the same conditions that would apply if the exam were taken at an in-state location.

Vendors should be required, on an ongoing basis, to collect the data on customer satisfaction and, if directed by the state, to make those data available to insurance regulators, the industry and the public.

**Test Administration**

The testing process should be fair and accessible for all candidates. A state should consider including the following elements below in its licensing process to ensure applicants have equal access to examinations.

**Secure Administration**

The security of the test center network is important in maintaining the integrity of a test. A vendor should be equipped with adequate security features and qualified test center administrators. Each proctor should be trained and tested on his or her ability to supervise exams. A vendor should have systems in place to ensure the fair, consistent and even administration of the exam in every location. A vendor also should have a method to detect attempts to record questions. For example, a vendor should track multiple examination attempts by individuals to assess if the candidate is intentionally failing the exam so it can be repeated. A vendor should be required to notify the state immediately if the vendor suspects that the integrity of an examination has been compromised.

**Test Locations and Registration**

Test locations should be set up to provide flexibility and convenience. Realizing that the states have different geographic challenges and diverse population density, a state should consider, where possible, requiring the following elements:
1. Testing should be made available at locations convenient to residents of all areas of the state.
2. Test locations should provide enough testing capacity so a candidate can test at the desired location within two to five business days of registration.
3. Exam site hours should include evening and weekend hours.
4. Test vendors should provide regular reports as required by the state detailing site usage and availability data.
5. Test registration should be available online or by telephone and allow for next day testing when space is available. A state should consider tracking telephone hold and wait times to monitor how long callers wait.
6. State guidelines should provide for flexible means for payment of fees for testing, fingerprinting and other licensing. The states should consider methods which facilitate payment by companies.

Disabilities

A state should require a vendor to develop a system that accommodates the physically impaired that is not related to a testing candidate’s knowledge of insurance. Visually impaired and hearing-impaired persons should be accommodated through all steps of the licensing process, pursuant to national standards set by the federal Americans with Disabilities Act (ADA).

Examinations in Languages Other Than English

Some industry experts suggest caution about using translated or interpreted exams. The material may not directly translate into equivalent terms or meaning. Cultural biases might cause incorrect interpretation of a meaning. Some experts recommend that tests should be developed and administered in English, especially if other materials necessary to perform job duties for the profession (such as contracts) are in English. State licensing directors should review state law and consult with legal counsel about the appropriateness of offering examinations in a foreign language.

Reporting Examination Results

State licensing procedures should include guidelines that facilitate the prompt issuance of licenses once an applicant passes a test. Elements might include:

1. Pass/fail notices should be issued at exam sites upon completion of the exam. If an applicant has not achieved a passing score, the applicant should receive immediate notification of failure. The states vary as to whether successful completion is reported with a precise score or merely an indication that the candidate passed the exam. When a candidate does not pass the exam, the state should provide the precise score and the percentage of questions in each subject area that the applicant answered incorrectly.

2. If a state issues a paper license, and if it has been predetermined that an applicant has met all requirements necessary for licensure, including any required fingerprint report, a license should be issued at the exam site, or within 48 hours of completing all necessary requirements.

3. The state should send an email or other timely communication to a candidate to whom a license has been issued outside the test site or provide information to applicants as to how to check online.

4. Within 24 hours of license issuance, the new licensee’s information should be added to the state’s database, and the updated status should be sent to NIPR.

5. The states should work with their vendors to report aggregate results in a way that is more uniform with other states.

6. First-time pass rates should be maintained and made available to the public. First-time pass rates are defined as the percentage of candidates who pass the whole test the first time.

7. In performing background checks, the use of an electronic process should be required whenever possible.

8. In those states requiring fingerprints, where possible, exam sites should have the capability to collect electronic fingerprints.

Retesting or Notice of Failure

A state licensing plan should include a method to facilitate prompt retesting of applicants who have failed a test. The “non-passing” notice should break scores out by each subject area. If the candidate requests to make another attempt, an examination should be made available within a reasonable time period.
### Producer Exam Content and Testing Administration Recommended Best Practices for Insurance Regulators

- The states should use accepted psychometric methods including job analysis to determine if the examination content falls within the content domain that a minimally competent candidate of that specific line of authority tested would be expected to know.
- The states should set passing scores (cut scores) and difficulty level using psychometric methods and appropriate SMEs based on what an entry-level producer needs to know.
- The states are encouraged to move to one-part exams to allow for more success among candidates without jeopardizing consumer protections.
- The states should require the test vendor (or other entity responsible for test development) to document the process for ensuring quality control and validity of the examination, including psychometric review and editing and analysis of item bias or cultural and gender sensitivity.
- To allow for meaningful comparison, all jurisdictions should define first-time pass rate as the percentage of candidates who pass the whole test the first time.
- At least annually, reports regarding exam pass rates, candidate demographics when collected and number of exams administered should be made available to the public. Reports should include first-time pass rate success and average scoring by subject area. Whenever possible, the reports should be available by education provider and provided to them.
- A state advisory committee consisting of insurance regulators and the industry—including, where possible, recently licensed producers—should annually work with the testing vendor to review the questions on each examination form for substantive and psychometric requirements. If, during any other time, any examination results exhibit significant unexplained deviations, the examination should be reviewed.
- The states should work with testing vendors and approve CIBs that describe the examinations and examination policies and procedures, and provide sufficient examination content outline and study references for the candidate to prepare for the examination. Updated editions of the CIB/content outline should be provided to prelicensing education providers at least six (6) weeks in advance of implementation so that training materials can be updated.
- Testing should be made available at locations reasonably convenient to residents of all areas of the state, with registration available online or by telephone and the ability for a candidate to schedule testing within two to five business days of registration.
- Pass/fail notices should be issued at exam sites upon completion of the exam. The fail notice should break out scores by subject area. The state should provide a method to facilitate prompt retesting, while allowing a reasonable time for candidates to review and prepare for retest.
- The states should deliver exams in a secure test center network that employs qualified test proctors.
- The states should set clear performance standards for test vendors and require accountability.
Chapter 9

Lines of Insurance

The Major Lines

A line of authority is a general subject area of insurance that a producer can be licensed to sell. The PLMA identifies and defines seven lines of authority; however, the ULS set forth six lines that are considered major lines of authority, as well as certain core limited lines. Additionally, the ULS set forth standards for non-core limited lines. The states should review all other lines of insurance and consider eliminating them in an effort to become compliant with the ULS. Uniform adoption of the major lines is essential to fully implement NAIC licensing reforms.

The six major lines of authority are defined in the PLMA as follows:

1. Life – insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income.
2. Accident and health or sickness – insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income.
3. Property – insurance coverage for the direct or consequential loss or damage to property of every kind.
4. Casualty – insurance coverage against legal liability, including that for death, injury or disability, or damage to real or personal property.
5. Variable life and variable annuity – insurance coverage provided under variable life insurance contracts and variable annuities.
6. Personal lines – P/C insurance coverage sold to individuals and families for primarily noncommercial purposes.

Because the ULS also require that each major line be available individually, the states should provide individual examinations for each of the major lines except variable life and variable annuity. It is acceptable for a state also to offer combined exams. The ULS contemplate that each state will require an examination for residents to qualify for all major lines. The states should give examinations only to residents, not nonresidents.

While the ULS do not specifically prohibit an examination for variable life and variable annuity products, most states do not require an examination. This line of authority is usually granted if the applicant holds a life line of authority and has successfully completed the Financial Industry Regulatory Authority (FINRA), formerly known as the National Association of Securities Dealers (NASD), examinations necessary to obtain a state securities license in that state. In most cases, this means successful completion of the FINRA Series 6 and/or Series 7 (according to the specific state’s requirements) and/or Series 63 exams.

The Producer Licensing (EX) Working Group has not specifically stated that states should not require an active state securities license of residents or nonresidents as a condition of granting the variable life and variable annuity products line of authority. The ULS do contemplate that no such requirement shall be imposed. For nonresident applicants, it is not appropriate to pend a request for the variable life/annuity products line of authority to verify existence of the underlying life line of authority in the home state. If a proper request for licensure is received and the applicant is in good standing in the home state with the variable life and variable annuity line of authority, the nonresident license should be granted. If a state cannot verify through the SPLD that the applicant holds a variable authority, it is permissible to pend the application and contact the applicant’s home state to verify the variable authority.

Information regarding an applicant’s status as to securities registration and securities examinations passed currently are easily accessible on FINRA’s public Web site (under “Check Out Brokers & Advisors” at www.finra.org/InvestorInformation/index.htm). Information available includes: employment history; states where the individual is securities licensed; securities examinations passed; and formal and final disciplinary history. To obtain Central Registry Depository (CRD) information regarding pending complaints and unresolved cases, a state insurance department must contact its state’s securities regulator.

1The PLMA does not address title insurance, which is considered a major line by some of the states and a limited line by others.
Limited Lines

A limited line of insurance is a line of insurance that covers only a specific subject matter. Limited line licenses generally have simpler licensing requirements than required by the major lines. Some states require an examination for credit insurance. For the other limited lines, some states require an examination, while some require only a simplified application process. In some states, a business entity is permitted to maintain a limited line license on behalf of individuals who make the limited line of insurance available to its customers. Often, a limited line is adopted by regulation and not by statute.

The PLMA contains a specific definition for credit insurance and allows states to define other limited lines. The Producer Licensing (EX) Working Group adopted definitions for specific “core” limited lines of insurance for producers, which have become part of the ULS. States are encouraged to adopt the definitions of those limited lines and to review and eliminate as many non-uniform limited lines as possible. The PLMA requires states to grant to a nonresident a nonresident limited line producer license with the same limited line of authority as the license issued by the home state. Many states have adopted a special licensing category to accommodate this type of situation.

The core limited lines are:

1. Car rental insurance.
2. Credit insurance.
3. Crop insurance.
4. Travel insurance.

The ULS provide that examinations are not generally required for limited lines, but that it is acceptable for examinations for areas such as crop and surety. The states should give examinations only to residents, not nonresidents. The ULS specifically state that CE is required for only the major lines of insurance. (See specifics for crop insurance.)

In 2009, the Producer Licensing (EX) Working Group was charged with reviewing limited line licensing issues, with particular focus on: 1) the establishment of a limited lines that encompasses several insurance products where the business of insurance is ancillary to the business of the person offering the product; 2) the licensing requirements of individuals selling limited line products; and 3) the fingerprinting of individuals selling limited line insurance products. Throughout the year, the Producer Licensing (EX) Working Group had discussions; however, no consensus was achieved. As a result, the Producer Licensing (EX) Working Group reported to the Producer Licensing (EX) Task Force and requested further guidance on its charge. For 2010, the Producer Licensing (EX) Working Group was asked to:

Finalize the review of limited-line licensing issues, with particular focus on the following: 1) individually review the licensing requirements for each core limited line; 2) review other limited lines, and determine what licensing requirements should apply to them; and 3) determine if another “catch all” limited line was needed to address licensing requirements for insurance products not already encompassed within the list of limited lines. Updates to the limited line charge may be obtained on the Producer Licensing (EX) Working Group’s web page on the NAIC website.

The NAIC has adopted a specific resolution rejecting a prior request by industry to adopt a new limited line for term life insurance. The full text of the resolution is in the Appendices.

As part of its 2010 charges, the Producer Licensing (EX) Working Group conducted a review of the ULS and adopted several amendments. Specifically related to this chapter, revisions were made to Standard 16 (Lines of Authority), Standard 33 (Definition of Core Limited Lines), Standard 34 (Travel) and Standard 37 (Non-Core Limited Lines).

**Recommended Best Practices for Regulators**

- Adopt the major lines and the definitions exactly as stated in the PLMA and provide separate testing for each line, except variable
- Allow combined examinations, as appropriate
A. Limited Line of Car Rental Insurance

Under the ULS, car rental insurance is defined as:

[I]nsurance offered, sold or solicited in connection with and incidental to the rental of rental cars for a period of [per state law], whether at the rental office or by pre-selection of coverage in master, corporate, group or individual agreements that (i) is non-transferable; (ii) applies only to the rental car that is the subject of the rental agreement; and (iii) is limited to the following kinds of insurance:

(a) personal accident insurance for renters and other rental car occupants, for accidental death or dismemberment, and for medical expenses resulting from an accident that occurs with the rental car during the rental period;

(b) liability insurance that provides protection to the renters and other authorized drivers of a rental car for liability arising from the operation or use of the rental car during the rental period;

(c) personal effects insurance that provides coverage to renters and other vehicle occupants for loss of, or damage to, personal effects in the rental car during the rental period;

(d) roadside assistance and emergency sickness protection insurance; or

(e) any other coverage designated by the insurance commissioner.

The states vary in their methods of supervising the sale of car rental insurance. In the states that require a license, there are generally three methods in use. The first is a registration requirement through submission of an application. The second is the successful completion of an exam and submission of an application. The states should give examinations only to residents, not nonresidents. Under the third method, a car rental company registers with the state insurance department. The company holds the license and is responsible for supervising the training and testing of its counter agents. The company reports to the department and pays all fees.

B. Limited Line of Credit Insurance

The PLMA defines limited lines credit insurance as:

Credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance or any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that is designated by the insurance commissioner as limited line credit insurance.

Credit insurance products are designed to protect the borrower against the risk of not being able to pay a debt. Credit life, disability and involuntary unemployment insurance are typical lines of coverage. These products are generally made available by the creditor at the time the loan transaction occurs. Because the insurance is purchased at the time the borrower completes the loan, policy and certificate forms, premium structures and underwriting conditions are generally simpler than other limited lines of insurance.

Credit insurance is issued under individual and group policies. This allows market flexibility for different distribution systems and variations in product design to insure the different types of credit risks. If an individual enrolls customers under a group insurance policy, the individual must obtain a limited lines license, if a commission is paid. Section 4(B)(2) of the PLMA provides an exception from licensing if no commission is paid to the enroller and the enroller does not engage in

Recommended Best Practices for Regulators

- Allow resident and nonresident limited lines license applications to be filed electronically.
- Eliminate state-specific applications.
- To further reciprocity, report all limited lines licensees to the SPLD.
- Adopt the applicable revisions to the ULS related to limited lines.

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selling, soliciting or negotiating.

Section 6(D) of the PLMA provides that each insurer that sells, solicits or negotiates any form of limited line credit insurance shall provide its producers a program of instruction that may be approved by the insurance commissioner.

**Recommended Best Practices for Insurance Regulators**

- A state should establish a method to verify that each credit insurer has established a program of instruction.

**C. Limited Line of Crop Insurance**

Under the ULS, crop insurance is defined as:

Insurance providing protection against damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease, or other yield-reducing conditions or perils provided by the private insurance market, or that is subsidized by the Federal Crop Insurance Corporation (FCIC), including multi-peril crop insurance.

There are two types of crop insurance: multiple peril crop insurance (MPCI) and crop hail insurance.

The federal government is involved with crop insurance because a single event (such as drought) often results in multiple losses. Automobile accidents or health problems generally are independent, random events that do not trigger multiple insurance losses. For crop insurance, multiple losses are the norm rather than the exception. For many years, capital requirements to maintain adequate reserves to cover widespread losses were so high that commercial development of MPCI policies by companies was unrealistic. As a result, the federal government created a federally subsidized risk management program.

**Multiple Peril Crop Insurance**

An MPCI policy provides protection against crop losses from nearly all natural disasters, including: adverse weather conditions; fire; insects, but not damage due to insufficient or improper application of pest control measures; plant disease, but not damage due to insufficient or improper application of disease control measures; wildlife; earthquake; volcanic eruption; or failure of the irrigation water supply if due to an unavoidable cause of loss occurring within the insurance period.

MPCI is subsidized by the federal government and delivered by private insurance companies. The insurer’s functions include hiring and training producers; paying for marketing and advertising; hiring and training loss adjusters; and carrying out loss adjustment activity, billing and collecting premiums, processing and verifying applications, conducting actual production history reviews, processing and verifying acreage reports, paying claims, auditing and verifying claims data, paying uncollected premiums, and maintaining the necessary automated data processing infrastructure to communicate data with the Risk Management Agency (RMA) on a routine basis for all MPCI policies.

The MPCI policy is a contract between the producer and the insurance company and not with the federal government. However, a farmer cannot receive the federal subsidy attached to the program unless the insurance policy followed the federal standards and rates. Like many insurance companies, crop insurance companies have reinsurance agreements to transfer risk to other private companies known as reinsurers. Unlike most other insurance lines, the private insurance companies also transfer some of the risk associated with the crop insurance program directly to the federal government.

There are many MPCI plan options available: yield-based, revenue-based or a combination of both. The basic policy provisions for all these plans, as well as the rates, are set by the FCIC. A combination of commodity markets results and the U.S. Department of Agriculture (USDA) establish the maximum price for each crop each year for insurance purposes (i.e., the value of each bushel in the event of loss).

While the RMA controls pricing and policy forms, producer licensing and enforcement of proper sales practices are left to the states.
Crop/Hail Insurance

Crop/hail insurance is offered through companies licensed by state insurance departments. A private market has existed for crop/hail insurance for more than a century. Companies have developed stand-alone full coverage and deductible crop hail policies, as well as companion policies that function very well in conjunction with the different MPCI plans that are offered at varying coverage levels. The premium rates for these crop/hail policies are determined by historical loss experience and are set by the companies.

Continuing Education

Subsequent to the adoption of the ULS, the Producer Licensing (EX) Working Group considered and agreed that a CE requirement for crop insurance shall not be a violation of the uniform standards. Under federal law, insurance producers selling MPCI are required to attend CE classes each year.

D. Limited Line of Surety

As part of the discussion of limited lines, the Producer Licensing (EX) Working Group made the determination to remove surety as a limited line. Although this determination was made, it is understood that surety is considered a major line by some of the states and a limited line by others.

E. Limited Line of Travel Insurance

Under the ULS (as revised Aug. 6, 2010), travel insurance is defined as:

Insurance coverage for personal risks incidental to planned travel, including, but not limited to:

1. Interruption or cancellation of trip or event.
2. Loss of baggage or personal effects.
3. Damages to accommodations or rental vehicles.
4. Sickness, accident, disability or death occurring during travel.

Travel insurance does not include major medical plans, which provide comprehensive medical protection for travelers with trips lasting six months or longer, including, for example, those working overseas as an ex-patriot or military personnel being deployed.

Standard 34 recognizes and sets the guidelines for the creation of an additional business entity licensing model under the travel limited line licensing structure. This structure creates the concept of a “travel retailer” in which the entity and a certain number of its employees may disseminate travel insurance under the direction of a responsible licensed producer. Said producer maintains responsibility for the training and conduct of any and all associated travel retailer(s).

F. Non-Core Limited Lines

After much discussion about the concept of “auxiliary” or “miscellaneous” lines, the Producer Licensing (EX) Working Group formally adopted Standard 37 as a basis for any future addition of other non-core limited line. The standard states, in part, that:

A state is not required to implement any non-core limited line of authority for which a state does not already require a license or which is already encompassed within a major line of authority; however, the states should consider products where the nature of the insurance offered is incidental to the product being sold to be limited line insurance products. If a state offers non-core limited lines (such as pet insurance or legal expense insurance), it shall do so in accordance with the following licensing requirements. Individuals who sell, solicit or negotiate insurance, or who receive commission or compensation that
is dependent on the placement of the insurance product, must obtain a limited line insurance producer license. The individual applicant must: 1) obtain the limited lines insurance producer license by submitting the appropriate application form and paying all applicable fees as set forth in applicable state law; and 2) receive a program of instruction or training subject to review by the insurance department.

No prelicensing or testing shall be required for the identified non-core limited lines insurance.
Chapter 10 – (NOT REVISED DURING 2019 REVIEW)

Surplus Lines Producer Licenses

In order to operate in a state, P/C insurance companies are generally categorized in one of two ways. An admitted company obtains a certificate of authority to operate in a given state and is fully subject to and regulated by the laws of the state. Its policyholders are protected, at least to some extent, by the state’s guaranty fund.

A nonadmitted company, otherwise known as a surplus lines company, has limited authority to operate in a state. These companies may be required to be eligible in a state but are subject to significantly less regulation. States allow surplus lines companies to operate because they recognize that certain types of insurance, or insurance at certain amounts, are not available from admitted companies. Generally, surplus lines companies are not subject to rate and policy form regulation, and their policyholders are not covered by state guaranty funds.

Under the ULS, a producer who wishes to engage in the sale of surplus lines insurance (SLI) must first obtain a surplus lines producer license. Under the ULS, this is considered a license type and not a line of authority; however, in some of the states, it is treated as a line of authority. The ULS require that a resident producer hold both property and casualty lines of authority before an SLI producer license can be issued. Under the previous reciprocity provisions of the GLBA, surplus lines producers were entitled to reciprocal licensing if they were licensed for surplus lines and in good standing in the producer’s home state. The NAIC uniform application is to be used for application as a surplus lines producer.

Some of the states also require a resident producer placing SLI to complete an examination or post a bond. However, to comply with the reciprocity provisions of Section 8 of the PLMA, these requirements cannot be imposed on nonresidents. States cannot impose an additional CE requirement on nonresident SLI producers.

The Nonadmitted and Reinsurance Reform Act

The federal Nonadmitted and Reinsurance Reform Act (NRRA) was signed into law by President Barack Obama on July 21, 2010, as part of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act, 12 U.S.C. § 5301. The NRRA set federal standards for the collection of surplus lines premium taxes, insurer eligibility, producer licensing and commercial purchaser exemptions. Most of the provisions of the NRRA went into effect on July 21, 2011.

For licensing of surplus lines brokers, the most significant change was to limit the licensing requirements to only the home state of the insured. Specifically, to place a surplus lines multistate risk policy, the broker needs only to be licensed as a surplus line broker in the insured’s home state, not in all of the states where the policy risk is located. The NRRA defines the home state of the insured as “(i) the state in which an insured maintains its principal place of business or, in the case of an individual, the individual’s principal residence; or (ii) if 100% of the premium of the insured risk is located out of the state referred to in clause (i), the state to which the greatest percentage of the insured’s taxable premium for that insurance contract is located.” The definition goes on to clarify that, with respect to affiliated groups, “[i]f more than one insured from an affiliated group are named insureds on a single non-admitted insurance contract, the term ‘home state’ means the home state, as determined pursuant to [clauses (i) and (ii) above], of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.”

The NRRA also prohibits a state from collecting fees relating to the licensing of a surplus lines broker unless the state participates in the NAIC’s national insurance producer database for surplus lines broker licensure by July 21, 2012. Currently, all states accept applications and renewals for surplus lines broker licenses for individuals through the NIPR and all but one state accept applications and renewals for surplus lines broker licenses for business entities.

Surplus Lines Distribution Systems

Surplus lines insurance is generally produced through one of two distribution systems. One, generally referred to as a retail distribution system, involves a single broker accessing the surplus lines company directly to place insurance. The second, generally referred to as a wholesale distribution system, involves a surplus lines broker that operates as an intermediary between a “retail agent” and a surplus lines company. In the retail distribution system, there is only one producer in a transaction, so that producer would need to conduct the diligent search of the admitted markets prior to accessing the surplus lines markets (unless there is some exception such as a large commercial purchaser or an export list). In the wholesale
distribution system, the diligent search is often conducted by the retail broker, who determines there is no admitted market prior to contacting the surplus lines wholesale broker; however, some of the states have different requirements.

The vast majority of the states take the position that a broker conducting a diligent search would need a P/C agent’s license because it is necessary to solicit insurance, take an application and make a submission to an admitted company. Many states do not require a retail producer to obtain a surplus lines broker’s license unless the broker is going to access the surplus lines companies directly. There are a couple of states that require a retailer to have a surplus lines license before using the services of a surplus lines wholesale broker.

**Diligent Search Requirements**

The vast majority of the states require a “diligent search” of the admitted market to determine if there is an admitted carrier willing to write the risk, prior to accessing the surplus lines markets. A couple of states have abolished the diligent search requirement. Many of the states require that brokers search those admitted companies that are actually writing the coverages sought. If there is no admitted carrier willing to write the risk, the risk can be placed in the surplus lines markets. Many of the states require an affidavit to be completed documenting that the diligent effort was completed. Recently, a number of the states have replaced the affidavit, which was sworn under penalty of perjury, with a report from the surplus lines licensee that the diligent search was conducted. Some of the states also have replaced the requirement that the affidavit (or report) be filed with the insurance department or Surplus Line Association (SLA) with a requirement that the report of the diligent search be maintained in the office of the broker and available for audit by the insurance department.

Many of the states specify that the diligent search can be conducted by the retail broker (commonly called producing broker), when a surplus lines wholesaler accesses the surplus lines markets. The retail broker has access to admitted markets. The retailer uses the services of a surplus lines wholesale broker only after the retail broker has determined that the admitted markets are not willing to underwrite the risk.

The most common diligent search standard requires declinations from three admitted carriers, but as many as five are required. Other states simply require the producing broker to make an effort, a reasonable effort or a good faith effort to place the coverage in the admitted markets. A couple of states have abolished the diligent search requirement. Many of the states specify that the diligent search can be conducted by the retail broker (commonly called producing broker), prior to contacting the surplus lines wholesale broker; however, some of the states have different requirements.

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The NRRA established a single “exempt commercial purchaser” exemption from state diligent search requirements that is applicable in every state. As of July 21, 2011, a diligent search in the admitted market is not required to place a policy for an exempt commercial purchaser if: 1) the broker has disclosed to the exempt commercial purchaser that coverage may be available from the admitted market, which may provide greater protection with more regulatory oversight; and 2) the exempt commercial purchaser has requested in writing that the broker procure/place such coverage with a surplus lines insurer.

An “exempt commercial purchaser” is defined in the NRRA as a purchaser of commercial insurance that:
1) employs or retains a qualified risk manager to negotiate insurance coverage; 2) has paid aggregate nationwide commercial P/C insurance premiums in excess of $100,000 in the immediately preceding 12 months; and 3) meets at least one of the following criteria: (i) possesses a net worth in excess of $20 million (as adjusted for inflation); (ii) generates annual revenues in excess of $50 million (as adjusted for inflation); (iii) employs more than 500 full-time employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate; (iv) is a not-for-profit organization or public entity generating annual budgeted expenditures of at least $30 million (as adjusted for inflation); or (v) is a municipality with a population of more than 50,000.

A number of the states elected to maintain their statutory exemptions from diligent search requirements, which were sometimes known as industrial insured exemptions. If the state’s industrial insured exemption was more liberal than the NRRA exempt commercial purchaser (ECP) exemption, then the state’s requirements were not in conflict with the NRRA, and the exemption in the NRRA would not apply.

SLI producers are routinely subject to additional state administrative requirements that are considered to be outside the scope of licensing reciprocity considerations or the ULS. The regulations regarding the administration of surplus lines are different from other types of insurance because the states typically require the licensed surplus lines producers to perform certain compliance activities that would usually be the responsibility of the licensed insurance company in a transaction in the admitted market. In a surplus lines transaction, the compliance obligations are imposed upon the producer because the producer is the licensed party. The surplus lines insurer is unlicensed and often referred to as a “nonadmitted insurer” in some of the states or “unauthorized insurers” in other states.

There are additional administrative requirements in some of the states for licensed surplus lines producers that apply once the coverage is placed. These may include:

1. Filing reports with state insurance departments or state stamping offices of placements made.
2. Collecting and paying surplus lines premium taxes.
3. Maintaining a record of all surplus lines placements made.
4. Providing the insured with a disclosure stating that the policy he or she has purchased is being issued by an insurer that is not licensed in the state, is not subject to the financial solvency regulation and enforcement that apply to the state’s licensed insurers, and does not participate in any of the insurance guarantee funds created by the state’s law.
5. Using a designated stamping office.
6. Including declaration or binder pages with the surplus lines tax filings.
7. Filing a report stating that no policies were written that are known as “zero reports” (as discussed later in this section).

In order for a producer to place business in the surplus lines market, the producer must first determine that the company is an eligible surplus lines company in a given state. Most of the states require that a surplus lines company be deemed “eligible” by meeting certain financial criteria or by having been designated as “eligible” on a state-maintained list. Prior to the enactment of the NRRA, state eligibility standards varied widely from state to state.

As of July 21, 2011, a surplus lines transaction is subject only to the eligibility requirements of the NRRA. The NRRA eligibility requirements are based on two provisions from the Nonadmitted Insurance Model Act (#870).

Specifically, the NRRA requires surplus lines carriers to comply with Section 5A(2) and Section 5C(2)(a) from Model #870, which require an insurer to be authorized in its domiciliary state to write the type of insurance that it writes as surplus lines coverage in the state where it is eligible and to have capital and surplus, or its equivalent, under the laws of its domiciliary jurisdiction, equaling the greater of: 1) the minimum capital and surplus requirements under the law of the home state of the insured; or 2) $15 million. The insurance commissioner in the insured’s home state may reduce or waive the capital and surplus requirements (down to a minimum of $4.5 million) after the insurance commissioner makes a finding of eligibility based on several factors set out in Model #870, such as the quality of management, the surplus of a parent company and reputation within the industry.

In addition to eligibility requirements for U.S. domiciled insurers, the NRRA requires the states to permit the placement of surplus lines coverage with surplus lines companies organized in a foreign country (alien insurers) that are listed on the NAIC Quarterly Listing of Alien Insurers. The states cannot prohibit a broker from making a placement with an NAIC-listed
alien insurer. A state also may allow placement of coverage with alien insurers not on the NAIC list. A number of the states have authority to individually approve an alien carrier that is not listed on the Quarterly Listing of Alien Insurers.

The Quarterly Listing of Alien Insurers is available for reference and download on the NAIC Products – AVS, Data & Publications website at http://www.naic.org/prod_serv_alpha_listing.htm# (Quarterly Listing of Alien Insurers)

**Premium Taxes**

Surplus lines premium tax generally is the obligation of either the policyholder or the surplus lines producer, depending on the applicable state law. In all states, the producer or the insured, rather than the insurance company, remits the surplus lines tax. If the policy covers risks that are located entirely in one state, the tax is assessed at that state’s tax rate.

Under the NRRA, the home state of the insured has sole regulatory authority over the collection of surplus lines premium taxes. The NRRA prohibits any state other than the home state of the insured from requiring any premium tax payment for surplus lines insurance.

The NRRA permitted, but did not require, allocation of the surplus lines taxes among the states where the exposure was located. The states initially pursued three different approaches to allocation of taxes following the adoption of the NRRA: 1) the Nonadmitted Insurance Multi-State Agreement (NIMA); 2) the Surplus Lines Insurance Multi-State Compliance Compact (SLIMPACT); and 3) taxing and keeping 100% of surplus lines premium tax on policies in the home state of insureds. NIMA is no longer operational and SLIMPACT never became operational. The prevailing rule is that states are taxing and keeping 100% of the premium. The NRRA requires surplus lines brokers to adhere to the law of the home state of the insured to determine the amount of premium tax owed on a surplus lines transaction and for any other regulatory requirements the state may require in connection with the payment of the premium tax, such as the timing of tax payments and whether the state requires the submission of risk allocation information for multi-state transactions. The NRRA requires surplus lines brokers to submit the premium tax payment on a surplus lines transaction only to the insured’s home state. In the case of a state that has joined NIMA, the payment will be made to the clearinghouse in accordance with the home state’s law. Should SLIMPACT become operational, it also could elect to require multistate payments to be made to the clearinghouse.

Many of the states require brokers to submit documentation regarding allocation by state of the risks covered by a surplus lines transaction. If the home state of the insured is a state that has joined NIMA, the broker will be required to use the NIMA risk-allocation formula. If the home state is a state that has joined SLIMPACT, the broker will be required to use the SLIMPACT risk-allocation formula. As of May 2013, both NIMA and SLIMPACT have adopted the same allocation formula. Other states require the broker to submit allocation data in accordance with individual state laws and regulations, but the vast majority of states do not require allocation data because there are very few states allocating premium at this time. In some of the states, taxes are paid to a state agency other than the insurance department, such as the department of revenue.

**Guaranty Fund Warning**

Nearly all of the states require a disclosure regarding the unavailability of guaranty fund coverage for a surplus lines policyholder, even if the state represents a small portion of the risk. Prior to the NRRA, when a multistate risk was involved, the company would be required to include several pages of guaranty fund notices, many of which had nearly the same language with minor variations. Brokers may choose to continue to use this approach following the enactment of the NRRA, but the NRRA initiated a compliance system that requires compliance only with laws of the home state of the insured.
As an example, a typical disclosure statement is as follows:

**NOTICE TO POLICYHOLDER**

This contract is issued, pursuant to Section of the (State) Insurance Code, by a company not authorized and licensed to transact business in (State), and as such, is not covered by the (State) Insurance Guaranty Fund.

After review of this and other issues by a special NAIC subgroup in 2006, the Producer Licensing (EX) Working Group adopted its recommendation that, on a multistate risk, the home state’s disclosure should fulfill all other states’ disclosure requirements.

**Stamping Offices**

Stamping offices are entities that are not governmental agencies but whose existence is authorized by law. These offices act as the liaison between the surplus lines producer and the state insurance departments. The stamping offices have varied responsibilities, which may include evaluation of insurance companies for inclusion on a white list, review of surplus lines policies and education. Stamping offices also provide reports of premiums and taxes to the state insurance department.

Stamping offices are nonprofit and are funded by stamping fees assessed on each policy of surplus lines insurance written in the state. As of April 2017, there are stamping offices in 14 states.

**Zero Reports**

In some of the states, a producer is required to file a report, known as a “zero report,” stating that the producer has not placed any SLI business during a specified time period.

In 2006, a special NAIC study group documented that five states require this report monthly, 12 quarterly, seven semi-annually and 27 annually. The states also use the reports for different recording purposes, so it was not determined if it would be possible to eliminate these reports altogether. However, the study group concluded and recommended to the Producer Licensing (EX) Working Group that zero reports be eliminated. The group also recommended further study to determine feasibility of any other use of a zero report. As of January 2017, the Producer Licensing (EX) Working Group has not taken any formal action on this issue.
Chapter 11

Appointments

An appointment is a registration with the state insurance department that a producer is acting on behalf of an insurer. The PLMA contains several sections related to appointments. Section 14 of the PLMA establishes the requirement that a producer acting as an agent of an insurer must have an appointment. This is an optional provision and applies only in those states that require appointments. Section 15 of the PLMA establishes a procedure for the reporting of appointment terminations. The GLBA, as modified in 2015, prohibits any state other than a producer’s home state from imposing any appointment requirements upon a member of NARAB.

In 2002, the Producer Licensing (EX) Working Group adopted a uniform appointment process. The full text is included in the Appendices and is available on the Producer Licensing (EX) Working Group’s web page. This process is referred to in the ULS. The key elements include:

1. States should allow electronic filing of appointments and appointment terminations. Paper filings are discouraged.
2. States should establish a billing system for payment by insurers of initial appointments.
3. States shall allow insurers to select the effective date of the initial appointment.
4. States shall require insurers to follow a prescribed timeline to file appointments.
5. States shall require only one appointment or termination form or transaction per producer per company. (At this writing, appointments by company group are not available.)
6. States shall require insurance companies to submit terminations to the insurance department in accordance with the requirements of Section 15 of the PLMA.
7. States shall require that, if a producer is terminated for cause, the insurer must submit supporting documentation. Any information received by the insurance department must remain confidential in accordance with Section 15 of the PLMA.

In states that are required to renew appointments, the key elements include:

1. States shall provide or publish a pre-renewal notice to insurers informing them that appointment renewals are imminent.
2. At the time for renewal, a state will deliver an invoice. The invoice may not be altered, amended or used for appointing or terminating producers.
3. Insurers shall return the invoice and the payment to the department or its designee.
4. States shall establish a dispute resolution process to accommodate errors after the fact.

Appointment Terminations

Section 15 of the PLMA imposes a requirement on insurers to report terminations of producer appointments. Section 15 requires that the insurer report a termination within 30 days of its occurrence. If a termination is for any of the reasons listed in Section 12 (License Denial, Nonrenewal or Revocation) of the PLMA, insurers are required to submit a detailed report to the state and a copy of the report to the producer. Section 15 (E) grants immunity from civil liability for good-faith reporting to insurers and insurance regulators. Reports filed under Section 15 are considered confidential.
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<th>Recommended Best Practices for Insurance Regulators</th>
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<td>• Automatically terminate appointments if a license goes inactive for any reason.</td>
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<tr>
<td>• Eliminate fees for appointment terminations and instead assess all charges at the time of an appointment. This will eliminate delays in cancellations.</td>
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<tr>
<td>• Do not require an appointment as a condition of licensure. The PLMA and the ULS provide that a producer can hold a license without holding an active appointment.</td>
</tr>
<tr>
<td>• Require only one appointment or termination form or transaction for each company for each producer per state.</td>
</tr>
<tr>
<td>• Sub-appointments and Business Entity appointments are discouraged.</td>
</tr>
<tr>
<td>• Immediately accept terminations for cause and refer them for investigation. States should follow the procedures as outlined in the PLMA. No advance notice should be required to the producer or the state insurance department.</td>
</tr>
<tr>
<td>• Use electronic filing for appointments, terminations and renewals, to the extent possible, to eliminate delays and increase efficiency.</td>
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Chapter 12

Business Entities

Prior to the PLMA, most states used the term “insurance agency” to refer to the business structure used by insurance producers. Under the PLMA, the term “business entity” (BE) is used. This term is intended to cover a broad range of legal business operating structures. BEs are considered to be producers under the PLMA.

Section 2(A) of the PLMA defines a BE as a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

The Producer Licensing (EX) Working Group has adopted a uniform application form that is the standard for all states for resident and nonresident BE applications. Section 6(B) of the PLMA provides further guidance about the licensing of BEs:

A BE acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the Uniform Business Entity Application. Before approving the application, the insurance commissioner shall find that:

1. The BE has paid the fees set forth in [insert appropriate reference to state law]; and
2. The BE has designated a licensed producer responsible for the BE’s compliance with the insurance laws, rules and regulations of this state.

Since BEs are considered producers, the reciprocity issues discussed in other sections also apply to BEs. States should not require additional attachments to the application that might interfere with reciprocity.

A common issue that arises with resident and nonresident BE licensing is the role of the secretary of state (SOS) and the state corporation statutory requirements. Most states have adopted a Model Corporation Law that requires resident and nonresident businesses to register with the state corporation department. The issue for state licensing directors is whether the state insurance department should require some proof of registration with the SOS as a pre-condition to licensing. The NAIC legal department has studied this issue extensively and advised the Producer Licensing (EX) Working Group that states should not require items such as articles of incorporation or proof of registration with the SOS as a pre-condition to licensing for nonresident BEs.

The PLMA does require that all producers, including BEs, notify the insurance commissioner prior to using an assumed name. Section 10 of the PLMA states:

An insurance producer doing business under any name other than the producer’s legal name is required to notify the insurance commissioner prior to using the assumed name.

The uniform appointment process as adopted by the Producer Licensing (EX) Working Group does not specifically address BEs. Section 14 of the PLMA states that a producer acting as an agent of an insurance company must be appointed. States vary in the interpretation of these guidelines. This issue is one that the Producer Licensing (EX) Task Force considered in 2010 as part of its efforts to streamline BE licensing. In the absence of specific guidance from the Producer Licensing (EX) Working Group, the guidelines discussed in the paragraphs below are suggested.

Insurance regulators should balance the cost of a regulatory requirement with the benefit that requirement adds to consumer protection. If detailed information is collected, such as several levels of appointments, that information should be a meaningful part of the state insurance department’s consumer protection plan. If information is only rarely used in support of investigations, it may not be cost-effective to collect that information and require staff to compile it and process it. During a recent assessment of state insurance department licensing units, it was often found that information about affiliations and branch offices often required at the time of application was rarely used. Sub-appointments and BE appointments are discouraged.

Just as the uniform appointment process contemplates that only one appointment will be required for an individual producer no matter how many types of products that producer sells for a given company, if a state requires appointments for a BE, then
the state should require only one appointment per BE per company—no matter how many types of products that BE sells for a given company.

Section 6(B)(2) of the PLMA requires a BE to designate a licensed producer as responsible for compliance. This is commonly referred to as the designated responsible producer (DRP). There is no provision in the PLMA to require multiple DRPs if the BE chooses to write multiple lines of insurance. For example, if a DRP holds a life LOA only, and an affiliated producer is authorized to sell P/C products, it is not necessary for a DRP with a P/C LOA to be named as a second DRP.

The PLMA does not give specific guidance on appropriate action to take when a notification is received that the DRP has lost their home state license. A recommended practice is to send a notification to the BE and inform it that the BE license will go inactive unless a new DRP is named and approved within a reasonable number of days.

A BE has an ongoing responsibility to report misconduct of the BE or any of its affiliated producers. Section 12(c) of the PLMA states:

The license of a BE may be suspended, revoked or refused if the insurance commissioner finds, after hearing, that an individual licensee’s violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation and the violation was neither reported to the insurance commissioner nor corrective action taken.

### Recommended Best Practices for Insurance Regulators

- Use the NAIC uniform application for BEs, and eliminate all other state-specific forms.
- Review all state insurance laws and regulations, and amend any that require attachments that might violate reciprocity.
- Review the practical consumer protection value of all information collected, and collect only information that adds value.
- Require only one DRP per BE.
- If appointments are required for a BE, require only one appointment per state, and require no sub-appointments.
- Use electronic filings for more efficiency.
Chapter 13

Temporary Licenses

Section 11 of the PLMA contains a provision that allows a state insurance director to issue a temporary license to the survivor of a producer if the insurance commissioner deems it necessary for servicing the deceased producer’s customers.

The license is limited to 180 days and also may be limited in scope by the insurance commissioner. The intent of this section is to wind up the business affairs of the producer and not to indefinitely continue the decedent’s insurance business.

The PLMA gives three examples of persons eligible for a temporary license:

1. The surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the producer, or for the recovery or return of the producer to the business, or to provide for the training and licensing of new personnel to operate the producer’s business.
2. A member or employee of a BE licensed as an insurance producer, upon the death or disability of an individual designated in the BE application or the license.
3. The designee of a licensed insurance producer entering active service in the armed forces of the U.S.

The insurance commissioner also is given discretion to grant a temporary license in any other circumstance where the insurance commissioner deems that the public interest will best be served by the issuance of this license. The insurance commissioner also may require the temporary licensee to have a licensed producer as a sponsor.
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Chapter 14

Continuing Education

The completion of CE is the method used by state insurance regulators to ensure continued competence of producers. Under the previous GLBA reciprocity requirements, a state had to recognize a producer’s completion of a CE requirement in the producer’s home state as satisfying the other state’s CE requirement for license renewal. The only exception was if the producer’s home state refused to provide reciprocity to another state.

Some states have adopted special training requirements for specific lines of insurance. When such a requirement exists, it is typically imposed on resident and nonresident producers selling a specific insurance product. A specific CE standard, which is derived from federal mandates, may be imposed on nonresidents such as for long-term care insurance (LTCI), annuity, flood or crop insurance and would not violate the ULS.

Section 16(B) of the PLMA specifically states:

A nonresident producer’s satisfaction of his or her home state’s CE requirements for licensed insurance producers shall constitute satisfaction of this state’s CE requirements if the nonresident producer’s home state recognizes the satisfaction of its CE requirements imposed upon producers from this state on the same basis.

Under the ULS, producers are to complete 24 credits of CE for each biennial compliance period. Three of the 24 credits must be in ethics. Fifty minutes is equal to one credit hour of CE. If applicable, the CE compliance period should coincide with the license renewal. The ULS indicate that the license term should be tied to the birth date or birth month. Calculation of one credit hour of CE should be based on the NAIC Guidelines for CE. If applicable, the CE compliance period should coincide with the license renewal. The ULS indicate that the license term should be tied to the birth date or birth month.

CE is required if the producer holds one of the six major lines of authority contained in the PLMA, but it is not required for each line of authority. For example, if a producer holds a life and a property line of authority, the requirement for renewal is 24 credits. If a producer holds only the life line of authority, the requirement for renewal is 24 credits. States may limit the subject area requirements for CE. Some states prohibit CE credit for training on sales techniques. Generally, CE is not required for limited lines. States may limit the subject area requirements for CE. Some states prohibit CE credit for training on sales techniques. Generally, CE is not required for limited lines. Under the ULS, producers may repeat CE courses for credit in successive renewal terms but are not permitted to take a course for credit more than once in the same license continuation period. States must accept both classroom study and verifiable self-study. States should not impose a limit on the use of self-study courses.

Producers and CE providers must submit evidence of course completion in the method specified by the insurance commissioner. Some states require the producer to present a certificate of completion at the time of license renewal. Many states require the CE provider to report attendance. Under this system, a producer is required to present only the attendance certificates if there is a discrepancy. Another option is to require producers to self-certify completion and then verify compliance by random desk audits.

The PLMA and the ULS contain two exemptions from CE requirements. The exemptions are an inability to comply due to military service and/or a demonstration of an extenuating circumstance, such as medical disability. States with waivers for professional designations should consider allowing CE credits for filed and approved courses used to obtain and maintain professional designations.

Some states grant an extension instead of an exemption. This decision is left to each state to decide.

Course Approvals

The Producer Licensing (EX) Working Group has adopted standards for course approval and reciprocity in filing of courses. States are to follow the standards set forth in the Continuing Education Reciprocity (CER) process as adopted by the Producer Licensing (EX) Working Group. Under a reciprocity filing, states are to accept the number of credits awarded by another state and treat a request for reciprocity as a registration. Only the home state of the CE provider is to perform a content review of the course filing. The Appendices contain information on CER and the current filing forms. The most current information on CER can be found on the Producer Licensing (EX) Working Group web page.
States vary in their method for course content approval. Some states use outside vendors, and others do the course reviews internally. The Producer Licensing (EX) Working Group has not adopted any guidelines on methods for approving classroom courses.

The Producer Licensing (EX) Working Group has adopted guidelines for approval of online and self-study courses. The goal of these standards is to deliver functional computer-based Internet courses that offer quality insurance and/or risk management material in a password-protected online environment.

The key elements are:

1. Material that is current, relevant and accurate, and includes valid reference materials, graphics and interactivity.
2. Clearly defined objectives and course completion criteria.
3. Specific instructions to register, navigate and complete the coursework.
4. Technical support or provider representative available during business hours.
5. A process to authenticate student identity.
6. A method for measuring the student’s successful completion of course material and for evaluating the learning experience.
7. A process for requesting and receiving CE course-completion certificates.

The standards call for an examination that is proctored by a disinterested third party. The standards also provide several methods to compute the number of credits that should be awarded. The standards also recommend acceptance of courses that are part of a program that is part of a nationally recognized professional designation. For designation courses, the course should receive credit hours equivalent to hours assigned to the same classroom course material.

The Continuing Education Recommended Guidelines on Online and Self-Study is included in the Appendices.

The ULS prohibit CE providers from advertising CE programs until state course approval is received.

The Appendices contain a sample list of questions and answers frequently asked by insurance producers about CE requirements.

**Continuing Education Providers**

A state should have a process for registering and qualifying persons who wish to be recognized as CE providers. The process should include duties, responsibilities and performance standards for CE providers. An aspiring CE provider should demonstrate an ability to deliver quality instruction and to comply with all reporting and course supervision requirements. These standards should also contain the conditions under which a CE provider may be removed from the state’s approved provider list.

The Appendices contain a sample outline of instructions to CE providers.

**Recommended Best Practices for Insurance Regulators**

- Require CE providers to electronically report class attendance to the state insurance department or its designated vendor.
- Set a reasonable deadline for CE providers to deliver electronic reports.
- Require CE providers to promptly issue attendance certificates (or certificate of completion for self-study courses) and require producers to retain them. The certificates should be sent only to the state insurance department in the event of a dispute.
- Provide access for producers and insurers to department records to monitor CE credits on file.
- Implement an audit program to observe and evaluate CE providers and instructors.
- Participate in the NAIC Personalized Information Capture System (PICS) to receive alerts or monitor actions against existing licensees.
Chapter 15

Reporting of Actions and Compensation Disclosure

Reporting of Actions

Section 17 of the PLMA requires a producer to report, to all states in which the producer is licensed, any administrative action taken against the producer in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. Producers also are required to report any criminal prosecution of the producer taken in any jurisdiction within 30 days of the initial pretrial hearing date.

The challenge for producers is that it can be difficult to ensure that all relevant states received the report. NIPR has created an electronic solution, called Reporting of Actions (ROA), to facilitate distribution of one report to multiple states. States should encourage the use of this electronic process to save time and create an electronic record of timely submission.

State licensing directors should have a method to receive these reports and refer them for investigation. The director should consider giving staff limited authority to review and clear reports that include violations such as traffic citations or certain misdemeanors.

Recommended Best Practices for Insurance Regulators

- Use the Attachment Warehouse/Reporting of Action system to receive electronic notifications to alert a state when an individual or business entity producer has added information into the Attachment Warehouse since their initial entry regarding administrative, criminal or civil actions.

Compensation Disclosure

Section 18 of the PLMA requires disclosure where the producer receives any compensation from the customer for the placement of insurance or represents the customer with respect to that placement. This section contains several specific definitions and exceptions to the disclosure requirement. The Producer Licensing (EX) Working Group has not developed any formal guidance on the implementation of Section 18, but the NAIC issued an FAQ document to give additional guidance. This FAQ is in the Appendices. State licensing directors should confer with their legal counsel as to appropriate methods for implementing this section.
Chapter 16

License Renewal and Reinstatement

License Renewal

Under the PLMA, the general rule is that a producer license remains in effect unless suspended, cancelled or revoked. All states have a procedure for individual producers to verify compliance with CE requirements. In states that renew licenses, the CE compliance period should coincide with the license renewal.

The Producer Licensing (EX) Working Group has adopted a uniform license renewal application that is recommended for use by states that renew producer licenses. The current version of the application can be found on the Producer Licensing (EX) Working Group web page. States should use the data elements from the uniform renewal application, whether renewal is done via paper application or electronically.

The previous reciprocity provisions of the GLBA also applied to license renewal of nonresidents. The process should be similar to initial licensing:

1. The proper application and fee are submitted.
2. If the answers to any of the questions on the renewal application indicate conduct prohibited by Section 12 of the PLMA, a state can require additional documentation.
3. No other attachments should be required.

A number of states use the electronic license renewal process. This process automatically checks the NAIC and NIPR databases to verify the producer’s standing in the home/resident state. The NIPR process uses the data elements from the uniform renewal application.

The PLMA contains a special process for producers who cannot comply with CE requirements due to military service or other extenuating circumstances.

Reinstatement

The PLMA allows a producer to reinstate a lapsed license within 12 months of expiration. No examination is required as long as the producer was otherwise eligible to renew. The PLMA also provides that a penalty fee can be assessed.
Chapter 17

Post Licensing Producer Conduct Reviews

Section 12 of the PLMA contains a list of 14 reasons a producer may be disciplined. The insurance commissioner is given authority to take administrative action against a producer who commits any of these acts. Disciplinary action may include suspension, revocation or refusal to renew the producer license. Some states have added additional provisions to this list. For example, if a state does not align the CE compliance term with license renewal, it may be necessary to commence an administrative action to suspend the producer’s license for failure to timely complete CE. In some states, insurance departments are required to suspend the license of any individual who fails to pay student loans on a timely basis.

States should use caution in adding additional disciplinary reasons and should carefully review the requirements of the ULS. The full text of the PLMA can be found in the Appendices.

After a license is issued, an insurance regulator may become aware of potential violations of Section 12 in several ways:

1. A licensed producer notifies the insurance regulator of pending criminal charges.
2. The insurance regulator receives a notice from PICS indicating that a nonresident producer failed to disclose criminal charges.
3. A PICS Notice is received of previously unreported administrative action.
4. A letter is received from the producer informing of an administrative sanction by another state or FINRA.
5. The insurance regulator receives subsequent arrest or conviction information from the state’s department of justice (DOJ).

The following considerations should be taken into account:

1. If the producer is a nonresident, the insurance regulator should consider what, if any, action was taken by the producer’s resident state or FINRA.
2. Whether the criminal charge or administrative action indicates that the producer is or may be a danger to consumers.
3. Whether the charge involves theft or other financial fraud, or involves an activity that threatens the safety of consumers, such that action should be taken immediately to revoke or suspend the producer’s license.
4. Whether it is appropriate to contact the producer and request a voluntarily surrender of the license.
5. If the producer failed to report an action, the insurance regulator should consider contacting the producer and request an explanation from the producer. Technical violations (e.g., bad address, failure to timely report) generally do not merit formal action. However, the failure to report an action in itself can be cause for administrative penalty or a warning letter, depending on the particular state’s statutes and regulations.
6. Whether the individual did not disclose previous criminal or administrative actions taken in response to the answers to the background questions on any application.

License Reinstatement or Reissuance After Disciplinary Action

Reinstatement of a producer license means the producer’s previous license is re-activated and will expire at the end of the license term. Reissuance of a license means the issuance of a new license with a full license term.

Reinstatement or reissuance of a license after disciplinary action usually is not automatic. A producer whose license has been revoked or suspended by order, or who forfeited a license in connection with a disciplinary matter, should be required to make a written request to the insurance commissioner for reconsideration of the action taken on the license whether it be reinstatement or reissuance in accordance with the terms of the order of revocation or suspension or the order accepting the forfeiture.

When a producer’s license has been suspended for a period of time that extends beyond the producer’s license expiration date, reinstatement is not an option. The producer must request reissuance of a license and should not be allowed merely to apply for a new license by passing an examination and submitting a new application.

The producer’s request for reinstatement or reissuance must include sufficient information to allow the insurance department to determine whether the basis of the revocation, suspension or forfeiture of the applicant’s license no longer exists and whether it will be in the public interest to grant the request for a new or reinstated license. The burden of proof to establish such facts is on the producer. In most states, the producer will have a right to an administrative hearing if the reinstatement request is denied.
Some states allow a license to be voluntarily forfeited in lieu of compliance with an order of the insurance commissioner. In this scenario, a request for voluntary forfeiture of a license should be made in writing to the insurance commissioner. The written consent of the insurance commissioner usually is required.

Forfeiture of a license is effective upon submission of the request, unless a contested case proceeding is pending at the time the request is submitted. If a contested case proceeding is pending at the time of the request, the forfeiture becomes effective when and upon such conditions as required by order of the insurance commissioner. A forfeiture made during the pendency of a contested case proceeding is usually considered a disciplinary action subject to reporting to RIRS.

**Collaboration and Referrals Among Insurance Regulators**

There are several NAIC tools to facilitate communication about enforcement actions among insurance regulators.

The NAIC’s Market Actions (D) Working Group (MAWG) identifies and reviews insurance companies that are exhibiting or may exhibit characteristics indicating a current or potential market regulatory issue that may affect multiple jurisdictions. The Working Group determines if regulatory action should be taken and supports collaborative actions in addressing problems identified.

The NAIC has adopted the *Market Regulation Handbook* to guide state insurance regulators in the conduct of investigations and enforcement activities. The *Market Regulation Handbook* also gives guidance to market conduct examiners on some licensing issues. The Producer Licensing (EX) Working Group has advised examiners that insurers should not be required to keep a hard copy of each individual producer license. Under the PLMA and the *Market Regulation Handbook*, insurers and insurance regulators are directed to rely on the SPLD to verify license status.

**Recommended Best Practices for Insurance Regulators**

- Report all formal final administrative actions to RIRS regardless of the voluntary forfeiture, fine or penalty amount.
- Use CRD, SPLD, RIRS, 1033 Application, PICS and state court records to verify information submitted by applicants. State court records databases may be available online to analysts.
- Check the producer’s resident or home state’s website or other licensing records to verify actions reported or taken by that state. The NAIC website has a map with links to each state insurance department website.
- Develop form letters or consent order templates pre-approved by legal staff to be used by experienced licensing staff to propose settlement of minor violations without need to involve legal staff.
- Adopt an administrative rule that if an order of revocation or suspension does not contain terms regarding reissuance or reinstatement, an application for reinstatement or reissuance may not be made until at least one year has elapsed from the date of the order or acceptance of the forfeiture of a license.
- Maintain a record tickler system of all special conditions imposed on any producer licenses so that the compliance with the conditions can be reviewed as the end of any special supervision term nears.
Part II

Miscellaneous Licenses

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Chapter 19  Bail Bond Agents
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Chapter 18

Adjusters

An adjuster is a person who investigates claims, determines coverage, examines relevant documents and inspects property damage. An adjuster also may determine the amount of a claim, loss or damage payable under an insurance contract or plan. An adjuster often settles or negotiates settlement of the claim. In some states, the adjuster’s authority is limited to a specialty area such as auto, homeowner, workers’ compensation or crop insurance.

There are three kinds of adjusters: 1) public; 2) independent including crop; and 3) company (sometimes called staff adjusters). Public adjusters represent the insured, while independent and staff adjusters represent the insurer. More than 30 states require licensure of one or more of these types of adjusters.

Public adjusters directly contract with the person who is seeking coverage or benefits under an insurance policy or other kind of insurance plan. The role of a public adjuster is to represent an insured or claimant in the settlement of a claim. The NAIC has adopted the Public Adjuster Licensing Model Act (#228).

Under the model, a public adjuster is defined as:

“Public adjuster” means any person who, for compensation or any other thing of value, acts on behalf of an insured by doing any of the following:

1. Acting for or aiding an insured in negotiating for or in effecting the settlement of a first-party claim for loss or damage to real or personal property of the insured.
2. Advertising for employment as a public adjuster of first-party claims or otherwise soliciting business or representing to the public that the person is a public adjuster of first-party claims for loss or damage to real or personal property of an insured. 3. Directly or indirectly soliciting the business of investigating or adjusting losses, or of advising an insured about first-party claims for loss or damage to real or personal property of the insured.

Staff adjusters are typically salaried employees of an insurer or an insurer’s affiliates and do not adjust claims for entities other than their employer or its affiliates. Independent adjusters are self-employed or associated with or employed by an independent firm. Independent adjusters may adjust claims on behalf of many insurers. The NAIC has adopted model guidelines for Independent Adjuster Licensing Guidelines adjustments that states are encouraged to adopt. The Appendices contain the model guideline.

Most states recognize one or more of the following exemptions to adjuster licensing:

1. Attorneys-at-law admitted to practice in this state, when acting in their professional capacity as an attorney.
2. A catastrophe situation officially declared by the insurance commissioner or governor (according to state law). Registration may be required, but no permanent license should be required of a nonresident adjuster who is sent on behalf of an insurer for the purpose of investigating or adjusting a loss or a series of losses resulting from a catastrophe.
3. A person employed solely to obtain facts surrounding a claim or to furnish technical assistance to a licensed independent adjuster.
4. An individual who is employed to investigate suspected fraudulent insurance claims but who does not adjust losses or determine claims payments.
5. A person who solely performs executive, administrative, managerial or clerical duties, or any combination thereof, and who does not investigate, negotiate or settle claims with policyholders, claimants or their legal representative.
6. A licensed health care provider or its employee who provides managed care services as longs as the services do not include the determination of compensability.
7. A managed care organization or any of its employees or an employee of any organization providing managed care services as long as the services do not include the determination of compensability.
8. A person who settles only reinsurance or subrogation claims.
9. An officer, director, manager or employee of an authorized insurer, surplus lines insurer, a risk retention group (RRG) or an attorney-in-fact of a reciprocal insurer.
10. A U.S. manager of the U.S. branch of an alien insurer.
11. A person who investigates, negotiates or settles life, accident and health, annuity, or disability insurance claims.
12. An individual employee, under a self-insured arrangement, who adjusts claims on behalf of his or her employer.
13. A licensed insurance producer to whom claim authority has been granted by the insurer.
14. A person authorized to adjust workers’ compensation or disability claims under the authority of a third-party administrator (TPA) license pursuant to [applicable licensing statute].

Drafting Note: This guideline is drafted to eliminate redundant licensure requirements with respect to the activities engaged in by a licensee. If licensed as an independent adjuster, TPA or similar business entity, licensees should not be required to obtain separate independent adjuster licenses, provided that the types of claims adjusted do not include life, health, annuity or disability insurance claims.

Qualifications of an Adjuster

States that do require licensure assess the qualifications of potential adjusters in various ways. States use one or more of the following methods to determine that a person has the requisite knowledge to properly adjust claims:

1. Specialized or related education prior to licensure, i.e., prelicensing coursework.
2. A specified amount of experience that is relevant to the kind of adjusting work the applicant will be doing (i.e., P/C, workers’ compensation or life/health).
3. A license examination.
4. Relevant professional designation such as the Chartered Property Casualty Underwriter (CPCU) or Associate in Claims (AIC).
5. Prior similar licensure in another state.

For states implementing a new regulatory scheme for adjusters, it is common practice to waive the initial exam for applicants with appropriate credentials and experience.

Fitness and Character Considerations

Like insurance producers, many states also evaluate an applicant’s fitness, character and trustworthiness to engage in this aspect of the insurance business. Insurance regulators typically consider:

1. Criminal history.
2. Administrative actions taken by other state insurance regulators.
3. Civil judgments that may shed light on an applicant’s character or fiscal integrity.

In some states, an adjuster must apply for a license by line of insurance, or line of authority, similar to the manner in which producers are licensed. Other states require adjuster licenses by categories such as motor vehicle physical damage, workers’ compensation or crop.

States are encouraged to implement a fingerprint requirement for public and independent adjusters, similar to the manner in which producers are licensed. Additionally, if a state permits a nonresident adjuster to designate that state as its home state, fingerprinting of that nonresident should be required. States are encouraged to adopt the Authorization for Criminal History Record Check Model Act (1222) when evaluating and considering whether an applicant or licensee has met the character and trustworthiness requirements to obtain, maintain or renew a license.

Reciprocity

In almost every jurisdiction where licensure is required, it is the “home state” insurance regulator who assesses the qualifications of his or her resident adjusters. Based upon securing a license in one’s home state, many states will grant a comparable or similar nonresident license to such an individual. This is not the case in all states, and varying lines of authority, qualification standards and license types have created barriers to nonresident licensure. In addition, an adjuster based in a state that does not license adjusters may be required to take exams in multiple states.

The New NAIC Public Adjuster Model Act defines home state as:

“The New NAIC Public Adjuster Model Act defines home state as:

“Home state” means the District of Columbia and any state or territory of the U.S. in which the public adjuster’s principal place of residence or principal place of business is located. If neither the state in which the public adjuster maintains the principal place of residence nor the state in which the public adjuster maintains the principal place of business has a substantially similar law governing public adjusters, the public adjuster may declare another state in which it becomes licensed and acts as a public adjuster to be the “home state.”
The NAIC Independent Adjuster Guidelines defines home state as:

“Home state” means the District of Columbia and any state or territory of the U.S. in which an independent adjuster maintains his, her or its principal place of residence or business and is licensed to act as a resident independent adjuster. If the resident state does not license independent adjusters for the line of authority sought, the independent adjuster shall designate as his, her or its home state any state in which the independent adjuster is licensed and in good standing.

There are a few states that will not grant nonresident licensure based upon a person having qualified and passed a license exam in the applicant’s home state. Instead, these states require the nonresident applicant to take an exam in the nonresident state even though the person has taken and passed the license exam in the home state.

Adjuster licensing processes were modeled on producer licensing processes and in 2011, the NAIC adopted the Independent Adjuster Reciprocity Best Practices Guidelines paper, which provides jurisdictions with a model to meet reciprocity requirements, as well as take major steps toward reaching uniformity. The NAIC uniform licensing forms are designed to be used by applicants for adjuster licenses. Producer licensing for nonresidents is predicated on the producer satisfying the requirements for a home state license. Those producer requirements often include prelicensing education and examination. Since, at this writing, 40 states license public adjusters, 33 states license independent adjuster licenses and only 15 states require company adjusters to be licensed, obtaining nonresident adjuster licenses becomes more complex because adjusters often do not have an underlying resident license. Until states adopt the provision that allows an individual to qualify for licensure by designating another state as the person’s home state or to designate the state in which the application is filed as the person’s home state, obtaining a nonresident adjuster license becomes more complex because adjusters often do not have an underlying resident license.

Some states do not license adjusters. In order for the use of electronic licensing systems, adjusters residing in states that do not license adjusters can select an Adjuster Designated Home State (ADHS). The ADHS is the state in which the adjuster does not maintain his, her or its principal place of residence or business, and the adjuster qualifies for the license as if the person were a resident.

A state whose laws permit a nonresident adjuster to designate that state as its home state will require the nonresident to qualify as if the person were a resident (exam requirements; fingerprinting, if required; and CE). Once the individual has met the qualifications, the designated home state will issue a nonresident license. The PDB and designated home state will list the record as nonresident, designated home state.

If the resident state of the adjuster does not require an adjuster license, adjusters cannot use the NIPR ADHS module unless they declare another state to be the home state. NIPR has recently added a new Nonresident Adjuster Licensing (NRAL) application that allows an individual to designate a state other than the resident state as the home state. NIPR contains functionality to allow adjusters that have designated another state as the home state to renew online. Adjusters with any license can update contact information through the NIPR CCR.

Continuing Education

Approximately 18 states have CE requirements for their resident adjusters. Reciprocity exists among a majority of these states but not all, in part as a result of the inconsistency among lines of authority granted within each state’s adjuster licensing scheme. It also becomes problematic when the resident adjuster’s home state does not have any CE requirements.

Model #228 and the Independent Adjuster Licensing Guidelines contain a CE requirement that the home state shall require 24 hours of CE every two years, with three of the 24 hours covering ethics. It is recommended that a state accept an adjuster’s satisfaction of its home state’s CE requirements as satisfying that state’s CE requirements, provided that the home state recognizes CE satisfaction on a reciprocal basis. For a state that permits a nonresident adjuster to designate that state as its home state, the home state will require and track CE compliance for that adjuster.

Emergency/Catastrophic Adjusters

A state that offers temporary licensure or registration for emergency/catastrophic adjusters are encouraged to follow the Independent Adjuster Licensing Guidelines and develop an automated notification or registration procedure that allows for an immediate, streamlined and efficient filing process for adjusters who are seeking authority to adjust claims in the event an emergency or catastrophe is declared.
Non-U.S. Adjusters for Limited Lines Portable Electronics Insurance Products

Many states license, or are considering licensure for, limited lines portable electronics insurance producers. Because some major portable electronics insurance companies provide claims adjustment services via non-U.S. entities, the issue of licensing adjusters who do not reside in the U.S. has gained increased prominence. The Independent Adjuster Licensing Guidelines and Model #228 are silent on the licensing of non-U.S. citizens beyond the requirement to designate a home state. Some states, however, have tax laws or other laws that require licensees and applicants for licenses to submit and maintain a Social Security number (SSN). State license laws that allow for the licensing of non-U.S. adjusters must take this possible barrier to licensure into consideration. States also should require non-U.S. citizens to comply with all necessary qualification requirements, such as passing the resident license examination (if applicable).

### Recommended Best Practices for Regulators

- Adopt the NAIC Model Act for Public Adjusters.
- Adopt the NAIC Independent Adjuster Licensing Guidelines.
- Use the NAIC uniform applications and develop a mechanism for electronic submission and electronic bulk submissions.
- Use the definition of “home state” as defined in the NAIC Public Adjuster Model Act as the basis of reciprocity.
- Provide resident and nonresident adjuster licensing requirements on forms and Web sites and on the SPLD.
- Allow electronic payment for residents and nonresidents for authorized submitters as well as individual adjusters.
- Post applications and license status information on Web sites and on the SPLD.
- Eliminate perpetual licenses, eliminate the word “perpetual” from issued licenses, and adopt a biennial renewal process tied to the uniformity standards.
- Adopt the NAIC Independent Adjuster Reciprocity Best Practices Guidelines.
- Use the definition of “home state” as defined in the NAIC Independent Adjuster Licensing Guidelines (#1224).
- Participate in the NIPR ADHS application.
- Participate in the NAIC Personalized Information Capture System (PICS) to receive alerts or monitor actions against existing licensees.
- Use the Attachments Warehouse/Reporting of Action system to receive electronic notifications to alert a state when an adjuster has added information into the Attachments Warehouse since their initial entry regarding administrative, criminal or civil actions. For nonresidents that designate your state as the “home state”, a nonresident license should be issued.
- For nonresidents that designate your state as the “home state”, develop internal data fields that will allow the tracking of CE compliance.
- Include a provision in law that prohibits simultaneous licensure as both an Independent Adjuster and a Public Adjuster.
- If your state requires a license examination, require applicants for a resident license to pass your own state’s examination, not simply use passing results from another state’s examination. However, recognition of an exam taken in another state may be given where a nonresident license is being requested.
- Grant an exemption from the license examination requirement to applicants for the crop line of authority who have satisfactorily completed the National Crop Insurance Services Crop Adjuster Proficiency Program or the loss adjustment training curriculum and competency testing required by the Federal Crop Insurance Corporation Standard Reinsurance Agreement.
- If your state allows non-U.S. citizens to receive a license, ensure that other laws in your state (such as tax laws) do not require every licensee or applicant for a license to submit a Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN).
Chapter 19

Bail Bond Agents

A bail bond is one method used to obtain the release of a defendant awaiting trial upon criminal charges from the custody of law enforcement officials. A bail bond can be based on an insurance product or collateral. The defendant, the defendant’s family and friends, or a professional bail bond agent executes a document that promises to forfeit the sum of money determined by the court to be commensurate with the gravity of the alleged offense if the defendant fails to return for the trial date. A bail bond is considered a three-part contract between the defendant, the government and the insurance company.

Some states regulate bail bonds through the insurance department, and others leave the administration to the discretion of the court system. It is usually required that a bail bond insurer file a power of attorney with the local court authority. This power of attorney is proof to the court that the bail agent is authorized to write bonds for that insurer up to a certain dollar amount.

State insurance departments vary in the manner in which bail bond activities are regulated. There is no NAIC model to guide state licensing directors for bail bond agents. A number of states use the surety line of authority to regulate only the bonds that are insurance-based. In other states, a more comprehensive system has been developed that includes examinations, background checks and personal integrity bonds. The majority of bail bond transactions are executed by resident bail bond agents. Some states prohibit nonresident bail bond agents. In many states, the state court system and local county sheriff may also have a process for approval of bail bond agents.

States that regulate bail bond agents should consider including the following elements in their regulatory scheme:

1. Minimum content and disclosure requirements for the bail bond contract.
2. Detailed record-keeping.
3. Requirement that bail funds be segregated in a trust account.
4. Appointments for all bail bond agents.
5. Written examination.
6. Background check, including fingerprints.
7. Prelicensing education on state laws and bond procedures.
8. Completion of CE.
9. Laws that clearly place liability on insurers’ appointed bail bond agents who fail to comply with state law on bail bonds and return of collateral.
10. Cross reference the PLMA and the state’s unfair trade practices act to apply penalties for misconduct.
11. Laws that create a fiduciary relationship between the bail bond agent and the criminal defendant.
12. Dialogue with the appropriate state court and law enforcement officials to coordinate efforts at regulating bail bond agents.
13. Adoption of a specific list of prohibited activities by bail bond agents.

Bond Forfeiture

Forfeiture enforcement may or may not be the responsibility of the state insurance department. In some states, enforcement is left to the court system. This may result in a bail agent’s bond privileges being revoked in a particular county. If enforcement is the responsibility of the state insurance department, the state likely will have authority to suspend or revoke the license of a bail agent.

Prohibited Activities

The following list contains excerpts from several states’ laws and regulations regarding bail bond agent licenses. This is a suggested starting point for states to draft a list of prohibited activities for bail bond agents and insurers:

1. Pay, rebate, give or promise anything of value to a jailer, peace officer, magistrate or any other person who has power to arrest or hold a person in custody, or to any public official or public employee for the purpose of securing a settlement, compromise, remission or reduction of the amount of bail bond, or to secure delay or other advantage. This section does not prohibit public reward paid for the return of a fugitive.
2. Pay, rebate, give or promise anything of value to an attorney in a bail bond matter, except in defense of an action on a bail bond, collateral or indemnification agreement.
3. Pay, rebate, give or promise anything of value to a defendant or anyone acting on the defendant’s behalf in exchange for a referral of bail bond business.
4. Recommend a particular attorney to represent a defendant.
5. Solicit business where a prisoner is confined in or near a courtroom if otherwise prohibited by court order or law.
6. Sign or countersign a bail bond that the licensee did not execute.

Immigration Bonds

An immigration bond guarantees the Immigration and Naturalization Service (INS) that an alien will comply with one of several obligations under U.S. immigration laws. Most often, an immigration bond guarantees the alien while released from U.S. custody during the pendency of the government’s case for unlawful entry into the country. An immigration bond can be in the form of a surety product or collateral. (See INS Form I-352.) With respect to surety products, the underlying guarantee is an insurance product permitted to be issued solely by a licensed insurer. Consequently, an individual selling, soliciting or negotiating an immigration bond must maintain a resident or nonresident producer license in order to legally sell the bond in a state.

States should recognize that immigration bonds are a form of insurance required to be issued by a licensed insurer and that the sale, solicitation and negotiation of immigration bonds constitute activities for which an individual must maintain a license as a resident or nonresident producer under the respective states’ licensing laws. New Jersey Bulletin No. 09-09 contains an example of notification regarding appropriate treatment of immigration bonds.
Chapter 20

Charitable Gift Annuities

A charitable gift annuity (CGA) is a transfer by a donor to a charitable organization. In return, the donor receives an annuity payable over one or two lives. If the actuarial value of the annuity is less than the value of the property transferred, then the difference in value constitutes a charitable deduction for federal tax purposes. CGAs are not investments. Annuity payments are tax-free partial returns of the donor’s gift based on actuarial tables of life expectancy.

To qualify as a charitable organization under the federal law, the entity must be one described in either Section 501(c)(3) or Section 170(c) of the Internal Revenue Code (IRC).

The maximum rates of return that are typically paid on these uninsured annuities are established by the American Council on Gift Annuities (ACGA).

Gift annuity payments are fixed. They never go down or up. CGAs are not insured. A charity could become insolvent and be unable to make annuity payments. Most gift annuities are not protected by any state guaranty fund.

The NAIC has adopted two models to regulate CGAs. The Charitable Annuities Model Act (#240) contains a detailed licensing scheme for CGAs. The Charitable Gift Annuities Exemption Model Act (#241) calls for a simplified registration mechanism.
Chapter 21

Fraternals and Small Mutuals

Fraternal Benefit Societies

A fraternal benefit society is a membership organization that is legally required to offer life, health and related insurance products to its members, be not-for-profit, and carry out charitable and other programs for the benefit of its members and the public. It must be composed of members having a common bond and be organized into lodges or chapters (local membership groups). A fraternal benefit society exists solely for the benefit of its members and their beneficiaries. Fraternal benefit societies must have a representative form of governance.

Federal law allows a fraternal to offer life and health insurance products. Section 501(c)(8) of the IRC defines a fraternal beneficiary society as:

(a) a nonprofit mutual aid organization;
(b) operating under the lodge system or for the exclusive benefit of the members of a fraternity itself operating under the lodge system; and
(c) providing for the payment of life, sick, accident or other benefits to the members of such society, order or association, or their dependents.

Fraternal benefit societies offer insurance products, are chartered and licensed according to state insurance laws, and are regulated and examined by state insurance departments. Individuals who sell, solicit or negotiate insurance products for a fraternal benefit society are required to obtain a state insurance producer license.

The NAIC has adopted the Uniform Fraternal Code (#675). However, this model is not widely in use. At this writing, 45 states had adopted a version of the Model Fraternal Code as drafted by the National Fraternal Congress of America (NFCA). Both the NAIC model and the NFCA model contain a section about producer licensing that pre-dates the PLMA. States should check the fraternal law that has been adopted in their state and update it to reference the PLMA.

Small Mutual Insurers

Small mutual insurers are risk-bearing entities that historically formed around common interests of farmers, householders, and ethnic and religious groups. Small mutuals, commonly known as farm mutuals, may also be called “town” or “county” or “state” mutuals.

Small mutuals provide, with only a few exceptions, property insurance for homes, farmsteads, crops and some small businesses. They do not, except for the legal liability associated with those risks, write casualty insurance. In some states, small mutuals are allowed to offer liability coverage through an affiliation with an insurer. State laws usually limit small mutuals to either a certain premium volume or geographic area or both. Most states also impose a lighter regulatory burden than that applied to larger mutual and investor-owned insurers.

Mutual insurers are owned and operated by the policyholders. Unlike a stock company, a mutual policyholder has an indivisible interest in the enterprise that, in general, cannot be bought or sold like a share of stock. Policyholders often are referred to as “members.” In some cases, a dividend or return of premium is paid when the mutual’s board of directors judges it has sufficient capital. Members of the board also are policyholders.

Individuals who sell products for small mutuals should be licensed as producers as outlined in the PLMA and the ULS.
Chapter 22

Insurance Consultants

An insurance consultant is a person who charges a fee for giving advice about insurance products. Not all states require a separate consultant license. In those states, the individual can obtain a producer license and abide by the disclosure provisions for insurance consultants. In states that do require a special license, the applicant usually is required to pass an examination. The exam may be either one of the same subject-matter examinations that insurance producers must pass or an examination specific to consultants. In states that require an examination, a waiver may be granted if the applicant can demonstrate a specified amount of insurance experience.

States usually adopt exemptions from the consultant licensing requirement. The exemptions are available as long as the person is acting in his or her professional capacity or in the normal course of business. Common exemptions are:

1. A licensed attorney.
2. A trust officer of a bank.
3. An actuary or certified public accountant.
4. A risk manager who consults for his or her employer only.

If a state requires appointments for insurance producers, appointments should not be required of insurance consultants. The consultant represents the insured and is not an agent of the insurance company. Some states prohibit an individual from holding both an insurance producer license and an insurance consultant license. Other states allow an insurance producer to function in either capacity with full disclosure. In all cases where an individual is acting as an insurance consultant, a written contract should be used to clearly explain the terms of the consultant arrangement.

In states that have a separate insurance consultant license, it is a common practice to have a CE requirement that mirrors the CE requirement for insurance producers.
Chapter 23

Managed Care Providers

Health Maintenance Organizations

A health maintenance organization (HMO) is a type of managed care organization that provides a form of health care coverage that is fulfilled through hospitals, doctors and other providers with which the HMO has a contract. Unlike traditional health insurance, an HMO sets out guidelines under which doctors can operate. On average, an HMO costs less than comparable traditional health insurance, with a trade-off of limitations on the range of treatments available. Unlike many traditional insurers, HMOs do not merely provide financing for medical care. The HMO actually delivers the treatment as well. Doctors, hospitals and insurers all participate in the HMO business arrangement.

The NAIC has adopted a model law and regulation that governs the licensure of HMOs: Health Maintenance Organization Model Act (#430) and Model Regulation to Implement Rules Regarding Contracts and Services of Health Maintenance Organization (#432). In most cases, access to an HMO is only available to employer group plans.

Preferred Provider Organizations

A preferred provider organization (PPO) is a group of doctors and/or hospitals that provides medical service only to a specific group or association. The PPO may be sponsored by a particular insurance company, by one or more employers, or by some other type of organization. PPO physicians provide medical services to the policyholders, employees or members of the sponsor(s) at discounted rates and may set up utilization review programs to help control the cost of medical care.

In some states, managed care providers may be licensed by an agency outside the insurance department.
Chapter 24

Managing General Agents

A managing general agent (MGA) is an insurance producer authorized by an insurance company to manage all or part of the insurer’s business in a specific geographic territory. Activities on behalf of the insurer may include marketing, underwriting, issuing policies, collecting premiums, appointing and supervising other agents, paying claims, and negotiating reinsurance. Many states regulate the activities and contracts of MGAs.

The NAIC has adopted the Managing General Agents Act (Model #225) to guide states in regulating MGAs. Under the model, an MGA is defined as any person who engages in all of the following:

1. Negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer—including the management of a separate division, department or underwriting office—and who acts as an agent for such insurer whether known as a managing general agent, manager or other similar term or title.
2. With or without authority and either separately or together with affiliates, directly or indirectly produces and underwrites an amount of gross direct written premium equal to or greater than 5% of the policyholder surplus in any one quarter or year, as reported in the last annual statement of the insurer.
3. Engages in either or both of the following:
   (a) Adjusts or pays claims in excess of an amount determined by the insurance commissioner.
   (b) Negotiates reinsurance on behalf of the insurer.

Under the model, an MGA does not include any of the following:

1. An employee of the insurer.
2. A manager of a U.S. branch of an alien insurer who resides in this country.
3. An underwriting manager who, pursuant to contract, manages all insurance operations of the insurer, who is under common control with the insurer, subject to [cite to state law] relating to the regulation of insurance holding company systems, and who is not compensated based upon the volume of premiums written.
4. An insurance company, in connection with the acceptance or rejection of reinsurance on a block of business.
5. The attorney-in-fact authorized by or acting for the subscribers of a reciprocal insurer or interinsurance exchange under a power of attorney.

In most states, MGAs must be licensed as producers and are not allowed to place business until a written contract exists among all parties. Under the Model #225, insurers are required to monitor the financial stability of MGAs under contract.
Chapter 25

Multiple Employer Welfare Arrangements

Multiple employer welfare arrangements (MEWAs) are arrangements that allow a group of employers collectively to offer health insurance coverage to their employees. MEWAs are most often found among employer groups belonging to a common trade, industry or professional association.

MEWA plans are generally available to the employees (and sometimes their dependents) of the employers who are part of the arrangement. People who do not have an employment connection to the group cannot obtain coverage through the MEWA plan. MEWA plans cannot be sold to the public.

To qualify as an MEWA, the organization must be nonprofit, in existence for at least five years and created for purposes other than that of obtaining health insurance coverage. In other words, employers cannot group together solely for the purpose of offering health insurance. However, employers that already have grouped together for another common purpose (for example, a trade association) may also offer health insurance coverage to their member employers.

States and the federal government coordinate the regulation of MEWAs pursuant to a 1982 amendment to the federal Employee Retirement Income Security Act (ERISA). This dual jurisdiction gives states primary responsibility for overseeing the financial soundness of MEWAs and the licensing of MEWA operators. The U.S. Department of Labor (DOL) enforces the fiduciary provisions of ERISA against MEWA operators to the extent a MEWA is an ERISA plan or is holding plan assets. State insurance laws that set standards requiring specified levels of reserves or contributions are applicable to MEWAs even if they also are covered by ERISA.

The NAIC has adopted a model regulation, Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation (#220), to give guidance to states in the supervision of MEWAs.
Chapter 26

Reinsurance Intermediaries

A reinsurance intermediary acts as a broker in soliciting, negotiating or procuring the writing of any reinsurance contract or binder. Reinsurance intermediaries act as insurance producers in accepting any reinsurance contract or binder on behalf of an insurer.

The NAIC has adopted the Reinsurance Intermediary Model Act (#790), which contains a simplified registration process for nonresident reinsurance intermediaries. Nonresident reinsurance intermediaries verify that they are licensed in their home states under similar laws as in the nonresident states, i.e., the NAIC Model, and the nonresident reinsurance intermediaries are granted reciprocity.
Chapter 27

Risk Retention Groups and Risk Purchasing Groups

Risk Retention Groups

Congress enacted the federal Risk Retention Act (RRA) in 1981. This federal law enabled product sellers to form RRGs to provide group self-insurance. RRGs are insurers licensed and fully regulated in one state pursuant to that state’s laws. In the mid-1980s, general liability insurance premiums skyrocketed, and certain lines were unavailable. Coverage for some classes of businesses was typically either unavailable or extremely expensive for the desired limits and coverages. Congress intervened again in 1986, this time expanding the RRA to permit RRGs to cover broader liability risks. The RRA is now referred to as the federal Liability Risk Retention Act (LRRA).

Under the Model Risk Retention Act (#705), an RRG “registers” in non-domicile states and is then exempt from most insurance laws in non-domicile states. RRGs are limited to providing non-workers’ compensation commercial lines liability insurance to its members. All owners of an RRG must be insureds, and all insureds must be owners.

RRGs can be required by states to:

1. Comply with the unfair claim settlement practices law.
2. Pay applicable premium and other taxes that are levied on admitted insurers and surplus lines insurers, brokers or policyholders.
3. Participate in residual market mechanisms.
4. Register and designate the insurance commissioner as agent for service.
5. Submit to a financial examination in any state in which the group is doing business if:
   a. The domiciliary insurance commissioner has not begun or refused to initiate an examination.
   b. Any examination shall be coordinated to avoid unjustified duplication and repetition.
6. Comply with a lawful order issued in a delinquency proceeding commenced by the insurance commissioner if there has been a finding of financial impairment or in a voluntary dissolution proceeding.
7. Comply with deceptive, false or fraudulent acts or practices laws, except that if the state seeks an injunction regarding the conduct, it must be from a court of competent jurisdiction.
8. Comply with an injunction issued by a court of competent jurisdiction, upon a petition by the state insurance commissioner alleging that the group is in hazardous financial condition or is financially impaired.
9. Provide the following notice, in 10-point type, in any insurance policy:

   NOTICE

   This policy is issued by your risk retention group (RRG). Your RRG may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your RRG.

   A state may require that a person acting, or offering to act, as a producer or broker for an RRG obtain a license from that state, except that a state may not impose any qualification or requirement that discriminates against a nonresident producer or broker.

Risk Purchasing Groups

The second type of entity allowed to operate under the RRA is a risk purchasing group (RPG). RPGs are vehicles for any insurer to market on a group basis, with the ability to discriminate as to rates for those groups. But as with RRGs, RPGs are only allowed to place liability coverage. RPGs are formed so that similar risks may pool purchasing power. RPGs are purchasing entities, not insurers, and are not generally subject to state insurance laws.

Insurance departments generally do not actively regulate RPGs. The insurer writing for an RPG is subject to all insurance laws, with few exceptions. The transaction of insurance for an RPG in a state generally follows a traditional transaction based on the form of the insurer in relation to that state. Hence, if the insurer is licensed in the state, then producer licensing and, if applicable, appointment procedures apply. If the insurer is a writer of surplus lines, then the traditional surplus lines producer
licensing rules apply. As with RRGs, a state may require that a person acting, or offering to act, as a producer or broker for a purchasing group obtain a license from that state. A state may not impose any qualification or requirement that discriminates against a nonresident producer or broker.
Chapter 28

Third-Party Administrators

A TPA is an entity that directly or indirectly underwrites, collects charges or premium from, or adjusts or settles claims on residents of a state, in connection with life, annuity or health coverage offered or provided by an insurer, unless accepted by statute.

When an employer offers its employees a self-funded health care plan (the employer helps finance the health care costs of its employees), the employer often contracts with a TPA to administer the plan. The employer also may contract with a reinsurer to pay amounts in excess of a certain threshold in order to share the risk for potential catastrophic claims experience.

In most states, a TPA is required to register with the state. Some states require a bond. The TPA is required to answer inquiries from the state insurance department, but, if the TPA is working for a self-funded ERISA plan, a state has limited authority to take enforcement action against the TPA. An insurer also may act as a TPA for certain customers. This can be confusing to a consumer who has an identification card that has a name similar to a well-known health insurance company. The consumer often thinks coverage is provided by that insurance company instead of the employer plan.
Chapter 29

Title Insurance Agents

Title insurance is insurance indemnifying against financial loss from defects in title of real property arising from conditions of title that exist on the date of issuance of the policy. While most insurance coverage indemnifies insureds against loss caused by future events, title insurance is unique as it focuses on the elimination of risk before the policy is issued. Title insurance policies are typically purchased when real property is conveyed or financed. Insureds pay one premium for coverage that has no expiration. In many states, title insurance has essentially replaced abstracts of title, and it is often required as a condition for obtaining a loan secured by a lien on real property.

Title insurance policies commonly guarantee or indemnify the fee title of owners or the lien priority of a lender from losses or damages from liens, encumbrances, defects or unmarketability of title, or adverse claims to title in the real property, and defects in the authorization, execution or delivery of an encumbrance on the real estate. Coverage is subject to standard exceptions, as well as specific exclusions listed on a schedule attached to the policy limiting the extent of the insurer’s liability. Coverage is often expanded or amended through endorsements attached to the policy.

Two types of title insurance policies are commonly issued: the owner’s policy and the lender’s loan policy. The owner’s policy ensures that the title to the real property is vested as described in the policy, that the title is marketable, that there is a right of access to the property, and against defects in or lien or encumbrances on the title. Title insurance does not require a written application. Policies often are ordered by real estate agents or lenders. The title insurance agent issues a commitment or binder basically revealing the current state of title to the property and agreeing to insure the property, provided that the requirements in the commitment are met to the satisfaction of the title insurer. Typically, even though the buyer/borrower pays for the loan policy, only the lender is covered by the loan policy.

The effective date of the policy is typically the date that transactional documents (deed, deed of trust, etc.) are recorded in the public real estate records. Losses under the policy are subject to the limits listed on Schedule A of the Policy, the title page, plus any costs of defense. The policy limit of an owner’s policy is generally the purchase price of the real property, and the policy limit of a lender’s loan policy is generally the original amount of the loan. Losses from title defects are rare, and loss ratios for insurers are relatively low. The goal of a title insurer is to find defects in title prior to issuing a policy; consequently, expense ratios are fairly high due to the cost of title research.

Most states place monoline restrictions on title insurers. Monoline restrictions prohibit title insurers from issuing any line of insurance other than title insurance. Rates and rate setting processes vary by state. Some states regulate only the risk premium, while other states regulate an all-inclusive premium, which generally includes all costs of issuing the policy, search expenses and the risk premium.

Functions of title insurance agents include conducting title searches, performing underwriting functions, preparing and issuing title insurance commitments and policies, maintaining policy records, and receiving premiums. In addition, many title agents perform real estate closings, and provide settlement and escrow services.

Many activities of state licensing divisions with regard to title insurance are the same as in other lines of insurance. In most states, agents are required to pass a licensing exam and fulfill ongoing (CE) requirements. In some states, the licensing division also will be responsible for receiving and filing agency appointments with insurers, bonds or letters of credit (LOCs), proof of errors and omissions (E&O) coverage, and forms disclosing controlled and affiliated business relationships. The NAIC has adopted the Title Insurance Agent Model Act (§230) to give guidance to state licensing directors.

Title insurance creates some unique regulatory issues, primarily due to the risk elimination nature of the insurance coverage, and the business relationships between title insurance agents and those who refer title insurance business. The entity referring the title insurance business often is viewed as the customer rather than the insured due to the nature of real estate transactions. Entities that regularly refer title insurance business—such as mortgage brokers, lenders, realtors and attorneys—are referred to as producers of title insurance business. Note that “producer of title insurance” as used in this context carries a very different meaning from “insurance producer.”

Controlled and affiliated business relationships refer to business relationships between title insurance agents and producers of title insurance business. Many states require that controlled and affiliated business relationships be disclosed both to the insured and to the insurance department in writing. Many states also prohibit title insurance agents from providing rebates, referral fees, inducements or financial incentives to producers of title insurance business. In addition to state laws, rebates and referrals related to most residential real estate transactions are prohibited under the federal Real Estate Settlement Procedures Act (RESPA).

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Chapter 30

Viatical and Life Settlement Providers and Brokers

The *Viatical Settlements Model Act (#697)* defines a viatical settlement as a transaction in which the owner of a life insurance policy sells the right to receive the death payment due under the policy to a third party. Typically, the owner/insured receives a cash payment, and the buyer agrees to make any remaining premium payments on the policy.

In 1993, the NAIC adopted the *Viatical Settlements Model Regulation (#698)* and *Model #697* to provide a regulatory structure to protect consumers involved in viatical settlements. The Model #697 was revised in 2003 and 2004 to address the issue of healthy consumers who might want to sell their insurance policy on the secondary market, better known as “life settlements.”

Licensing requirements vary as a result of the several versions of *Model #697*. Under the 1993 version of *Model #697*, a viatical settlement broker was required to have an underlying life producer license before being able to apply for and receive a viatical settlement broker license. This provision was not uniformly adopted.

The 2003 version of *Model #697* provided for licensing procedures of individuals who were not licensed life insurance producers by requiring CE to maintain the license. The 2003 version was modified in 2004 to allow for licensed life insurance producers to notify or register with the insurance regulator as prescribed by the insurance commissioner if they were engaging in the business of settlements, and exempted life insurance producers from the viatical settlement brokers’ examination and the CE requirements.

The 2003 and 2004 versions of *Model #697* also required the viatical settlement broker to maintain financial responsibility in the form of an errors and omissions policy, surety bond or cash deposit, or a combination of any of the three. It also placed fiduciary responsibility requirements on the broker. The 2003 and 2004 versions of Model #697 required brokers to disclose the method by which compensation was calculated and the amount of compensation. It is essential the viatical broker meet the licensing requirements of the state where the transaction occurs.

The 2003 version of Model #697 also provided for licensing procedures for viatical settlement providers.

*Model #697* was revised in 2007 to address, among other things, transactions that have been called stranger-originated life insurance (STOLI) or investor-originated life insurance (IOLI). These transactions are related to a life insurance policy exhibiting any one of three characteristics prior to or within two years of policy issue:

1. Non-recourse premium financing.
2. Guarantee of settlement.
3. Settlement evaluation.

Settlement of such policies is prohibited for five years.

Other key revisions include:

1. New consumer disclosures related to viatical settlement compensation.
2. A new consumer disclosure requiring a statement that the viatical settlement broker represents exclusively the viator and owes a fiduciary duty to the viator, including a duty to act in the best interest of the viator.
3. Allowing life agents to sell without a viatical license, but special conditions apply.
Additional revisions include:

Under specified circumstances, a life insurance producer may operate as a viatical settlement broker. The life insurance producer is deemed to meet the viatical settlement broker licensing requirements. The revisions also permit a person licensed as an attorney, certified public accountant (CPA) or financial planner accredited by a national recognized accrediting agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider, to negotiate viatical settlement contracts on behalf of a viator without having to obtain a viatical settlement broker’s license.

To receive and maintain a license, the 2007 revisions require a viatical settlement provider or broker to demonstrate evidence of financial responsibility through a surety bond or a deposit of cash, certificates of deposit or securities, or any combination thereof in the amount of $250,000. The surety bond must be issued in the favor of the state and must specifically authorize recovery by the insurance commissioner on behalf of any person in the state who sustained damages as the result of erroneous acts, failure to act, conviction of fraud or conviction of unfair practices by the provider or broker. The insurance commissioner may ask for evidence of financial responsibility at any time the insurance commissioner deems necessary. The revisions make clear that a provider or broker that is licensed in more than one state is not required to file multiple bonds in each state. Some problems have arisen with implementing the bonding requirements of the Model #697. Regulated entities argue that it is impossible to obtain a bond as described by Model #697.

The revisions also require an individual licensed as a viatical settlement broker to complete, on a biennial basis, 15 hours of training related to viatical settlements and viatical settlement transactions. A life insurance producer who is operating as a viatical settlement broker is not subject to this requirement.
NAIC CONTINUING EDUCATION RECIPROCITY AGREEMENT – 2019 VERSION UNIFORM DECLARATION – CE RECIPROCITY COURSE APPROVAL GUIDELINES

Whereas, the Commissioners find that it is in the best interest of each of their States and their insurance producers to simplify the continuing education (CE) reciprocity course approval process and reduce barriers to non-resident CE providers that reside in a State.

Whereas, the undersigned Insurance Commissioners of the National Association of Insurance Commissioners, hereafter the Commissioners, have determined that it is redundant unnecessary for each State to perform a substantive review of continuing education courses or individual instructors that have previously been approved by another State.

Whereas, the Commissioners find that it is in the best interest of each of their States and their insurance producers to simplify the continuing education (CE) reciprocity course approval process and reduce barriers to non-resident CE providers that reside in a State.

Definitions

Home State: the state in which the CE provider organization maintains his, her, or its principal place of residence or principal place of business.

Home State Course Approval: approval of a course that has had a substantive review in a home state.

Reciprocal State: state other than the home state and a party to of this continuing education reciprocity agreement.

Substantive Review: a thorough review of the course to confirm compliance with the home State’s applicable laws and regulations for the approval of insurance continuing education. The review includes a determination whether the:
  i. Subject matter meets the criteria for insurance education, to include approvable and non-approvable topic guidelines;
  ii. Provider has procedures for reviewing course material in order to keep it up to date and timely;
  iii. Course design and instructional strategies are appropriate for the method of delivery;
  iv. Credit hours are properly calculated based on instruction method;
  v. Criteria for completing the course meets the standards applicable to the instruction method.

The Commissioners agree as follows:

1. Each state will conduct a substantive review of continuing education courses submitted for home state approval. Once a CE provider residing in a State has received a home state course approval initial approval to offer courses in its home State, that a reciprocal State will not conduct a substantive review of that same course as a condition of approval. If the CE provider has been awarded credit by the CE provider’s home state, the CE provider may elect to recognize another home state in order to obtain a home state course approval for the filing of its national courses.

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2. Unless specifically limited by State law and regulations, a reciprocal State will award a course the same number of credits and will accept all course topics as approved by the CE provider’s home State.

3. A reciprocal State will agree to approve a course submission within 30 days of receipt, provided that the review and approval process for a course that is filed using the NAIC Uniform Continuing Education Reciprocity Course Filing Form (Appendix A) or an equivalent electronic submission method, and contains a home state course approval. A CE provider who wishes to offer topics that are not approvable by the home State may still file a course directly with a State by completing a specific State’s course approval form.

4. Each State will accept the NAIC Uniform Continuing Education Reciprocity Course Filing Form (Appendix A), or a substantially similar form, including an equivalent electronic submission method, and the required home state course approval document as the sole requirements required by for a reciprocal course submission non-resident CE provider.

5. Each State accepts and will use the following standards for substantive course approval:

   a. For classroom and webinar courses, one credit will be awarded for each 50 minutes of contact instruction. Each State will use its own method to award credit for self-study courses.

   b. For self-study/online courses, credit will be awarded based on the NAIC’s Recommended Guidelines for Online Courses (Appendix B).

   c. The minimum number of credits that will be awarded is one credit, no partial credits will be awarded and there is no maximum number of credits.

   d. Credits will only be awarded for courses whose subject matter will increase technical knowledge of insurance principles, coverages, ethics, laws or regulations and will not be awarded for topics such as personal improvement, motivation, time management, supportive office skills or other matters not related to technical insurance knowledge. If any credits are awarded for sales and/or marketing those credits will only be awarded in States that are permitted by law or regulation to accept credit for those topics. Additional guidance can be found in the NAIC’s Recommended Approved/Not Approved Course Topics (Appendix C).

NAIC UNIFORM DECLARATION – (CONT’D)

   e. Each State will use its own method to determine if an instructor is qualified and no instructor will be approved unless the CE provider has provided sufficient information to demonstrate that the instructor is qualified, according to that State’s laws and regulations, to teach the topics covered in the outline.

   f. A reciprocal State will not review an instructor’s qualifications once that instructor’s qualifications have been reviewed and approved by the CE provider’s home State.

5. A State’s course approval document or approved course application will include, at a minimum, the following information: course-name, whether the method of instruction is self study, whether a course is part of a national or professional designation program and the contact person. A National Course is defined as an approved program of instruction in insurance related topics including a course leading to a National Professional Designation or an insurance course at an institution offered as part of a degree conferring curriculum, presented by an approved CE Provider organization title, credit hours, credit category, method of instruction, and clearly indicate if it is a home state approval.

6. Each State reserves the right to disapprove individual instructors or CE providers who have been the subject of disciplinary proceedings or who have otherwise failed to comply with a State’s laws and regulations.

7. Each State agrees that it will notify other States when a CE provider or instructor has been the subject of a formal administrative action or other disciplinary action by that State.
Drafting Note: The Producer Licensing Working Group needs to make a formal request to NAIC staff to ensure the proper programming and electronic systems are in place through which a provider/instructor is assigned a unique identifier number and notification can be made through the use of electronic means. Can this become part of the NAIC’s Regulatory Information Retrieval Systems and the Personalized Information Capture System.


Drafting Note: The Producer Licensing Working Group needs to discuss how to proceed with getting these changes officially agreed upon by states and replacing the existing Midwest Zone Guidelines and Filing Form. The working group also needs to discuss the impact these changes will have for the Uniform Regulation Through Technology.
## Provider Information

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<thead>
<tr>
<th>Provider Name</th>
<th>FEIN # (if applicable)</th>
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<tbody>
<tr>
<td><strong>Contact Person</strong></td>
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<tr>
<td><strong>Submitter Name</strong></td>
<td><strong>Submitter Phone Number</strong></td>
</tr>
</tbody>
</table>

## Course Information

| **Course Title** | **Date of Course Offering** | **Existing Course Number** |

## Method of Instruction

### Non-Contact / Asynchronous*

- Self – Study
  - ☐ Correspondece
  - ☐ On-Line Training (Self-Study)
  - ☐ Recorded Media
  - ☐ Other ________________

- Word Count ________________

- Mandatory Run-time ________________
  (Interactive Components of Course)

### Contact / Synchronous*

- Classroom
  - ☐ Seminar/Workshop
  - ☐ Other ________________

- Webinar
  - ☐ Virtual Class/Webinar/Video Conference
  - ☐ Other ________________

## Measurement used for successful completion:

- ☐ Attendance
- ☐ Final Exam
- ☐ Other __________

## Is this course open to the public?

- ☐ Yes
- ☐ No

## National Designation?

- ☐ Yes
- ☐ No

If yes, Designation Type: ________________
<table>
<thead>
<tr>
<th>Course Concentration</th>
<th>Hrs Requested by Provider</th>
<th>Hrs Approved by Home State</th>
<th>Hrs Approved by Reciprocal State</th>
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<tr>
<td></td>
<td>Sales/Mktg Insurance</td>
<td>Sales/Mktg Insurance</td>
<td>Sales/Mktg Insurance</td>
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<td>A. Producer Topics:</td>
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<tr>
<td>(Circle Appropriate Course Concentration)</td>
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<tr>
<td>Life / Health</td>
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<td>Property / Casualty/Personal Lines</td>
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<td>Ethics</td>
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<tr>
<td>General (Applies to all lines)</td>
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<td>Insurance Laws</td>
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<tr>
<td>Other (LTC, NFIP, Viaticals, Annuities, etc.)</td>
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<td>B. Adjuster Topics</td>
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<td>(Circle Appropriate Course Concentration)</td>
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<td>General</td>
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<td>Total Hours</td>
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<td>C. Public Adjuster</td>
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<td>(Circle Appropriate Course Concentration)</td>
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<tr>
<td>Total Hours</td>
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</table>

**Information Below is for Regulator Use Only**

| Approval Date                      |                           |                           |
| Course Number assigned             |                           |                           |
| Course approval expiration date    |                           |                           |
| Signature of Home State Regulator/Representative |           |                           |
| OR ATTACH Provider Home State Approval Form |           |                           |
| Signature of Reciprocal State Regulator/Representative |           |                           |
| OR ATTACH Reciprocal State Approval Form |           |                           |
INSTRUCTION SHEET

NOTE: This course may NOT be advertised or offered as approved in the state to which application has been made until approval has been received from the insurance department.

1. If you are a PROVIDER filing for approval from the Home State:
   1.1 Complete all the fields in the “Provider Information” section except “Reciprocal State” and the adjacent “Provider #” fields.
   1.2 Complete the Course Information Section.
   1.3 In the “Credit Hours Requested and Course/Hours Decision” section, complete the “Hrs. Requested by Provider” columns, detailing in the respective columns the number of hours for sales – and marketing-related instruction and the number of hours for other insurance-related instruction. Please note the following:
      1.3.1 When using this application, which is governed by the NAIC CE Reciprocity Agreement in conjunction with ‘states’ laws, only whole numbers of credit hours will be approved – partial hours will be eliminated.
      1.3.2 States that approve sales/marketing topics will consider the hours in the “sales/Mktg” column and the hours in the “Insurance” column when deciding the number of hours to approve. States that do not permit sales/marketing topics as part of continuing education credit hours will only consider the hours shown in the “Insurance” column when making their credit-hour approval decisions.
      1.3.3 Contact the individual state to determine whether there are any state specific requirements for submitting courses.
   1.4 Submit the application form along with required course materials, a detailed course outline, instructor information, if required, and the required course application fee.

2. If you are a PROVIDER filing for approval from a Reciprocal State:
   2.1 Make a sufficient number of photocopies of the Home State approval form to enable you to submit a copy of this application to each of the Reciprocal States where you are seeking credit.
   2.2 On each application, write the Reciprocal State and the provider number assigned to you by that state in the “Reciprocal State” and adjacent “Provider #” fields.
   2.3 Send the CER application, home state approval, if home state issues one, a detailed course outline, and the required fee to the reciprocal state. If this is a National Course *, the Providers will be allowed to submit an agenda that must include date, time, each topic and event location in lieu of a detailed course outline.
   2.4 Subsequent national course offerings should only be reported for events that are conducted in the “home” state.

* National Course is defined as an approved program of instruction in insurance related topics, offered by an approved provider, and leads to a national professional designation or is a course offered to individuals who must update their designation once it is earned.

3. If you are the HOME STATE or designated representative of the Home State:
   3.1 After reviewing the course materials, complete the “Hrs Approved by Home State” column.
   3.1.1 Multiple types of credit and delivery methods can be approved using one CER Form.
   3.2 Enter the date of approval, course # assigned, course approval expiration date. Sign the CER Form OR attach the home state approval form.
   3.3 If the course is not approved, note it on the bottom of the CER Form.

4. If you are the RECIPROCAL STATE or designated representative of the Reciprocal State:
   4.1 After reviewing “Hrs approved by Home State” complete the “Hrs Approved by Reciprocal State”.
      4.1.1 It is unnecessary for each State to perform a substantive review of continuing education courses that have previously been approved by the Home State.
      4.1.2 Reciprocal states cannot award different credits than the home state unless certain aspects are not allowed by state law.
   4.2 Enter the date of approval, course number assigned, course approval expiration date. Sign the CER Form OR attach the reciprocal state approval form.
   4.3 If the course is not approved, note it on the bottom of the CER Form.
   4.4 The reciprocal state agrees to approve the CER submission within 30 days of receipt.

Substantive Review – A thorough review of the course to confirm compliance with the home state’s applicable laws and regulations for the approval of insurance continuing education. The review includes a determination whether the:

1. Subject matter meets the criteria for insurance education, to include approvable and non-approvable topic guidelines;
2. Provider has procedures for reviewing course material in order to keep it up to date and timely;
3. Course design and instructional strategies are appropriate for the method of delivery;
4. Credit hours are properly calculated based on instruction method;
5. Criteria for completing the course meets the standards applicable to the instruction method.

*Drafting Note: The instructor information matrix was eliminated in 2018 as this information should be readily available on individual state/jurisdiction websites.

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Continuing Education Recommended Guidelines for Online Courses
Adopted by NAIC Membership March 18, 2015

Goal: To deliver functional computer-based internet courses that offer quality insurance and/or risk management material in a password-protected online environment.

Key Components:
- Material that is current, relevant, accurate, and that includes valid reference materials, graphics and interactivity.
- Clearly defined objectives and course completion criteria
- Specific instructions to register, navigate and complete the course work
- Technical support/provider representative should be available during business hours and response provided within 24 hours of initial contact.
- Instructors/subject matter experts must be available to answer student questions during provider business hours
- Process to authenticate student identity such as passwords and security prompts
- Method for measuring the student’s successful completion of course which includes the material, exam and any proctor requirements.
- Process for requesting and receiving CE course-completion certificate and reporting student results to the appropriate regulator
- Instructors/subject matter experts must be available to answer student questions during provider business hours
- Require each agent to enroll for the course before having access to course material.
- Prevent access to the course exam before review of the course materials.
- Prevent downloading of any course exam.
- Provide review questions at the end of each unit/chapter and prevent access to the final exam until each set of questions are answered at a 70% rate.
- Provide final exam questions that do not duplicate unit/chapter questions.
- Prevent alternately accessing course materials and course exams. This does not apply if the state allows for “open book” exams.
- Have monitor affidavit containing specific monitor duties and responsibilities printed for monitor’s use to direct the taking of the final exam. Monitor will complete the affidavit after the exam is completed. (This only for states that require a monitored exam).

Final Assessment (exam) Criteria:
- Minimum of 10 questions for 1 credit hour course with additional 5 questions for each subsequent credit hour and a score of 70% or greater
- At least enough questions to fashion a minimum of 2 versions with a least 50% of questions being new/different in each subsequent version
- Inability to print the exam or to view the exam prior to reviewing material
- Proctor, if required by the state, who verifies identity by photo identification and processes affidavit testifying the student received no outside assistance

Procedures to determine Appropriate Number of Credit Hours:

Word Count/Difficulty Level
- Divide total number of words by 180 (documented average reading time) = number of minutes to read material
- Divide number of minutes by 50 = credit hours
- Course difficulty level is identified by the CE provider on the CER form and should be based on the NAIC CE Standardized Terms-Definitions for basic, intermediate and advanced course difficulty levels.
- Multiply number of hours by 1.00 for a basic level course; 1.25 for an intermediate level; 1.50 for an advanced course for additional study time = total number of credit hours (fractional hours rounded up if .50 or above and rounded down if .49 or less)

Interactive Course Content
• Elements included in the online course, in addition to text, such as video, animation, interactive exercises, quizzes, case studies, games, and simulations.
• Interactive elements should be applicable to course material and facilitate student learning.
• Only mandatory interactive elements should be included in the calculation of CE credit hours.
• Calculation of CE hour credits should be based on the run time of the interactive elements.
• CE providers will indicate run time of the interactive elements in the course content and upon request provide access to the state for review of the course.

Professional Designation Course
• Course that is part of a nationally recognized professional designation
• Credit hours equivalent to hours assigned to the same classroom course material

Final Assessment
• Time spent completing the final assessment should not be used in calculation of CE credit hours.

Adopted by the NAIC Membership 2015
These guidelines are intended to apply to courses conducted and viewed in real time (live) in all locations and are not intended to apply when courses have been recorded and are viewed at a later time or to other online courses.

Each student will be required to log in to the webinar using a distinct username, password and/or email. Students that view webinars in group settings which is two or more individuals should alternatively verify their participation in the form of sign-in and sign-out sheets submitted by a monitor with an attestation or verification code.

The provider will verify the identity and license number, or National Producer Number (NPN), of all students.

A provider representative, using computer-based attendance-monitoring technology, must monitor attendance throughout the course.

The provider must have a process to determine when a participant is inactive or not fully participating, such as when the screen is minimized, or the participant does not answer the polling questions and/or verification codes.

For webinars not given in a group setting, no less than two polling questions and/or attendance verification codes must be asked, with appropriate response provided, at unannounced intervals during each one-hour webinar session to determine participant attentiveness.

The provider will maintain an electronic roster to include records for each participant’s log-in/log-out times. If required by states chat history and polling responses should be captured as part of the electronic record.

When a student is deemed inactive or not fully participating in the course by the course monitor of failure to enter appropriate polling question response or verification codes, continuing education (CE) credit is denied.

All students and the instructor do not need to be in the same location.

Students in all locations must be able to interact in real time with the instructor. Students should be able to submit questions or comments at any point during the webinar session.

The course pace must be set by the instructor and does not allow for independent completion.

Instruction time is considered the amount of time devoted to the actual course instruction and does not include breaks, lunch, dinner or introductions of speakers.

One credit will be awarded for each 50 minutes of webinar/webcast instruction, and the minimum number of credits that will be awarded for webinar/webcast courses is one credit.

The provider must have a procedure that informs each student in advance of course participation requirements and consequences for failing to actively participate in the course.

A comprehensive final examination is not required.
Approved Topics

1. Actuarial mathematics, statistics and probability – in relation to insurance
2. Assigned risk – in relation to insurance
3. Claims adjusting
4. Courses leading to and maintaining insurance designations
5. Employee benefit plans – in relation to insurance
6. Errors and omissions – in relation to insurance
7. Estate planning/taxation – in relation to insurance
8. Ethics
9. Fundamentals/principles of insurance (including but not limited to: annuities, crop and hail, life, accident and health, property/casualty [P/C], etc.)
10. Insurance accounting/actuarial considerations
11. Insurance contract/policy comparison and analysis
12. Insurance fraud
13. Insurance laws, rules, regulations and regulatory updates
14. Insurance policy provisions
15. Insurance product-specific knowledge
16. Insurance rating/underwriting/claims
17. Insurance tax laws
18. Legal principles – in relation to insurance
19. Long-term care/partnership
20. Loss prevention, control and mitigation – in relation to insurance
21. Managed care
22. Principles of risk management – in relation to insurance
23. Proper uses of insurance products
24. Real Estate Settlement Procedures Act (RESPA) – in relation to insurance
25. Restoration – addresses claims, loss control issues and mitigation – in relation to insurance
26. Retirement planning – in relation to insurance
27. Securities – in relation to insurance
28. Suitability in insurance products
29. Surety bail bond
30. Underwriting principles – in relation to insurance
31. Viaticals/life settlements – in relation to insurance

Other topics approved that contribute substantive knowledge relating to the field of insurance and expands competence of the licensee.
RECOMMENDED APPROVED/NOT APPROVED TOPICS FOR CE CREDIT

Adopted by the Uniform Education (D) Working Group 12.20.17
Adopted by the Producer Licensing (D) Task Force 3.25.18

Not Approved Topics

1. Automation
2. Clerical functions
3. Computer science
4. Computer training/skills or software presentations
5. Courses on investments – stocks, bonds, mutual funds, Financial Industry Regulatory Authority (FINRA)/U.S. Securities and Exchange Commission (SEC) compliance (National Association of Securities Dealers [NASD]/SEC), etc.
6. Courses that are primarily intended to impart knowledge of specific products of specific insurers
7. Customer service
8. General management training
9. Goal-setting
10. Health/stress/exercise management
11. Marketing/telemarketing
12. Motivational training
13. Company and vendor-specific product launches
14. Office skills or equipment or procedures
15. Organizational procedures and internal policies of an individual insurer
16. Personal improvement
17. Prospecting
18. Psychology
19. Relationship building
20. Restoration – promoting products or services
21. Sales training
22. Service standards or service vendors
23. Time management

Other topics or courses not related to insurance knowledge or competence of the licensee.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Austin, TX, Dec. 8, 2019. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Ryan James and Suzanne Tipton (AR); Maria Ailor (AZ); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DE); Frank Pyle (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); LeAnn Crow (KS); Jeff Zewe (LA); Christopher Joyce (MA); Nour Benchaaboun (MD); Timothy Schott (ME); Michele Riddering (MI); Cynthia Amann and Stewart Freilich (MO); Paul Hanson (MN); Troy Smith (MT); Laura Arp (NE); Philip Gennace (NJ); Paige Duhamel (NM); Stephanie McGee (NV); Angela Dingus (OH); Cuc Nguyen (OK); Katie Dzurec and Gary Jones (PA); Michael Bailes (SC); Tracy Klausmeier (UT); Julie Blauvelt (VA); Christina Rouleau (VT); Erin K. Hunter and Tonya Gillespie (WV).

1. **Adopted its Nov. 21 Minutes**

The Working Group met Nov. 21 and took the following action: 1) adopted its Oct. 31 minutes; 2) adopted “other health” as a line of business in the Market Conduct Annual Statement (MCAS); and 3) discussed a uniform process for addressing MCAS extension requests.

Ms. Dzurec said she was concerned about the lack of clarity around the term “other health” and the possibility of insurance companies avoiding reporting by finding loopholes in what constitutes “other health.” Mr. Haworth said the Market Conduct Annual Statement Blanks (D) Working Group will be developing the blank and working out the details and definitions. He said the health MCAS blank took five years to complete. Ms. Dzurec said the development of the other health blank needs to be done carefully, due to the activity in the marketplace, including the combining of products to compete with qualified plans.

Ms. Arp said the short-term limited duration (STLD) data call focused on products with coverage periods less than 365 days. She asked if the other health MCAS would apply to more than STLD. Mr. Haworth said it would apply to more than STLD. He said the other health MCAS took five years to develop, but for the market Conduct Annual Statement Blanks (D) Working Group will have both the health MCAS and the STLD data call to use as templates. Ms. Ailor said the Market Conduct Annual Statement Blanks (D) Working Group is aware that there are many products, and it may consider segmenting the other health MCAS blank. She said all variables will be considered, and the Working Group will develop a blank that is useful to state insurance regulators.

Ms. Amann made a motion, seconded by Mr. Pyle, to adopt the Working Group’s Nov. 21 minutes (Attachment Six-A). The motion passed unanimously.

2. **Heard an Update on the STLD Medical Data Call Template**

Ms. Rebholz said the STLD data call is due on Dec. 13, and as of Dec. 8, there is only one STLD submission. She said there have been 29 users that requested and obtained the necessary role permission to submit data to the NAIC and that may represent more than 29 companies since some users may work with multiple cocodes.

Ms. Rebholz said a reminder email was sent on Dec. 5 to all the initial recipients of the call letter. Immediately after the reminder, numerous emails were received from companies that do not write STLD. She said over 600 emails from companies and groups of companies have been received advising that they do not write STLD business and have nothing to report.

Ms. Rebholz reminded the Working Group and interested parties that this is a mandatory data call and each participating state may take any actions that they would normally pursue whenever a company fails to report or does not file timely. She encouraged all the company representatives to check to be sure that their company has either completed an STLD filing or has sent an email to the NAIC advising that you do not write STLD business. She said she anticipates a flood of filings close to the Dec. 13 deadline, but she encouraged the states to consider what actions they can take in response to companies that fail to file.
or who say that they have no STLD products when, in fact, they do. She said Wisconsin is already considering its response to companies that file late or fail to file.

Ms. Dingus asked how soon the participating states will: 1) get a list of companies that did not file or said they had no STLD business to report; and 2) how soon the reported data will be available to them. Randy Helder (NAIC) said the list of companies should be ready within one week of the due date and the data itself should also be available within one week.

3. Discussed Revisions to the MCAS Best Practices Guide

Ms. Rebholz said that during the Nov. 21 conference call, she asked for additional volunteers to form a small group to review and make suggested revisions to the MCAS Best Practices Guide. She said five volunteers are on the group, and she welcomes anyone else who is interested. She asked volunteers to send a note to Mr. Helder.

Ms. Rebholz said that in the first week of January, she plans to send a list of the materials the small group needs to look at and potentially update. She will then schedule the group’s first conference call for mid to late January. She said the topics that the group will look at as part of the update process include: 1) identifying threshold issues, such as the number of extension requests that a company has made in recent years and the reasons the company cites; 2) specifying the length of the extensions allowed in order to try to bring consistency in the states’ responses to company extension requests; 3) mapping out a generic process that the states can use as a template; and 4) developing templates for extension request response letters and orders to be available to the states.

Ms. Rebholz said the materials to be reviewed are the MCAS Best Practice Guide; the MCAS web page; the MCAS Frequently Asked Questions (FAQs); the MCAS Industry User Guide; the MCAS data call letters; and all MCAS training materials.

Finally, Ms. Rebholz said the small group will explore what type of extension request report the NAIC can provide on an annual basis to help the states determine where threshold issues are triggered. She said that as part of the State Ahead strategic plan, the NAIC market regulation staff will be developing a Tableau report that will be able to track historical extension and waiver requests. She said the work of the Best Practices small group will be to provide input into what should be included in this tool and its design.

4. Discussed its 2020 Proposed Charges

Mr. Haworth said there are no changes to the charges from 2019.

Mr. Haworth said the Working Group’s first charge is to “[r]ecommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions.” He said the Working Group is to provide recommendations to the Market Regulation and Consumer Affairs (D) Committee by the 2020 Fall National Meeting. He said the current framework used by most market analysts on the state departments is described in chapter 7 of the NAIC Market Regulation Handbook. He suggested that the Working Group review chapter 7 in light of the experiences of its members as analysts to see if any improvements on the methodology can be made. He said it would be helpful to determine how well the process works and what can be done to improve the abilities of analysts to identify concerns and make recommendations to the insurance department leadership.

Mr. Haworth said the Working Group’s second charge is to “[d]iscuss other market data-collection issues and make recommendation as needed.” He said Working Group continues to do a good job of identifying new data-collection needs, such as the STLD data call, and it is also working this year on the MCAS Best Practices Guide.

Mr. Haworth said the third charge is to recommend new lines of business in the MCAS. He encouraged everyone to be thinking of which lines need to be added to the MCAS throughout 2020. He said the Working Group should be considering at least one line of business per year, but preferably two or three.

5. Discussed Other Matters

Charles Piacentini (American Council of Life Insurers—ACLI) said the consideration of other health as the next line of business in the MCAS was tabled in 2018, but when it was re-introduced, there was a lack of discussion before adopting it. He said the industry can assist in defining health plans that are alternatives to qualified federal Affordable Care Act (ACA) plans and
welcome the possibility of participating. He said if the other health line is not properly defined, the reporting could be misleading and disruptive. He said much of the best data comes from consumer complaints.

Mr. Haworth said carriers are welcome to participate in the process, as well as the industry representatives. He said the Market Conduct Annual Statement Blanks (D) Working Group spends a lot of time in the development of MCAS blanks.

Ms. Dzurec said complaints are very helpful, but consumers are often not aware that they can complain or that there is any issue. Mr. Haworth said all the analytics, including reported complaints, will be considered in the development of the blank.

Heather Jerbi (America’s Health Insurance Plans—AHIP) agreed with Mr. Piacentini, and she said AHIP is concerned with the lack of specificity about what is being considered for this line of business. She said she wants industry and state insurance regulators to work together with a robust discussion.

Birny Birnbaum (Center for Economic Justice—CEJ) said the Market Analysis Procedures (D) Working Group only identifies lines of business; it is the Market Conduct Annual Statement Blanks (D) Working Group’s job to develop the blank. He said industry is always invited to participate in the creation of the blank.

Ms. Dzurec said the Market Conduct Annual Statement Blanks (D) Working Group must be very clear on what is to be reported to make the blank most effective. Ms. Ailor said the Working Group recognizes that the term “other health” is very broad, but she said the term is taken from the Financial Annual Statement’s Supplemental Health Care Exhibit. She said definitions may be able to be found in the Financial Annual Statement instructions. She said the ACLI and AHIP will be invited to participate in the development of the blank.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Oct. 31, 2019. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Melissa Grisham (AR); Maria Ailor (AZ); Don McKinley (CA); Damian Hughes (CO); Kurt Swan (CT); Robin David (DE); Scott Woods (FL); Tate Flott (KS); Russell Hamblen (KY); Jeff Zewe (LA); Dawn Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Cynthia Amann and Teresa Kroll (MO); Reva Vandevoorde (NE); Douglas Rees (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Angela Dingus (OH); Landon Hubhart (OK); Gary Jones and Katie Dzurec (PA); Michael Bailes (SC); Julie Fairbanks (VA); and Christina Rouleau (VT). Also participating was: October Nickel (ID).

1. **Adopted its Aug. 27 Minutes**

The Working Group met Aug. 27 and took the following action: 1) adopted its Summer National Meeting Minutes; 2) adopted the Disability Insurance Market Conduct Annual Statement (MCAS) scorecard ratios; and 3) agreed to post 2018 national Health MCAS ratios. Ms. Dingus made a motion, seconded by Ms. Amann, to adopt the Working Group’s Aug. 27 minutes (Attachment Six-A1a). The motion passed unanimously.

2. **Heard an Update on the STLD Medical Data Call Template**

Ms. Rebholz said the call letters were sent to all companies licensed in the 40 participating jurisdictions. She said the due date for responses is Dec. 13 and there will be no opportunity to submit data through the Regulatory Data Collection (RDC) tool after that date. Any late submissions allowed by any of the participating jurisdictions will have to be submitted outside of the tool directly to the jurisdiction, and they will not be in the aggregated totals. Ms. Rebholz said an NAIC web page has been set up for the Short-Term Limited Duration (STLD) data call with the RDC tool, the data call, instructions, a Frequently Asked Questions (FAQ), and other assistance for companies. She said the RDC only provides form and format validations. Data quality and accuracy will need to be determined by each jurisdiction.

Ms. Rebholz said the NAIC will compile a list of all companies receiving the call. The list will include whether the company indicated on their Accident and Health Policy Experience Exhibit that it collected premium for Short-Term Medical products and whether the company filed any STLD products in the System for Electronic Rate and Form Filing (SERFF). Companies that do not have any STLD products to report are being instructed to send an email to the NAIC stating that they have no data to report. Ms. Rebholz said after Dec. 13, the participating jurisdiction will be provided lists of companies that provided no response. The participating jurisdictions will follow up with the companies.

3. **Discussed an Analysis of LPI MCAS Data**

Mr. Haworth said the first submission of Lender-Placed Insurance (LPI) was received earlier in the year. He said comments were received from Tom Keepers (Consumer Credit Industry Association—CCIA) about reporting concerns for Blanket Vehicle Single Interest (VSI) insurance.

Mr. Keepers said Blanket VSI provides protection only for the lender’s financial interest. A commercial insurance policy is issued to the lender that covers all eligible property. Mr. Keepers said no certificates are issued to individuals. He said the MCAS blank has 17 underwriting data elements requesting certificate information for the Blanket VSI business which companies have answered with “0”’s. He said some participating MCAS states are insisting on responses for these data elements. He wanted to bring this issue to the attention of the Working Group so that analysts would understand why “0”’s are being reported.

Mr. Keepers questioned whether Blanket VSI belongs in the MCAS because it is a commercial product protecting commercial lenders. Mr. Haworth asked what the size of the marketplace is. Mr. Keepers said there are six to 10 insurers writing in the 10’s of millions of dollars in premium. He said it was a very small market.

Birny Birnbaum (Center for Economic Justice—CEJ) agreed with the description of Blanket VSI, but he said all single interest LPI is commercial in that it protects the lender. Blanket VSI is still LPI. He said because there are no certificates or reporting

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on an individual basis, it creates problems for analysts because the companies still report on claims, complaint, canceled policies, and other underwriting and claims information. He said this can skew the ratios in comparison to other LPI coverages. He suggested, however, that blanket VSI does not need to be excluded in the MCAS, but it could be broken out into a separate coverage. He recommended a special data call on blanket VSI and then creation of the separate MCAS blank. Ms. Ailor agreed and said the issue should be referred to the Market Conduct Annual Statement (D) Working Group for consideration. She recommended that companies use the comments to explain their data if they expect that their data will create questions.

4. **Discussed the Uniform Process for Addressing MCAS Extension Requests**

Ms. Rebholz said the best way to address how to consistently handle extension requests is to review and update the *MCAS Best Practices Guide* developed by the Working Group in 2014. She asked for volunteers to review and update the *MCAS Best Practices Guide*. Mr. Haworth volunteered and asked other volunteers to contact Randy Helder (NAIC).

5. **Discussed the Reporting of Phantom Claims in the MCAS**

Mr. Haworth said there seemed to be no concerns by any of the members about the reporting of phantom claims, and he said he would take this item off the agenda for the next meeting.

6. **Discussed the Inclusion of Fraternals in the MCAS**

Mr. Haworth said several states have expressed opposition to adding fraternals to the MCAS because they operate differently in different states. Additionally, he said many of the fraternals are small companies. Ms. Vandevoorde said Nebraska strongly opposes adding fraternals to the MCAS. Ms. Huisken said that while many fraternals are small, there are a number of large fraternals for which MCAS data would be helpful. She said small fraternals could be eliminated by the premium threshold for reporting. Mr. Birnbaum agreed with Ms. Huisken and noted that reporting from large fraternals should not be excluded just to protect small fraternals.

Mr. Haworth said there is no proposal one way or the other concerning the inclusion of fraternals. He solicited a proposal before considering this further.

7. **Discussed Adding “Other Health” as a Line of Business in the MCAS**

Mr. Haworth said the discussion to add “other health” as a line of business in the MCAS is being considered in order to collect market data regarding medical plans that are not required to be compliant with the federal Affordable Care Act (ACA).

Ms. Ailor supported adding the “other health” line of business to the MCAS. She noted that the line of business was never disapproved by the Working Group, but only put on hold. She said the STLD data call will provide some necessary data for analysts, but work should begin on the “other health” line of business. Ms. Nickel and Ms. Rebholz also supported adding the “other health” line of business.

Ms. Ailor said now that the STLD template has been developed and the first collection of data will occur soon, the STLD data call can be used as a pilot for the development of an “other health” line of business blank for the MCAS. Ms. Rebholz and Mr. Pyle said they support including “other health” in the MCAS.

Mr. Haworth said the Working Group would accept comments until Nov. 15 and consider adoption of “other health” as the next line of business in the MCAS during the Working Group’s next meeting.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

© 2019 National Association of Insurance Commissioners
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Oct. 31, 2019. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Melissa Grisham (AR); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Robin David (DE); Scott Woods (FL); Tate Flott (KS); Russell Hamblen (KY); Jeff Zewe (LA); Dawn Kokosinski (MD); Timothy Schott (ME); Jill Huiskens (MI); Cynthia Amann and Teresa Kroll (MO); Reva Vandevooerde (NE); Douglas Rees (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Angela Dingus (OH); Landon Hubbart (OK); Gary Jones and Katie Dzurec (PA); Michael Bailes (SC); Julie Fairbanks (VA); and Christina Rouleau (VT). Also participating was: October Nickel (ID).

1. **Adopted its Aug. 27 Minutes**

The Working Group met Aug. 27 and took the following action: 1) adopted its Summer National Meeting Minutes; 2) adopted the Disability Insurance Market Conduct Annual Statement (MCAS) scorecard ratios; and 3) agreed to post 2018 national Health MCAS ratios. Ms. Dingus made a motion, seconded by Ms. Amann, to adopt the Working Group’s Aug. 27 minutes (Attachment Six-A1a). The motion passed unanimously.

2. **Heard an Update on the STLD Medical Data Call Template**

Ms. Rebholz said the call letters were sent to all companies licensed in the 40 participating jurisdictions. She said the due date for responses is Dec. 13 and there will be no opportunity to submit data through the Regulatory Data Collection (RDC) tool after that date. Any late submissions allowed by any of the participating jurisdictions will have to be submitted outside of the tool directly to the jurisdiction, and they will not be in the aggregated totals. Ms. Rebholz said an NAIC web page has been set up for the Short-Term Limited Duration (STLD) data call with the RDC tool, the data call, instructions, a Frequently Asked Questions (FAQ), and other assistance for companies. She said the RDC only provides form and format validations. Data quality and accuracy will need to be determined by each jurisdiction.

Ms. Rebholz said the NAIC will compile a list of all companies receiving the call. The list will include whether the company indicated on their Accident and Health Policy Experience Exhibit that it collected premium for Short-Term Medical products and whether the company filed any STLD products in the System for Electronic Rate and Form Filing (SERFF). Companies that do not have any STLD products to report are being instructed to send an email to the NAIC stating that they have no data to report. Ms. Rebholz said after Dec. 13, the participating jurisdiction will be provided lists of companies that provided no response. The participating jurisdictions will follow up with the companies.

3. **Discussed an Analysis of LPI MCAS Data**

Mr. Haworth said the first submission of Lender-Placed Insurance (LPI) was received earlier in the year. He said comments were received from Tom Keepers (Consumer Credit Industry Association—CCIA) about reporting concerns for Blanket Vehicle Single Interest (VSI) insurance.

Mr. Keepers said Blanket VSI provides protection only for the lender’s financial interest. A commercial insurance policy is issued to the lender that covers all eligible property. Mr. Keepers said no certificates are issued to individuals. He said the MCAS blank has 17 underwriting data elements requesting certificate information for the Blanket VSI business which companies have answered with “0”s. He said some participating MCAS states are insisting on responses for these data elements. He wanted to bring this issue to the attention of the Working Group so that analysts would understand why “0”s are being reported.

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4. Discussed the Uniform Process for Addressing MCAS Extension Requests

Ms. Rebholz said the best way to address how to consistently handle extension requests is to review and update the MCAS Best Practices Guide developed by the Working Group in 2014. She asked for volunteers to review and update the MCAS Best Practices Guide. Mr. Haworth volunteered and asked other volunteers to contact Randy Helder (NAIC).

5. Discussed the Reporting of Phantom Claims in the MCAS

Mr. Haworth said there seemed to be no concerns by any of the members about the reporting of phantom claims, and he said he would take this item off the agenda for the next meeting.

6. Discussed the Inclusion of Fraternals in the MCAS

Mr. Haworth said several states have expressed opposition to adding fraternals to the MCAS because they operate differently in different states. Additionally, he said many of the fraternals are small companies. Ms. Vandevenorde said Nebraska strongly opposes adding fraternals to the MCAS. Ms. Huisken said that while many fraternals are small, there are a number of large fraternals for which MCAS data would be helpful. She said small fraternals could be eliminated by the premium threshold for reporting. Mr. Birnbaum agreed with Ms. Huisken and noted that reporting from large fraternals should not be excluded just to protect small fraternals.

Mr. Haworth said there is no proposal one way or the other concerning the inclusion of fraternals. He solicited a proposal before considering this further.

7. Discussed Adding “Other Health” as a Line of Business in the MCAS

Mr. Haworth said the discussion to add “other health” as a line of business in the MCAS is being considered in order to collect market data regarding medical plans that are not required to be compliant with the federal Affordable Care Act (ACA).

Ms. Ailor supported adding the “other health” line of business to the MCAS. She noted that the line of business was never disapproved by the Working Group, but only put on hold. She said the STLD data call will provide some necessary data for analysts, but work should begin on the “other health” line of business. Ms. Nickel and Ms. Rebholz also supported adding the “other health” line of business.

Ms. Ailor said now that the STLD template has been developed and the first collection of data will occur soon, the STLD data call can be used as a pilot for the development of an “other health” line of business blank for the MCAS. Ms. Rebholz and Mr. Pyle said they support including “other health” in the MCAS.

Mr. Haworth said the Working Group would accept comments until Nov. 15 and consider adoption of “other health” as the next line of business in the MCAS during the Working Group’s next meeting.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
Market Analysis Procedures (D) Working Group
Conference Call
August 27, 2019

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Aug. 27, 2019. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Melissa Grisham (AR); Maria Ailor and Cheryl Hawley (AZ); Pam O’Connell (CA); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Frank Pyle (DE); Pamela Lovell (FL); Susan Lamb and Matthew Ryan (IL); Tate Flott (KS); Russell Hamblen (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Raymond Guzman (MD); Timothy Schott (ME); Paul Hanson (MN); Cynthia Amann and Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandevooorde (NE); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Sylvia Lawson (NY); Angela Dingus (OH); Joel Sander (OK); Jeffrey Arnold (PA); Michael Bailes (SC); Julie Fairbanks (VA); and Theresa Miller (WV).

1. Adopted its Summer National Meeting Minutes

Ms. Amann made a motion, seconded by Mr. Hanson, to adopt the Working Group’s Aug. 4 minutes (see NAIC Proceedings – Summer 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Three). The motion passed unanimously.

2. Heard an Update on the STLD Medical Data Call Template

Ms. Rebholz said the confidentiality agreement was sent to the participating states on Aug. 15, and responses have been received from around 25 jurisdictions. Randy Helder (NAIC) said the confidentiality agreement indicated the data call would cover the period of September 2018 to March 2019. Because it was decided to possibly conduct the short-term, limited duration (STLD) data call multiple times, the NAIC Legal Department will send an email to the participating states asking for their agreement to leave the data call period open and not limited to just the September 2018 to March 2019 period. Mr. Helder also said the date the Regulatory Data Collection (RDC) tool will be ready was pushed to Oct. 1.

3. Adopted Disability Insurance MCAS Proposed Scorecard Ratios

Mr. Haworth said that during the Summer National Meeting, he asked for technical comments regarding the proposed disability insurance Market Conduct Annual Statement (MCAS) scorecard ratios. He said comments were received from the American Council of Life Insurers (ACLI), America’s Health Insurance Plans (AHIP) and the Center for Economic Justice (CEJ).

Michael Lovendusky (ACLI) said his comments concerned ambiguities in the definitions of paid and denied claims within the definitions of the MCAS blank, as well as technical comments on six of the ratios. Mr. Haworth told Mr. Lovendusky to limit with comments to the ratios because data element and definitional matters belong to the Market Conduct Annual Statement Blanks (D) Working Group.

Mr. Lovendusky said ratio 1, “Percentage of claims denied,” would be improved by making the denominator the sum of claims denied and new paid claim determinations. He said ratio 6, “The number of complaints relating to group policies to the average number of group policies in force during the reporting period,” could produce false positives because the denominator is the average number of policies, but the number of members in group policies can vary substantially from company to company. He also noted that ratio 4, ratio 5 and ratio 6 refer to “complaints from consumers” but should read “complaints from insureds.”

Mr. Lovendusky said ratio 7, “The percentage of lawsuits closed with consideration for the consumer,” does not actually measure any wrong-doing or fault on the part of the insurer because some litigation results in good-will settlements by the insurer. He also cautioned that it could be exploited by the plaintiff bar. He was also unsure if the impact of class action lawsuits were considered. Mr. Arnold said he would like a better understanding of the ratio. Mr. Haworth said class action lawsuits were considered and noted this was just one data point that needed to be reviewed in addition to the raw data. Mr. Birnbaum said the definition of a lawsuit closed with consideration to the consumer states that the settlement has to be larger than the last offer of the company before the lawsuit was brought. A company with a higher ratio may be making offers that more often compel litigation. He noted that if a data element is adopted, the assumption is it has value to market analysts.

Mr. Lovendusky said the titles of ratio 8, “Non-renewals and cancellations to average policies in-force,” and ratio 9, “Covered lives affected by non-renewals to average policies in-force,” should specify that the cancellations and non-renewals are by the
insurer, not the insured. He said ratio 9 has the same confusion as ratio 6 in that the number of members in a group can vary significantly. Mr. Lovendusky said the purpose of ratio 10, "Average pending benefit determinations to claims received," was unclear. He said if claims are handled appropriately by being processed within the standards set for timely claim handling, then there is no significance to average pending determinations.

Mr. Birnbaum said the disability insurance blank was adopted one year ago and will collect 2019 data year experience. The only issue to be considered now is the scorecard ratios. He said the ratios have no effect on the actual data elements or their definitions. He said the ratios can be revised, added to or removed once they are tested with live data.

Ms. Ailor made a motion, seconded by Ms. Amann, to revise ratio 4, ratio 5 and ratio 6 to change the word “consumer” to the actual terminology in the blank, “any entity other than the DOI,” and to clarify the titles of ratio 8 and ratio 9 to make it clear they refer to insurer non-renewals and cancellations. The motion passed unanimously.

Ms. Ailor made a motion, seconded by Ms. Amann, to adopt the proposed disability insurance MCAS scorecard ratios. The motion passed unanimously.

4. Agreed to Post a 2018 National Health MCAS Scorecard

Mr. Haworth said that for the 2017 data year, it was decided that the public health MCAS scorecards would not be posted. He said there was a concern of having only one or two companies writing health business within a jurisdiction. He said that at the Summer National Meeting, it was agreed again not to post the state by state scorecards for the 2018 data year. He said a proposal was made to post a single national scorecard instead.

Mr. Zewe noted there were no comments in opposition to a national scorecard.

Demetria Tittle (Blue Cross and Blue Shield Association—BCBSA) said since the national scorecard was only introduced at the last meeting, it would be helpful for all state insurance regulators and interested parties to see it prior to posting it as the 2018 health scorecard. Mr. Haworth noted that whether it was publicly exposed as a working document or if it was posted as the scorecard, it would be publicly viewable. Joseph Zolecki (BCBSA) said there was some confusion regarding how the scorecard ratios would be calculated. Mr. Helder explained that for each numerator and denominator, the total of all reported data by all companies would be calculated regardless of which state or states it was reported to. It will not be an average. Mr. Zolecki asked that the statement regarding the methodology employed be included on the scorecard.

Mr. Zewe made a motion, seconded by Ms. Amann, to post a 2018 data year national health MCAS scorecard. The motion passed unanimously. Mr. Haworth said a statement regarding the methodology for the calculation will be included.

5. Discussed Uniform Process for Addressing MCAS Extension Requests

Ms. Rebholz said there was interest by the Working Group for a uniform process and what would and would not be in that process. She said, for example, that many states are not interested in fines, but many states do want a template letter that can be sent if a company meets a trigger, such as two or three consecutive years of requesting an extension. She volunteered to draft a process to begin the discussions.

6. Discussed the Reporting of Phantom Claims in the MCAS

Ms. Kroll said she brought this issue up at the Summer National Meeting. She said she understands the property/casualty (P/C) insurers were originally given latitude on the reporting of claims in the MCAS. She said, however, that after 15 years, they should be able to report accurate claims numbers without including claims setup for precautionary reasons only or set up just to address an inquiry of coverage and closed without payment. She suggested the participating MCAS states need to make a firm stand on this issue. Ms. Ailor noted the Market Conduct Annual Statement Blanks (D) Working Group made revisions in 2017 to the P/C MCAS definitions to address claims reported for informational reasons only.

Mr. Haworth asked state insurance regulators to let the Working Group and Ms. Kroll know if they are seeing the same issues.
7. **Discussed Inclusion of Fraternals in the MCAS**

Mr. Haworth said fraternals are currently not required to file an MCAS because the MCAS submission tool is only available to companies that file their financial annual statements on the life, property and health statement types. He said because fraternals used to file their financial statements on a fraternal statement type, they were unable to access the MCAS submission tool. He said beginning with the 2019 data year, fraternals will no longer submit on the fraternal financial statements; instead, they will be reporting on the life, health and P/C financial statements. He noted that this means fraternals could now be required to file an MCAS if the Working Group decides it would be useful to have them submit MCAS filings.

Ms. Vandevoorde said there are only a few fraternals that account for most of the premium generated by fraternals. She said for most fraternals, submitting an MCAS would be a cost burden. She said Nebraska does not support requiring fraternals to report an MCAS. Ms. Rebholz said in Wisconsin, there are not many complaints relating to fraternals. She suggested adding a line to the MCAS that has more issues that need addressing.

Ms. Huisken asked if the consideration was to add an MCAS blank specifically for fraternals or to require fraternals to file on the already established MCAS blanks. Mr. Haworth said the consideration was for fraternals to report on already established MCAS blanks. Ms. Huisken said that was not too much of a burden and that the consumers of products provided by fraternals are subject to the same issues as consumers of products offered by other types of insurance companies. Mr. Arnold said a stand-alone fraternal MCAS blank is not necessary. He said the top six fraternals in Pennsylvania account for 90% of the premium written by fraternals. Mr. Birnbaum said it would be helpful to quantify the cost burden to fraternals for comparison to the qualitative benefits of adding fraternals.

Mr. Haworth noted that fraternals are regulated differently from other companies in Washington. He said the Working Group would continue the discussion.

8. **Discussed Adding “Other Health” as a Line of Business in MCAS**

Mr. Haworth said the discussion to add “other health” as a line of business in MCAS was tabled last year while the Working Group developed the STLD data call. He said interest was expressed in reopening the discussion of adding “other health” to the MCAS. Ms. Ailor said that now that the STLD template has been developed and the first collection of data will occur soon, the STLD data call can be used as a pilot for the development of an “other health” line of business blank for the MCAS. Ms. Rebholz and Mr. Pyle said they support including “other health” in the MCAS.

Mr. Haworth said this agenda item will remain on the Working Group agenda.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Nov. 21, 2019. The following Working Group members participated: Maria Ailor, Chair (AZ); Angela Dingus, Vice Chair (OH); Melissa Grisham (AR); Kurt Swan (CT); Scott Woods (FL); October Nickel (ID); Lori Cunningham (KY); Teresa Fischer (MN); Teresa Kroll and Cynthia Amann (MO); Katie Dzurec (PA); Ned Gaines and John Haworth (WA); Jo LeDuc (WI); and Letha Tate (WV). Also participating were: Laura Arp and Martin Swanson (NE).

1. **Adopted its Oct. 23 Minutes**

The Working Group met Oct. 23 and took the following action: 1) adopted its May 2 minutes; 2) heard an update on the Life and Annuity Market Conduct Annual Statement (MCAS) Data Element Review Project; 3) heard an update on the Other MCAS Lines of Business Data Element Review Project; and 4) heard an update on the health MCAS industry questions meetings.

Ms. Dingus made a motion, seconded by Mr. Haworth to adopt the Working Group’s Oct. 23 minutes (Attachment Seven - A). The motion passed.

2. **Agreed to Change MCAS Due Dates Occurring on Weekends and Federal Holidays**

Ms. Ailor advised concerns were expressed to the Working Group related to when an MCAS due date falls on the weekend. It was asked if the due date could be moved to a weekday. The Working Group discussed this concern and agreed that if the due date falls on a weekend or a federal holiday, the due date will be moved to the next business day.

3. **Extended the Health MCAS Filing Deadline for 2020, 2021 and 2022**

Ms. Ailor advised a letter was received requesting the health MCAS filing due date be permanently changed from April 30 to June 30. The letter is attached to the minutes for reference (Attachment ___-B).

Joseph Zolecki (Blue Cross and Blue Shield Association—BCBSA) provided the Working Group with a summary of the request. He went through the points outlined in the letter and explained that one of the concerns health carriers have with an April 30 filing deadline instead of a June 30 deadline is that certain health MCAS data may not be complete or entirely reliable due to the numerous health claim adjustments that occur in the beginning of the year and the year-end claim submissions in the first and second quarters. He advised that based on carrier experiences in the first two years of health MCAS filings, a June 30 filing date will allow for adequate time to pull and process this information and will result in more accurate and useful health MCAS filings. He advised the amount of external data required for health MCAS reporting compared to the life and property/casualty MCAS reporting is disproportionate, yet the filing dates are similar. He explained there is not currently an automated way to compile the data into the health MCAS because health data is received from so many different sources, and, as a result, health carriers are required to manually compile the data. He advised it would likely be several years before full automation is possible, noting that a June 30 filing date should minimize and/or eliminate extension requests. He stated that unless there are extraordinary circumstances, June 30 would be the firm due date.

Prior to requesting comments and/or questions from the Working Group, Ms. Ailor explained that any decision by the Working Group to amend the due date would need to be considered and approved by the Market Regulation and Consumer Affairs (D) Committee at the Fall National Meeting.

Ms. Nickel expressed concern with getting corrections from health carriers made within the next data year for Idaho. She said Idaho has a small department and a small market conduct section. She explained that getting all carriers and lines of business together at once to evaluate the MCAS data in a consistent manner and have enough time to analyze those carriers and provide companies with letters and/or contact information when irregularities/outliers are seen is already going into the next year. Then, after adding in time for responses and re-evaluations, many times the next data year is already underway. To review if there are violations going on, the department would like to cure that as soon as possible.
Mr. Gaines said Washington has the same issue as Idaho, noting that the department is required to review all domestic companies. Most of the domestic companies that must report happen to be health carriers, and, with a June 30 date, the department cannot even start reviews until August at the earliest, which puts staff in a bind to get everything completed by the end of the year. If reviewing data at the end of the year, it makes it difficult to go back to the carrier and try to get any corrections, as so much time has passed and the carrier is already looking at submitting new data for the next year.

Ms. Dingus advised she understands the issues with companies trying to get data and she is not opposed to extending the deadline but not on a permanent basis. She advised a period of three years would be acceptable, with the understanding the due date would be reevaluated.

Mr. Haworth asked for clarification on what would be considered extraordinary circumstances. He advised that Washington often gets requests for extension the day of or day before the due date, claiming the carrier was unable to get data from a third-party vendor and wants to know if this would qualify.

Ms. Dingus added the example of carriers requesting extensions because the person who was handling the data left the company and did not think this should qualify as an extraordinary circumstance.

Ms. Arp said she believes three years is fair, with the understanding that this due date will be reevaluated in three years.

Mr. Swanson said he envisions that an extraordinary circumstance would be a fire or an “Act of God,” not a staffing issue. Ms. Arp said changes in personnel should be excluded.

Ms. Nickel suggested a May 30 deadline, explaining the Working Group cannot really define “extraordinary” and, if an extension is requested, trying to qualify “extraordinary” could become problematic.

Ms. Ailor asked Mr. Zolecki what he considers to be “extraordinary,” and he agreed it would not be a change of personnel. He asked if he could go back to the carriers and send some examples for consideration, but said he agrees something like an Act of God is a reasonable parameter.

Mr. Birnbaum (Center for Economic Justice—CEJ) asked that the deadline be kept at April 30 and enforced because the purpose is not to be aligned with other reporting dates, but to provide data to regulators in a timely fashion. He advised that routine reporting requirements enables insurers to develop procedures for timely reporting. He advised the annual financial statement is far more complex than the health MCAS and insurers are able to report just two months following the end of the experience period, as insurers have developed the tools and resources to meet this reporting deadline despite the complexity, noting that regulators have confirmed the importance of this data for regulatory purposes.

Ms. Ailor expressed her understanding of the concerns presented from all parties and advised she supports extending the deadline to June 30 or May 30 with a reevaluation date in the future, such as three years as previously discussed. She asked how the Working Group would like to move forward with this request.

Ms. Dingus made a motion, seconded by Ms. Dzurec, to extend the health MCAS deadline to June 30 for three reporting periods of 2020, 2021 and 2022, to be reevaluated in 2022, only if companies request the reevaluation. If companies do not request reevaluation of the due date in 2022, the due date will roll back to April 30. The motion passed.

Tressa Smith (NAIC) confirmed with the Working Group that this motion is for the 2019 data to be reported in 2020, the 2020 data to be reported in 2021, and the 2021 data to be reported in 2022.

4. Discussed Other Matters

Ms. Amann advised that regarding the life MCAS, there was not enough desire from the small group to expand the life and annuity MCAS due to time and staff limitations. Mr. Haworth advised the State Ahead initiative is taking a lot of NAIC resources and adding extra data fields may not be feasible at this time.

Teresa Cooper (NAIC) advised that while the State Ahead initiative is taking a lot of resources, the Working Group should not let that be a factor in this decision and to make changes as needed.
Mr. Birnbaum asked who the members of the small group are, noting that such information is not readily available. He then asked if the NAIC was specifically asked if this request would be a burden or conflict with the *State Ahead* initiative, and Ms. Amann confirmed the NAIC was not asked that question.

Mr. Birnbaum then asked for clarification on why this would be difficult for regulators. Ms. Amann advised the difficulty is collecting data they are not able to analyze because they either do not have the time or they have limitations on the data being accurate. Mr. Birnbaum then asked that a more robust report be provided from the small group and that a discussion take place about it.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call October 23, 2019. The following Working Group members participated: Maria Ailor, Chair (AZ); Angela Dingus, Vice Chair (OH); Melissa Grisham (AR); Kurt Swan represented by Steve DeAngelis (CT); Scott Woods (FL); Paul Hanson (MN); Teresa Kroll and Cynthia Amann (MO); Michael Bailes (SC); Ned Gaines and John Haworth (WA); Jo LeDuc (WI); and Letha Tate (WV).

1. **Adopted its May 2 Minutes**

The Working Group met May 2 and took the following action: 1) adopted its March 28 minutes; 2) adopted the Private Flood Market Conduct Annual Statement (MCAS) Data Call and Definitions; 3) adopted items from its Jan. 23–24 meeting; and 4) made a motion to add a Health MCAS blank for the “number of member months for policies terminated during the period.” This motion passed unanimously (see NAIC Proceedings, Summer 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Four). If adopted, it will be added to the 2020 health MCAS blank, which would be reported in 2021.

2. **Heard an Update on the Life and Annuity MCAS Data Element Review Project**

Ms. Amann said there was a previous survey generated regarding product category expansion/modification for Life and Annuity data elements. The smaller review group is currently reviewing the comments and survey responses, and it will provide a written update to the Working Group by the end of the month.

Birny Birnbaum (Center for Economic Justice—CEJ) said he recently submitted supplemental survey comments referring to changes in the Statutory Annual Statement. The changes to the Statutory Annual Statement provide for the recording of more categories, so he suggested that the Working Group consider tracking these changes since they break Life and Annuity into more product categories. The comments he submitted will be reviewed.

Michael Lovendusky (American Council of Life Insurers—ACLI) asked that Ms. Amann include him on the distribution list for the written update on this subject matter, and she confirmed that she would. He asked when the 2019 MCAS User Guide would be posted since Disability Income is being reported for the first time, and Teresa Cooper (NAIC) said it should be posted by the end of the month.

3. **Heard an Update on the Other MCAS Lines of Business Data Element Review Project**

Ms. Ailor said the Working Group needs to review the other lines of business for MCAS. She suggested that a survey be sent out to see if there is any interest in updating or changing data elements for Homeowners and Private Passenger Auto to begin the reviews for other lines of business. The survey would be similar to the one generated for the pending Life and Annuity data element review. Depending on the results of the survey, subject matter expert (SME) groups can be formed to review the data elements.

4. **Heard an Update on the Health MCAS Industry Questions Meetings**

Ms. Ailor said letters were received yesterday from Health Insurance Industry Interested Parties regarding the MCAS submission process and filing deadline. A Working Group meeting is being arranged for Nov. 21 to further discuss these details after Working Group members have had an opportunity to review these letters which will soon be generated with the meeting notice.

Joseph E. Zolecki (Blue Cross Blue Shield Association—BCBSA) asked if there would be time to get this reviewed before the Market Regulation and Consumer Affairs (D) Committee meets in December. Ms. Cooper explained that system changes related to validations and attestations do not have to go through the Working Group. Ms. Ailor explained that, if needed, there may need to be separate handling of these matters between scheduled meetings.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Nov. 20, 2019. The following Working Group members participated: Bruce R. Ramge, Chair, Martin Swanson and Reva Vandevoorde (NE); Russell Hamblen, Vice Chair (KY); Melissa Grisham and Mel Heaps (AR); Damion Hughes (CO); Kurt Swan (CT); Frank Pyle (DE); Sarah Crittenden (GA); Lindsay Bates and Kim Cross (IA); Mary Lou Moran (MA); Jill Huiskens and Gloria Mason (MI); Cynthia Amann, Stewart Frelich and Win Nickens (MO); Edwin Pugsley (NH); Ralph Boeckman (NJ); Sylvia Lawson (NY); Rodney Beetch and Angela Dingus (OH); Landon Hubbart and Joel Sander (OK); Scott Martin (OR); Katie Dzurec and Christopher Monahan (PA); Julie Fairbanks and Yolanda Tennyson (VA); Marcia Violette (VT); John Haworth and Jeanette Plitt (WA); Barbara Belling, Sue Ezalarab, Darcy Paskey, Rebecca Rebholz and Mary Kay Rodriguez (WI); and Desiree Mauller (WV).

1. **Adopted its Oct. 9 Minutes**

The Working Group met Oct. 9 and took the following action: 1) adopted its Aug. 29 minutes; 2) discussed revisions made to the draft travel insurance examination standards subsequent to comments received in September from Nebraska, the U.S. Travel Insurance Association (USTiA) and the American Property Casualty Insurance Association (APCIA); and 3) adopted the travel insurance-related examination standards for inclusion in the *Market Regulation Handbook* (Handbook).

Mr. Swan made a motion, seconded by Ms. Plitt, to adopt the Working Group’s Oct. 9 minutes (Attachment Eight-A). The motion passed unanimously.


Director Ramge said that a new draft farmowners in force standardized data request (SDR) and a new draft farmowners claims SDR were developed by regulator subject matter experts (SMEs) for the Working Group’s review, discussion and consideration of adoption, for inclusion in the reference documents of the Handbook. The drafts were exposed Oct. 29 for a public comment period ending Dec. 2.

Ms. Vandevoorde said the field name CanTerRs (reason for cancellation/termination of coverage) in the farmowners in force SDR duplicates the data that is obtained by field name CanTer (who cancelled the coverage); Ms. Vandevoorde will submit revised language for the field name CanTerRs, and Petra Wallace (NAIC staff) will circulate a revised draft farmowners in force SDR prior to the Working Group’s next conference call. Director Ramge encouraged state insurance regulators and interested parties to submit comments on the draft SDRs by the comments due date so that the Working Group can discuss the comments during its next conference call, which is scheduled for Dec. 18.

3. **Discussed New Draft Limited LTC Chapter, Oct. 29 Draft, for Inclusion in the Handbook**

Director Ramge said that new draft limited long-term care (LTC) exam standards were developed by regulator SMEs for the Working Group’s review, discussion and consideration of adoption, for inclusion as a new market conduct examination standards chapter in the Handbook. The drafts were exposed Oct. 29 for a public comment period ending Dec. 2.

Ms. Moran said there is language in 1) Marketing and Sales Standard 1 and 2) Standard 1 Appeal of Benefit Trigger Adverse Determination of the draft that may not be relevant. Ms. Moran said that she will provide revisions to these areas and that Ms. Wallace will circulate revised draft standards prior to the Working Group’s next conference call. Director Ramge encouraged state insurance regulators and interested parties to submit comments on the draft standards by the comments due date so that the Working Group can discuss the comments during its Dec. 18 conference call.

4. **Discussed Other Matters**

Director Ramge said NAIC staff will provide advance email notice of the Working Group’s Dec. 18 conference call.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.

© 2019 National Association of Insurance Commissioners
The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Oct. 9, 2019. The following Working Group members participated: Bruce R. Ramge, Chair, and Reva Vandevoorde (NE); Russell Hamblen, Vice Chair (KY); Mel Heaps (AR); Maria Ailor (AZ); Damion Hughes (CO); Kurt Swan (CT); Frank Pyle (DE); Sarah Crittenden (GA); Lindsay Bates (IA); Mary Lou Moran (MA); Jill Huisken and Gloria Mason (MI); Paul Hanson (MN); Win Nichols (MO); Ralph Boeckman (NJ); Otis Phillips (NM); Peggy Willard-Ross (NV); Sylvia Lawson (NY); Rodney Beech and Angela Dingus (OH); Kevin Foor, Landon Hubbart, Joel Sander and Shelly Scott (OK); Scott Martin (OR); Gary Jones (PA); Joy Morton and Yolanda Tennyson (VA); Christina Rouleau (VT); Jeanette Plitt (WA); Barbara Belling, Darcy Paskey, Rebecca Rebholz and Mary Kay Rodriguez (WI); and Desiree Mauller (WV).

1. **Adopted its Aug. 29 Minutes**

The Working Group met Aug. 29 and took the following action: 1) adopted a new workers compensation standardized data request for inclusion in the Market Regulation Handbook (Handbook) reference documents; and 2) continued its discussion of new travel insurance-related examination standards for inclusion in the Handbook.

Ms. Plitt made a motion, seconded by Ms. Dingus, to adopt the Working Group’s Aug. 29 minutes (Attachment Eight-A1). The motion passed unanimously.

2. **Adopted New Travel Insurance-Related Examination Standards for Inclusion in the Handbook**

Director Ramge said the draft travel insurance exam standards were developed by state insurance regulator volunteers Ms. Morton and Rebecca Nichols (VA). The draft was first circulated on May 22, and the Working Group discussed the draft during its May 30, June 18, July 18 and Aug. 29 conference calls. Director Ramge said the draft being discussed during today’s conference call was circulated Oct. 3 and contains revisions made by Ms. Morton and Ms. Nichols after they reviewed the following comments: 1) Sept. 20 comments received from Ms. Vandevoorde; 2) Sept. 27 comments received from John P. Fielding and LeeAnn Goheen (Steptoe & Johnson LLP), on behalf of the U.S. Travel Insurance Association (USTiA); and 3) Sept. 30 comments received from Angela Gleason (American Property Casualty Insurance Association—APCIA). Director Ramge said that the Oct. 3 draft was circulated in a Track Changes version and a Track Changes accepted version. Additionally, a summary of changes made to the document was also provided to the Working Group, interested state insurance regulators and interested parties.

Ms. Morton presented the changes made to the draft. Ms. Vandevoorde said that the first sentence in the first review procedures and criteria paragraph in Marketing and Sales Standard 1 should be replaced with: “Examiners should request a listing of all marketing materials and select a sample according to the jurisdiction’s sampling protocols.”

Ms. Plitt made a motion, seconded by Ms. Lawson, that in Marketing and Sales Standard 1, in the next to last bullet point in the “Materials should…” review procedures and criteria section, the bullet should be changed from “… indicate that the travel protection plan being marketed includes insurance” to “… indicate that the travel protection plan being marketed is insurance.” A voice vote was held, and a majority of the Working Group agreed to the change. Ms. Morton and Ms. Vandevoorde opposed this change.

Mr. Hamblen made a motion, seconded by Mr. Pyle, to adopt the new travel insurance-related examination standards draft, including all revisions made during the conference call, for inclusion in the Handbook. (Attachment XXXXX). The motion passed unanimously.

3. **Discussed Other Matters**

Director Ramge said NAIC staff will provide advance email notice of the Working Group’s next conference call, which is scheduled for Nov. 20.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Aug. 29, 2019. The following Working Group members participated: Bruce R. Ramge, Chair (NE); Russell Hamblen, Vice Chair (KY); Melissa Grisham and Mel Heaps (AR); Sarah Borunda and Maria Ailor (AZ); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Frank Pyle (DE); Sarah Crittenden (GA); Lindsay Bates (IA); Mary Lou Moran (MA); Jill Huisken (MI); Win Nichols (MO); Paul Hanson (MN); Edwin Pugsley and Maureen Belanger (NH); Ralph Boeckman (NJ); Bogdanka Kurahovic and Otis Phillips (NM); Peggy Willard-Ross (NV); Sylvia Lawson (NY); Rodney Beetch and Angela Dingus (OH); Kevin Foor, Landon Hubbart, Joel Sander and Shelly Scott (OK); Scott Martin (OR); Christopher Monahan (PA); Joy Morton, Rebecca Nichols and Yolanda Tennyson (VA); Christina Rouleau (VT); Jeanette Plitt (WA); Barbara Belling, Darcy Paskey, Diane Dambach and Rebecca Rebholz (WI); and Desiree Mauller (WV).

1. **Discussed New Travel Insurance-Related Examination Standards for Inclusion in the Handbook**

Director Ramge said Ms. Nichols and Ms. Morton developed draft travel insurance-related examination standards and a high-level summary of the draft standards for the Working Group’s review and discussion, based on the Travel Insurance Model Act (#632) and to be incorporated into the Market Regulation Handbook (Handbook). He said the draft examination standards were exposed May 22 for a public comment period ending June 24, and the comment period was subsequently extended to July 10 and then to Aug. 15.

Ms. Morton said that a revised draft was circulated Aug. 26 for the conference call, and the draft included revisions she and Ms. Nichols made in response to comments received in July from John P. Fielding (Steptoe & Johnson LLP), on behalf of the U.S. Travel Insurance Association (UStiA) and Angela Gleason (American Property Casualty Insurance Association—APCIA).

Ms. Morton presented the redlined changes made to the draft. Ms. Plitt suggested that in Marketing and Sales Exam Standard 1 in the sentence “Indicate that the travel protection plan being marketed is insurance,” that “is” be changed to “can include.” Ms. Gleason and Mr. Fielding said that they would both be submitting additional comments on the draft.

Director Ramge extended the comment due date to Oct. 2, and Ms. Gleason and Mr. Fielding said that they would both be submitting additional comments on the draft by that date. Director Ramge asked for comments by Oct. 2 so Ms. Nichols and Ms. Morton can review any comments received and provide a revised draft for discussion during the next Working Group conference call, which is scheduled for Oct. 9. Director Ramge said NAIC staff will provide advance email notice of the conference call.

2. **Adopted a New Workers’ Compensation Standardized Data Request for Inclusion in the Reference Documents of the Handbook**

Director Ramge said the new workers’ compensation in force standardized data request, which was circulated July 15 and discussed during the Working Group’s July 18 and Aug. 29 conference calls, was developed by state insurance regulator subject matter experts (SMEs) for the Working Group’s review, discussion and consideration of adoption.

Mr. Hamblen made a motion, seconded by Ms. Nichols, to adopt the new workers’ compensation standardized data request. The motion passed unanimously.

3. **Discussed Other Matters**

Director Ramge welcomed Oregon’s new representatives, TK Keen and Mr. Martin, to the Working Group.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Nov. 20, 2019. The following Working Group members participated: John Haworth, Chair (WA); Melissa Grisham (AR); Lindsay Bates (IA); Holly Williams-Lambert (IN); Mary Lou Moran (MA); Jason Decker (MD); Chlora Lindley-Myers and Cynthia Amann (MO); Tracy Biehn (NC); Reva Vandevoorde (NE); Edwin Pugsley (NH); Angela Dingus (OH); Brian Fordham (OR); Christopher Monahan (PA); Rachel Moore (SC); Julie Fairbanks (VA); Christina Rouleau (VT); and Theresa Miller (WV). Also participating were Pam O’Connell (CA); Sarah Crittenden (GA); and Russell Hamblen (KY).

1. Discussed Suggestions of the Certification Pilot Volunteers

Mr. Haworth said the pilot of the Voluntary Market Regulation Certification Program took place during 2017 and 2018 and included 18 states. He noted there have been previous attempts to develop an accreditation program for market regulation that, for a variety of reasons, never got off the ground. He said because the insurance industry is growing and changes are happening faster with the advent of new tools leveraging big data, there is an obvious benefit to a certification program so states can rely on the market regulation efforts of other states.

Mr. Haworth said the certification program is written broadly and maintaining flexibility for each state’s specific needs. Each state has its own authorities for the protection of its consumers. He said the certification program recognizes that domestic deference does not work well for market conduct regulation. Additionally, he said the market certification program is designed to be independent of the financial accreditation.

Mr. Haworth said that based on their experiences with attempting to comply with the requirements of the program, the volunteer states revised the certification program. He said the most obvious change is the reorganization of the program document to combine the requirements, guidelines and checklists by requirement such that for each requirement, the guidelines and checklists are immediately below the description of the requirement.

Mr. Haworth said the certification program is divided into 12 requirements that fall into the five general categories of: 1) the statutory authority for the department to conduct market regulation; 2) use of the NAIC Market Regulation Handbook; 3) staffing; 4) timely, accurate and complete use of shared market information systems; and 5) collaboration.

Mr. Haworth reviewed the suggested revisions to the 12 requirements, guidelines and checklists. Ms. O’Connell asked if there would be time allowed for state insurance regulators and interested parties to review and comment. Mr. Haworth asked that comments be sent to Randy Helder (NAIC) by Dec. 18. Ms. Crittenden asked whether the comments should be in the form of redlines to the current certification program document or simply reference the document. Mr. Haworth asked that comments not be made as redline in order to maintain version control.

Mr. Hamblen asked if the goal is to turn the program into a mandatory program or keep it voluntary. Mr. Haworth said there is no intent to make the program mandatory. He noted that the financial accreditation program is also voluntary, but the states recognize the value of being accredited.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Austin, TX, Dec. 8, 2019. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (OK); Theodore J. Patton (MN); Kendall Cotton (MT); Bob Harkins (NE); and Don Beatty (VA). Also participating were Ryan James and Suzanne Tipton (AR); Peg Brown (CO); Angela Dingus (OH); Brian Fordham (OR); Travis Jordan (SD); and Tracy Klausmeier (UT).

1. **Heard Opening Remarks**

Ms. Amann said this is the first meeting of the Working Group, as it was appointed by the Market Regulation and Consumer Affairs (D) Committee during its Oct. 1 conference call. She said the Working Group is in the process of building its membership, as well as forming distribution lists for interested regulators and interested parties. Ms. Amann asked those interested in joining the Working Group or being added to a distribution list to contact Lois Alexander (NAIC).

2. **Heard a Presentation from NAIC Staff on Model #670, Model #672, GDPR, CCPA and State Data Privacy Legislation Chart**

Ms. Amann said Jennifer McAdam (NAIC) would be providing an overview of the *Insurance Information and Privacy Protection Model Act* (#670), the *Privacy of Consumer Financial and Health Information Regulation* (#672), the European Union’s (EU) General Data Protection Regulation (GDPR), the California Consumer Privacy Act (CCPA) and the research chart of State Data Privacy Legislation prepared by NAIC Legal Division staff.

Ms. McAdam said she would be discussing what is currently happening at the state level with data privacy laws, but she would like to first give a quick overview of the NAIC model laws already in existence that address consumer privacy. She clarified that data privacy is related to how data is collected and used by businesses; data security is related to how data is stored and protected.

Ms. McAdam said she brought this up because the two are often conflated and—to make things more confusing—there are some laws that address both, like the GDPR, for example. She said an example of a data privacy law would be the CCPA. Ms. McAdam said this law governs how businesses collect and use consumer data; the rights consumers have so they know how that data is being used; the consumer’s right to challenge the accuracy of the data; and, if is being used, how it is being used. As such, these laws are focused on consumer protection and consumer rights.

She said an example of a data security law would be the *Insurance Data Security Law* (#668), which governs how businesses protect the data once it has been collected and what the businesses need to do in the event the company’s protections of that data fail during a data breach or cybersecurity event. Ms. McAdam said these laws are focused on business obligations, although such data security laws can have an impact on consumer protection, as well.

Ms. McAdam said the NAIC has three model laws governing data privacy: 1) The *Health Information Privacy Model Act* (#55); 2) Model #670; and 3) Model #672. She said because historical context is helpful, the first of these was Model #670, which was adopted in 1980. However, Ms. McAdam said the federal Fair Credit Reporting Act (FCRA) was enacted in 1970, and it addresses the fairness, accuracy and privacy of the personal information contained in the files of the consumer reporting agencies. Then, she said the Federal Privacy Act was enacted in 1974, and it governs the collection, maintenance, use and dissemination of personally identifiable information about individuals that is maintained in systems of records by federal agencies. So, Ms. McAdam said the NAIC began drafting Model #670 after the two federal laws were in already in place.

Ms. McAdam said Model #670 sets standards for the collection, use and disclosure of information gathered in connection with insurance transactions; it addresses how information is collected by insurance institutions, agents and insurance support organizations (ISOs). She also said the model balances the need for information by those conducting the business of insurance and the public’s need for fairness. Ms. McAdam said it establishes a regulatory mechanism to enable consumers to ascertain what information is being, or has been, collected about them and to have access to such information so they can verify or
dispute its accuracy. She said it limits the disclosure of information collected in connection with insurance transactions, and it enables insurance applicants and policyholders to find out the reasons for any adverse underwriting decision. Ms. McAdam said the model does this by requiring insurers to provide notice that alerts the individual of the insurer’s information practices and it gives consumers the right to request that an insurer: 1) give access to recorded personal information; 2) disclose the identity of the third parties to whom the insurance disclosed the information; 3) provide the source of the collected information; 4) correct and amend the collected information; 5) amend the personal information; and 6) delete the collected personal information.

Ms. McAdam said the definition of “personal information” is different from that of the protected information found in most of the data security or data breach notification laws. She said those laws tend to specifically enumerate the categories of data that must be protected. Ms. McAdam said in this model “personal information” means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual’s character, habits, avocations, finances, occupation, general reputation, credit, health or any other personal characteristics.

In 1998, following enactment of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the NAIC adopted Model #55, which sets standards to protect health information from unauthorized collection, use and disclosure by requiring carriers to establish procedures for the treatment of all health information. Ms. McAdam said Model #55 requires carriers to: 1) create policies, standards and procedures governing health information; 2) notify consumers of those policies, standards and procedures; 3) establish consumers’ right to access their personal health information (PHI); 4) establish consumers’ right to amend their PHI; 5) provide a list of disclosures of PHI; and 6) obtain authorization for the collection, use or disclosure of PHI (with exceptions).

Following enactment of HIPAA at the federal level, Ms. McAdam said the federal Gramm-Leach-Bliley Act (GLBA) was enacted in 1999. She said GLBA imposes privacy and security standards on financial institutions and directs state insurance commissioners to adopt certain data privacy and data security regulations. She said that is when the NAIC adopted both Model #672 and the Standards for Safeguarding Customer Information Model Regulation (#673). Ms. McAdam said Model #672 is about consumer privacy, and Model #673 is about data security and was used as the basis for drafting Model #668.

Ms. McAdam said this Working Group will be addressing data privacy; it will not be addressing data security. She also said Model #672: 1) requires that insurers provide notice to consumers about its privacy policies and practices; 2) describes the conditions under which a licensee may disclose nonpublic PHI and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and 3) provides methods for individuals to prevent a licensee from disclosing that information (“opt out” for financial info and “opt in” for health information). Ms. McAdam said this model is intended to be enforced via the state’s Unfair Trade Practices Act. She said the provisions governing protection of health information were taken directly from Model #55, as well as the health information privacy regulations promulgated by the U.S. Department of Health and Human Services (HHS) pursuant to HIPAA. Ms. McAdam said the provisions governing the protection of financial information are based on privacy regulations promulgated by federal banking agencies.

Ms. McAdam said the key difference between the treatment of financial information and health information is that insurers must give consumers the right to “opt out” of the disclosure or sharing of their financial information, but insurers must get explicit authorization prior to sharing health information (which is considered “opt in”).

Ms. McAdam said the protected information under Model #672 is “health information” and “personally identifiable financial information.” She said 17 states have adopted Model #670 and every state has adopted a version of Model #672, although 19 states have only adopted the provision regarding financial information and not the provision regarding health information. Ms. McAdam said NAIC guidance on data privacy includes the privacy standard used in market conduct examinations. She said standards 10 through 16 address how companies are to handle data privacy pursuant to Model #670, Model #672, Model #55 and any other data privacy laws to which companies are subject.

Ms. McAdam said there are generally applicable data privacy laws that apply to all businesses; not just to the insurance sector. She said data privacy started getting more attention when the GDPR became effective in May 2018. Ms. McAdam said although it is an EU law, it affects many U.S. companies if they collect data from citizens of the EU over the internet. She said the GDPR requires companies to obtain explicit consent from consumers to collect their data (“opt in”) with an explanation of how the data will be used and it contains standards for safeguarding the data.
Ms. McAdam said California became the first U.S. state to adopt an “omnibus” privacy law, which imposes broad obligations on businesses to provide consumers with transparency and control of their personal data. She said the CCPA was signed into law last summer, was amended last fall and becomes effective in 2020. Ms. McAdam said the CCPA gives consumers the right to request that a business:

- Disclose (a) the categories and specific pieces of personal information collected; (b) categories of sources the information was collected from; (c) the business purpose for collecting the information; and (d) the categories of third parties with whom the information is shared, and the specific pieces of personal information that was shared.
- Delete any personal information.
- Provide the right to opt-out of their information being disclosed to third parties, with separate opt-in requirements for minors.
- Provide the right to not be discriminated against for exercising rights.

Ms. McAdam said the CCPA is enforced by the state attorney general and there is a full exemption for protected health information governed by HIPAA and a partial exemption for information subject to the GLBA--if the information subject to GLBA is breached, the consumer can pursue a private civil action against the company.

Ms. McAdam said some states introduced similar data privacy laws to the CCPA that were generally applicable. She said amendments to the CCPA were introduced during the 2019 legislative session, but none of them specifically affect insurers; the full HIPAA exemption and partial GLBA exemption remain in place.

Ms. McAdam said, in 2019, 24 states had considered some type of data privacy legislation but only three states enacted laws: 1) Illinois, which bans insurers from using genetic testing information to set health or accident rates; 2) Maine, which bans internet providers from selling personal information without consent; and 3) Nevada, which requires businesses to allow consumers to opt out of any sale of their personal information and has exemptions for entities subject to the GLBA and HIPAA.

Ms. McAdam said five states passed bills establishing task forces to study the issue of data privacy by reviewing laws in other states and making recommendations for what would be appropriate privacy standards: Connecticut; Hawaii; Louisiana; North Dakota; and Texas. She said there are some states with legislation still pending and some that will carryover to 2020. For example, in New York, there was a bill pending that would go further than the CCPA and would establish a fiduciary duty for companies to act in the consumer’s best interest regarding their personal information; however, it did not make it out of committee but will be considered in 2020.

Ms. McAdam said a comparison of business obligations and consumer rights related to data privacy under both the CCPA and Model #670 shows the following similarities in those requirements.

<table>
<thead>
<tr>
<th>CCPA</th>
<th>Individual right to request that an insurer:</th>
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<tr>
<td>Disclose the categories and specific pieces of personal information collected</td>
<td>Disclose types of personal information collected</td>
</tr>
<tr>
<td>Disclose categories of sources</td>
<td>Disclose sources of the collected information</td>
</tr>
<tr>
<td>Disclose business purpose for collecting the information</td>
<td>Disclose purpose for collecting the information</td>
</tr>
<tr>
<td>Disclose categories of third parties with whom the information is shared, and specific pieces of personal information shared</td>
<td>Disclose identity of the third parties to whom information is disclosed</td>
</tr>
<tr>
<td>Right to access, correct, delete</td>
<td>Right to access, correct, delete</td>
</tr>
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Ms. McAdam said NAIC Legal Division staff created several legal research charts that were posted to the Privacy Protections (D) Working Group page on the NAIC website. She said one chart lists general state data privacy laws that are applicable to all businesses and are not specific to insurers. She also said the chart lists the entity responsible for enforcing the law; what exemptions there are, if any; whether it is “opt-in” or “opt-out”; and what consumer notice requirements are required.

Ms. McAdam said the Working Group will want to address insurance-specific data privacy issues while making sure that any new requirements work with already-existing laws. She said it will be important to consider the following questions going
forward: 1) what types of data collection, sharing and usage are specific to insurers; 2) what privacy risks affect insurance consumers; 3) where the gaps are in federal and state law; 4) what obligations insurers should have to consumers; and 5) what rights consumers should have to control their personal information.

Ms. Amann said Ms. McAdam will continue to provide any legal assistance the Working Group needs throughout the process. She then asked if any Working Group members had any comments.

Mr. Cotton said he is concerned about the consumer data that insurers already are presenting to Montana in rate filings. He said rate filings have ballooned up to thousands of pages of different data points on consumers. Mr. Cotton said Montana has seen an increased reliance on third-party risk scores that aggregate consumer information in order to make determinations and conclusions about that information. He said insurers have a responsibility to make sure that the third parties used are following state laws and complying with the state’s standards for accuracy and fairness. Besides providing disclosure of those third parties when consumers request it, Mr. Cotton said insurers are required to report how the information was gathered; where it was drawn from (e.g., web traffic, geolocation data, social media, etc.); and why the company thinks it needs to use these particular data points as the possibilities available to insurers are endless.


Ms. Amann said the Working Group will need to stay on track in order to accomplish its charges by the deadline. She said the proposed charges and workplan will be considered for adoption by the Market Regulation and Consumer Affairs (D) Committee during its Dec. 9 meeting (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment XX).

Ms. Amann said this Working Group will work closely with the other working groups in this arena—the Artificial Intelligence (EX) Working Group, the Accelerated Underwriting (A) Working Group, etc.—as each has its unique set of issues that nevertheless require coordination.

4. **Heard Comments from Interested Parties**

   a. **NAMIC**

   Cate Paolino (National Association of Mutual Insurance Companies—NAMIC) urged regulators to consider the impact of California’s law and the likely passage in 2020 of other state laws that may differ dramatically from it. Ms. Paolino asked that regulators analyze and identify any gaps that might need insurance-specific language. She said regulators could then determine the most appropriate vehicle to deliver that solution; i.e., whether to amend existing models or to draft new models.

   Ms. Paolino urged policymakers to consider several important concepts:

   - **Workability** – Allowing for various exemptions for operational and other reasons that acknowledge vital business purposes for insurers to collect, use, and disclose information. For example, she said Article IV of Model #672 was developed to implement the GLBA; it appears instructive on types of operational functions to preserve and facilitate. Ms. Paolino said it may also be useful to review the exceptions imbedded into Section 13 of the 1982 version of Model #672. She said clear and well-crafted provisions accounting for the GLBA and the FCRA would be important in any broader business legislation regulators may see.
   - **Exclusivity** – Avoiding dual regulation so insurers are not simultaneously subject to potentially inconsistent or conflicting interpretations by more than one regulator.
   - **Clarity** – Asking that care be taken to consider how best to dovetail with existing model laws/regulations; consulting other resources and educating legislators on how privacy bill language impacts the insurance industry, including the legal requirements to retain and use certain data, as well as data mandates.
   - **Effective Date** – Allowing advance time (like the two to five years that was afforded under the GDPR) for insurers to be ready for implementation, to avoid having revisions like the CCPA and the GDPR. She also suggested that a roll-out period with different dates for different provisions would be a more measured approach within that time frame to undertake such a significant endeavor.

   b. **APCIA**
Angela Gleason (American Property Casualty Insurance Association—APCIA) agreed with NAMIC’s assessment with regard to the implementation time frame, the initial survey request and the complex array of laws that state legislatures may pass during the December to January time frame that could put insurers in the position of complying with omnibus privacy bills in one state and industry-specific bills in another state. She said it could bring about some difficult compliance issues, which could reduce, rather than enhance, existing consumer protections and generate significant operational challenges. She said state insurance departments could play an important role in these legislative conversations based on their experience with insurance-specific privacy laws that are consistent with regulators’ objectives to protect consumers and ensure insurer solvency.

Ms. Gleason said insurers are scrambling to be ready for the effective date of the CCPA that takes effect Jan. 1, 2020 and gives consumers more ability to control what information is shared about them.

c. ACLI

Kate Kiernan (American Council of Life Insurers—ACLI) said the regulatory environment is evolving. She said existing privacy laws have been on the books since the mid-80s and late 90s with little change, which reflects well on the stability of the insurance regulatory structure. However, she said that advances in technology and changes in the insurance industry have resulted in rendering some of the existing financial services privacy laws as being somewhat outdated.

Ms. Kiernan asked the Working Group to think about how ride- and home-sharing services, such as Uber and Airbnb, have disrupted the livery and hospitality industries. She asked the Working Group to look at the big picture to ensure that the insurance industry does not encounter a complete change of its industry like that which happened in the hospitality and livery industry.

Ms. Kiernan said even though policyholders might welcome stiffer regulation initially, stiffer regulation could unintentionally harm the companies that serve those consumers. She said caution is warranted when considering additional regulation to ensure a level playing field with how all other companies are collecting personal information, so insurance companies are not disadvantaged when compared to the technology sector.

Ms. Kiernan said consistency across states and business types is necessary so insurers will not be required to meet industry-specific privacy rules, while companies like Amazon, Google and the Insure Techs have different rules to meet.

Ms. Kiernan asked the Working Group to consider the following questions:

- How do you envision the current financial services privacy regulatory system meshing with new comprehensive laws such as the CCPA?
- How will financial services companies be able to compete with technology companies with differing rules on the use of personal information?
- How can we provide control and equal protections to all consumers regarding their personal information no matter where they live or with whom they are doing business? In other words, provide consumers with legal transparency and the same level enforceable rights?
- How can we develop a regime that is robust and supports growth and innovation?

Ms. Kiernan said to put these questions another way:

- How do we avoid consumer confusion over this already complex issue?
- How do we avoid the obstruction of the flow of data and impediments to interstate commerce?
- How do we prevent the distortion of competition (tech versus retail versus financial services)?

In conclusion, Ms. Kiernan said technology is transforming both social norms and business capabilities. The internet is universal, and information is global. Consumers and businesses need standards that are coherent, and that provide a common understanding of privacy protections. Ms. Kiernan said policymakers should avoid creation of a system that would provide differing consumer rights; differing levels of protections; fragmented implementation of consumer protections; and legal uncertainty.

Ms. Kiernan said this complex issue warrants a comprehensive review and she looks forward to working with the Working Group as it moves forward. Ms. Kiernan said she would like to align her comments with the recently submitted observations
of NAMIC and the APCIA because she agrees with the thoughtful comments regarding specific issues and challenges that her sister national trade associations raised in their remarks.

d. **CEJ**

Birny Birnbaum (Center for Economic Justice—CEJ) said Model #670 addresses “personal information,” while Model #672 addresses “nonpublic personal financial information and nonpublic personal health information.” He said both models discuss “consumer reports” and “consumer reporting agencies,” as defined by the FCRA.

Mr. Birnbaum asked the Working Group to consider:

- Data vendors are scraping personal consumer information from public sources to produce consumer profiles, scores and other tools for insurers. The data vendor products, while assembled from public information, raise concerns over consumers’ digital rights and privacy.
- Many data vendors and many types of personal consumer information are not subject to FCRA consumer protections. In turn, many of the types of data and algorithms (essentially, a consumer report) used by insurers are not subject to either FCRA consumer protections or the NAIC model law/regulation protections.
- It is unclear if the NAIC models cover the new types of data being generated by consumers as part of, or related to, insurance transactions. For example, consumers are producing large volumes of data through telematics programs—from devices collecting personal consumer data in the vehicle or home or wearable devices.
- There are a lot of organizations working on consumer digital rights. He asked the Working Group to solicit input and presentations at Working Group meetings from, among others, the Center for Digital Democracy, the Electronic Privacy Information Center, the Electronic Frontier Foundation, the Public Knowledge-Privacy Rights Clearinghouse, the Public Citizen, the U.S. Public Interest Research Group and the World Privacy Forum. In addition, Mr. Birnbaum said there are several organizations active on digital rights in the EU that are familiar with the GDPR and whose perspectives would help the Working Group.
- He asked that if consumer disclosures are to be used, that the disclosure should be a compliance or enforcement tool that would be created using consumer focus testing and established best practices for the creation of such consumer disclosures.

Having no further business, the Privacy Protections (D) Working group adjourned.
MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

Market Regulation and Consumer Affairs (D) Committee Dec. 9, 2019, Minutes
Market Regulation and Consumer Affairs (D) Committee Oct. 1, 2019, Minutes (Attachment One)
Policy In Force Standardized Data Request Property & Casualty Line of Business Workers Compensation (Attachment Two)
Property/Casualty (P/C) Travel Insurance Examination Standards (Attachment Three)
Revisions to the NAIC State Licensing Handbook (Attachment Four)
NAIC Continuing Education Reciprocity (CER) Agreement (Attachment Five)
Market Analysis Procedures (D) Working Group Dec. 8, 2019, Minutes (Attachment Six)
  Market Analysis Procedures (D) Working Group Nov. 21, 2019, Minutes (Attachment Six-A)
  Market Analysis Procedures (D) Working Group Oct. 31, 2019, Minutes (Attachment Six-A1)
  Market Analysis Procedures (D) Working Group Aug. 27, 2019, Minutes (Attachment Six-A1a)
Market Conduct Annual Statement Blanks (D) Working Group Nov. 21, 2019, Minutes (Attachment Seven)
  Market Conduct Annual Statement Blanks (D) Working Group Oct. 23, 2019, Minutes (Attachment Seven-A)
Market Conduct Examination Standards (D) Working Group Nov. 20, 2019, Minutes (Attachment Eight)
  Market Conduct Examination Standards (D) Working Group Oct. 9, 2019, Minutes (Attachment Eight-A)
  Market Conduct Examination Standards (D) Working Group Aug. 29, 2019, Minutes (Attachment Eight-A1)
Market Regulation Certification (D) Working Group Nov. 20, 2019, Minutes (Attachment Nine)
Privacy Protections (D) Working Group Dec. 8, 2019, Minutes (Attachment Ten)