Draft: 8/4/21

Market Regulation and Consumer Affairs (D) Committee
Virtual Meeting
July 27, 2021

The Market Regulation and Consumer Affairs (D) Committee met July 27, 2021. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Alan McClain represented by Russ Galbraith (AR); Evan G. Daniels represented by Maria Ailor (AZ); Trinidad Navarro (DE); Dana Popish Severinghaus represented by Erica Weyhenmeyer (IL); Chlora Lindley-Myers represented by Jo LeDuc (MO); Chris Nicolopoulos represented by Edwin Pugsley (NH); Carter Lawrence represented by Vickie Trice (TN); and Jonathan T. Pike represented by Tanji J. Northrup (UT). Also participating were: Hermoliva Abejar (NV); Matt Gendron (RI); and Rebecca Rebholz (WI).

1. Adopted its Spring National Meeting Minutes

Mr. Pugsley made a motion, seconded by Ms. Trice, to adopt the Committee's April 13 minutes (*see NAIC Proceedings – Spring 2021, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Adopted Revised Charges for the Antifraud (D) Task Force

Commissioner Richardson said at the Spring National Meeting, Commissioner Navarro discussed the issue of the improper marketing of health insurance plans and reported that the Antifraud (D) Task Force was considering a proposal to form a working group under the Task Force. She asked Commissioner Navarro for an update.

Commissioner Navarro said the Task Force met May 25 to consider a motion for the creation of an Improper Marketing of Health Plans (D) Working Group with two charges:

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

Commissioner Navarro said the Task Force unanimously adopted the creation of the new Working Group with the two charges.

Commissioner Navarro made a motion, seconded by Ms. Northrup, to create the Improper Marketing of Health Plans (D) Working Group reporting to the Antifraud (D) Task Force with the two charges adopted by the Task Force. The motion passed unanimously.

3. Adopted the STLD MCAS Data Call and Definitions

Ms. Rebholz said the Short-Term Limited-Duration (STLD) data call and definitions were adopted by the Market Conduct Annual Statement Blanks (D) Working Group on May 26.

Ms. Rebholz said the drafting group's original intent was to develop a blank to cover all other health products that were not currently part of the Market Conduct Annual Statement (MCAS) Health blank; but because of interest in obtaining data on the STLD line of business in each state, the drafting group decided to focus only on STLD insurance to meet the June 1 deadline for adoption. She said the drafting group used the 2019 STLD data call as its jumping off point, but it significantly expanded the information to be collected.

Ms. Rebholz said the STLD MCAS is divided into six sections: 1) interrogatories; 2) policy/certificate administration; 3) prior authorizations; 4) claims administration; 5) consumer complaints and lawsuits; and 6) marketing and sales. She said the data in each section will be reported in three categories: 1) STLD insurance products sold through associations used in the state; 2) STLD insurance products sold through associations not used in the state; and 3) STLD insurance products not sold through an association. Each of these categories are divided into: 1) products with a term of less than or equal to 90 days; 2) products with a term of less than or equal to 180 days; and 3) products with a term of 181 to 364 days.

Ms. Rebholz said the instructions specify that the threshold is $50,000 in premium within each jurisdiction, and the STLD products should be reported by the residency of the individual insured.

Ms. Rebholz noted that the STLD MCAS blank is the product of a large group of state insurance regulators, industry, and consumer representatives who put in many hours of work. She thanked Katie Dzurec (PA) for chairing the drafting group.

Ms. LeDuc recognized the need for the STLD blank and supported its creation, but she noted that there was not enough time between its exposure to the Working Group and its adoption on May 26. She said some of the information is confusing, and she said it could result in data that is not useful. Ms. Rebholz said the draft blanks were exposed as the work of the drafting group. Commissioner Richardson said if the blank was not adopted at this meeting, the initial collection of data would be delayed another year, and she suggested that any possible data issues that arise could be fixed in subsequent years. Commissioner Clark said the data collected is pertinent and should not be delayed.

Commissioner Clark made a motion, seconded by Commissioner Navarro, to adopt the STLD MCAS data call and definitions. The motion passed unanimously with Missouri abstaining.

4. Adopted the Travel Insurance MCAS Data Call and Definitions

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group adopted the Travel Insurance MCAS data call and definitions on May 26.

Ms. Rebholz said the Working Group identified trip cancellation, trip interruption, trip delay, baggage loss or delay, emergency medical and dental, emergency transportation and repatriation, and other as the coverage breakouts for this MCAS blank, with additional breakouts for domestic and international coverages. She noted that emergency medical is broken out by primary and excess coverage.

Ms. Rebholz said the claims, underwriting, lawsuit, and complaint data elements are like other MCAS lines of business and, where possible, definitions from the *Travel Insurance Model Act* (#632) were used for consistency purposes.

Ms. Rebholz said since travel insurance is represented by a small number of companies and the policies are generally small in amount, there is no premium threshold for reporting. She said the Working Group decided to require reporting for all companies licensed and reporting for any travel insurance within any of the participating MCAS jurisdictions.

Commissioner Clark made a motion, seconded by Mr. Pugsley, to adopt the Travel Insurance MCAS data call and definitions. The motion passed unanimously.

5. Adopted Digital Claims Data in the PPA and Homeowners MCAS

Commissioner Richardson said she is asking the Committee to consider adoption of the digital claims data elements and the effective date of the digital claims data elements.

Commissioner Richardson said the *MCAS Data Element Revision Process* states that for any revisions to be effective for the following calendar year, the revisions must be adopted by the Market Conduct Annual Statement Blanks (D) Working Group by June 1 and the Committee by Aug. 1. She said the purpose of the deadlines is to allow companies time to make systems adjustments prior to the need to track the data elements beginning the following calendar year.

Commissioner Richardson said in the case of the digital claims data, the Working Group was ready to adopt the changes prior to June 1, but a late series of questions and suggested revisions were received just before its May 27 conference call. She said the chair of the Working Group correctly decided that it was more important to fully address all the questions and suggestions rather than push through the adoption on May 27. The changes were adopted by the Working Group on June 30.

Commissioner Richardson noted that the data elements themselves were developed with contributions by industry, have been posted on the Working Group web page since May, and did not change significantly since they were considered for adoption by the Working Group in May. She said if the Committee adopted the changes, it would meet its Aug. 1 deadline, and she would ask the Committee to consider an exception to the *MCAS Data Element Process* to adopt the changes to be effective for the 2022 data year.

Ms. Rebholz said in the Private Passenger Auto (PPA) and Homeowners blanks, the claims related data elements are broken out into types of claims, such as collision, comprehensive, property damage, and uninsured motorists and underinsured motorists (UMPD) for the PPA blank and dwelling and personal property for the Homeowners blank. She said on June 30, the Working Group adopted new claims data elements to identify digital claims, hybrid claims, and non-digital claims.

Ms. Rebholz said the definitions of digital, hybrid, and non-digital claims are in the data call and definitions. She said a digital claim is defined as a claim involving a claim settlement determination, which was accepted by the insured or claimant without adjustment, whereby the entire claim was handled without human intervention on the part of the insurance company in the loss appraisal process, settlement determination, and/or the production of the initial loss settlement offer.

Ms. Rebholz said on June 30, two revisions were made to the digital claims data elements. She said the first change was to the interrogatories. She said the interrogatories originally asked the company to identify digital claim vendors. This was revised to add, "and for each vendor, identify the vendor's specific role in the digital claims process" at the end of the interrogatory language. The Working Group decided it would later determine how to implement the reporting within this interrogatory. Ms. Rebholz said there was interest in receiving information for this interrogatory separately for each vendor being reported, but this poses an issue at the NAIC, since the MCAS data collection tool does not currently allow for a variable number of entries for a particular data element. She said the second change was to clarify the types of claims to be broken out between digital and traditional claims handling.

Ms. Abejar said there were discussions regarding the value of having vendor information and the value of the information. She noted that if the Working Group decides to ask for algorithms used in the digital claim settlement process, it should recognize that algorithms are code that are connected to insurance company databases and cybersecurity, and they would need to be protected.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she participated in the drafting of the digital claims data elements and definitions, and she commended the collaborative process. She said she disagreed with setting aside the June 1 deadline for the Working Group adoption of the new data elements. She said industry focused on the definitions of "lawsuit" because the digital claims data elements were not passed prior to June 1. She noted that the changes recommended to the digital claims data elements were proposed by the state insurance regulators.

Birny Birnbaum (Center for Economic Justice—CEJ) supported the new digital claims data elements. He said the additions are critical because of the significant increase in digital claims settlements since the COVID-19 pandemic. He said without the data, the MCAS claims ratios for the PPA and Homeowners blanks will be skewed if digital claims are not broken out. Regarding the effective date, he said the changes made by the Working Group after June 1 were editorial. The date that is relied on the most is the Aug. 1 date for the Committee adoption. He said there is no harm to industry, and they are not deprived of due process.

Ms. Brown agreed that there is an increase in digital claim settlements, but the defined due dates in the revision process do matter. She said after the June 1 deadline passed, industry turned its attention to other MCAS data discussions.

Commissioner Clark made a motion, seconded by Mr. Pugsley, to adopt the digital claims data elements for the PPA and Homeowners MCAS blanks. The motion passed unanimously.

Commissioner Richardson said the options for the effective date of the digital claims elements are to: 1) make an exception to the June 1 deadline of the Working Group and have the addition of the digital claims elements be effective for the 2022 data year; or 2) have the effective date be for the 2023 data year, in which case the data would not be reported until the following year on April 30, 2024.

Commissioner Clark made a motion to make an exception to the June 1 deadline of the Working Group and have the addition of the digital claims elements be effective for the 2022 data year. There was no second.

Commissioner Richardson said the effective date for the digital claims data elements will be the 2023 data year.

6. Discussed State Insurance Regulator, Consumer, and Industry Perspectives of Collecting Transaction-Level Market Conduct Data from Insurers

Commissioner Richardson said in 2020, the Market Conduct Annual Statement Blanks (D) Working Group considered options for the collection of transaction-level data. She said although the Working Group members expressed an interest in collecting transaction-level data, the Working Group determined that the collection of this type of data did not fit into the current structure of MCAS reporting, and review of this type of data at the state level would put a strain on available resources. Commissioner Richardson said the Working Group concluded its discussions on the topic and deferred further discussion to the Committee during the Committee's 2020 Fall National Meeting conference call.

Commissioner Richardson said there was a brief discussion by the Committee during the 2020 Fall National Meeting, and it decided to defer the discussion on transaction-level data collection. She said that is the reason for this meeting's discussion of the three perspectives on this issue. She said the Committee will hear from Ms. Brown, Mr. Gendron, and Mr. Birnbaum.

Ms. Brown said when the issue of transactional-level reporting was discussed at the Market Analysis Procedures (D) Working Group and the Market Conduct Annual Statement Blanks (D) Working Group, state insurance regulators decided they were not interested in pursuing data collection at that level of granularity.

Ms. Brown said market analysis is the beginning of the market regulation process. The current market analysis process allows market analysts to identify companies without deploying significant resources. In addition to the MCAS, she said market analysts also considers data from other sources such as complaints. She said the MCAS was created as a summary data tool, recognizing that if additional information was needed, more granular data could be requested. Asking for granular data at the beginning of the process is too burdensome. Ms. Brown said Mr. Birnbaum had spoken with NAIC staff, who assured him they were willing and able to collect transaction-level data, but the data is for the use of state insurance regulators, and they have concerns about their ability to use data at that granularity. She noted, as an example, the large amount of data generated by the addition and deletion of autos to all an insurer's policies. She questioned its utility for state insurance regulators.

Ms. Brown said the burden on insurers to provide transactional data would be enormous. Currently, there are hundreds and thousands of MCAS filings prepared by companies. In addition to being a burden on companies, state insurance regulators say they do not have the resources to cull through the data. She said the costs outweigh the benefits.

Ms. Brown said data at the transaction level is usually done at the examination phase, where more protections are available for proprietary information. She said the reverse engineering of transactional data is a valid concern of companies.

Mr. Gendron said transactional data is valuable and has its place in market analysis and examinations, but this occurs after the initial baseline analysis to determine which companies need more in-depth analysis. He said after the baseline analysis is done, more detailed analysis is done on about 100 companies. This detailed analysis begins with summary-level data to see if the concerns can be identified without the need for more granular-level data. Mr. Gendron said MCAS data is a main source of the summary-level data. He said about half of those companies will have follow-ups, including records testing.

Mr. Gendron said market conduct teams have competing priorities, including doing baseline analysis, summary-level analysis, market conduct examinations, inquiries along the continuum of market actions, special projects, participating in NAIC working groups, continuing education (CE), and lending expert assistance to other departments.

Mr. Gendron identified the benefits of requesting transactional data as: 1) having that level of data ready when needed; 2) having consistent and comparable data by creating industry standards for data elements, definitions, and formats; 3) more opportunities to monitor MCAS data quality; and 4) more opportunities for novel data analysis by state insurance regulators. Mr. Gendron also cited concerns with requesting transactional data as: 1) additional information to filter; 2) the protection of the data; 3) the cost to companies being passed on to consumers; 4) the opportunity cost for states as they learn how to manage and analyze transactional data; 5) uncertainty about what analysis would warrant the increase in data collection; and 6) it being unclear what additional quality control steps would need to be undertaken.

Mr. Birnbaum defined transactional data as separate records for each sales transaction and each claims transaction. He noted that new data elements can always be added with disturbing existing data elements. He said for market analysis, transaction-level data is more effective for market analysis by: 1) providing more granular data enabling analysts to discover issues rather than confirm issues; 2) providing more timely analysis in contrast to MCAS data, which is often stale when received; 3)

providing opportunities for predictive analytics; 4) allowing the ability to identify proxy discrimination and disparate impact; 5) being more consistent; and 6) being more efficient for market analysis.

Mr. Birnbaum said providing transactional data is less costly for insurance companies and state insurance regulators. For companies, it is less costly because it has simpler data reports and is consistent with other insurers. It is also less costly to revise data elements. Mr. Birnbaum also noted that providing transaction-level data will result in fewer special data call and regulatory inquiries. For the state insurance regulators, Mr. Birnbaum said transaction-level data collection is less costly because the data is more reliable, and less time needs to be spent on data validation. It also allows for more refined analysis that allows for better deployment of resources. Mr. Birnbaum said there is less need for planning and executing special data calls. Finally, he said state insurance regulators can utilize an existing statistical agent framework instead of a new data infrastructure.

Mr. Birnbaum said since 2004, industry has increasingly used third-party data, predictive models, and generalized linear models. Currently, industry utilizes dozens of non-insurance sources and has enhanced, real-time consumer insurance data. Mr. Birnbaum said companies have real-time data access available for decision making. With the increase in data companies can apply micro-segmentation to marketing, pricing, claims settlements, and anti-fraud efforts. Mr. Birnbaum said today, companies are routinely using advanced data analytics, such as data mining, generalized additive models, neural networks, machine learning (ML), and artificial intelligence (AI).

Mr. Birnbaum said in contrast, the market analysis of today is essentially the same as the market analysis of 2004. It still utilizes complaints, enforcement actions, new reports, lawsuits, and summary-level MCAS data on a limited number of lines of business.

Mr. Birnbaum said in 2000, the NAIC said market analysis would move market regulation from the auditing model to a more data-driven, analytical approach; but by not incorporating more transaction-level data, it cannot fulfill that goal. He concluded by saying transaction data collection on consumer market outcomes is the most important action needed to fulfill the promise of market analysis.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

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NAIC NATIONAL MEETING SUMMER 2021

Virtual Meeting
(in lieu of meeting at the 2021 Spring National Meeting)

ANTIFRAUD (D) TASK FORCE
Monday, July 26, 2021
11:00 a.m. – 12:00 p.m. ET / 10:00 – 11:00 a.m. CT / 9:00 – 10:00 a.m. MT / 8:00 a.m. – 9:00 a.m. PT

Meeting Summary Report

The Antifraud (D) Task Force met July 26, 2021. During this meeting, the Task Force:

1. Adopted its May 25 minutes, which included the following action:
   A. Adopted its March 24 minutes.
   B. Adopted a motion to appoint the Improper Marketing of Health Plans (D) Working Group.

2. Received an update from the Antifraud Education Enhancement (D) Working Group. The Working Group held a webinar on Feb. 11 from CARCO regarding the mobile capabilities it can provide state insurance departments to assist with fighting insurance fraud. The Working Group also conducted investigator safety training on June 2. The Working Group advised Task Force members to send any suggested training/webinar topics they would like to have provided.

3. Received an update from the Antifraud Technology (D) Working Group. The Working Group noted that the revision of the *Antifraud Plan Guideline* (#1690) was the first step in its charge to "review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions." The Working Group formed a subject-matter expert (SME) group to create a template for industry to use when creating their Antifraud Plan. The SME Group will meet every week through October in order to finalize this project.

4. Received an update on the NAIC Online Fraud Reporting System (OFRS) redesign project. The NAIC is continuing its work on the redesign of the OFRS. The Task Force was informed that beta testing is currently taking place, and the NAIC will be opening up the testing to industry in an effort to finalize this testing period.

5. Heard reports on antifraud activity from NAIC staff and the following organizations: the National Insurance Crime Bureau (NICB) and the Coalition Against Insurance Fraud (CAIF).

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NAIC NATIONAL MEETING SUMMER 2021

Virtual Meeting
(in lieu of meeting at the 2021 Summer National Meeting)

MARKET INFORMATION SYSTEMS (D) TASK FORCE
Wednesday, July 28, 2021

Meeting Summary Report

The Market Information Systems (D) Task Force met July 28, 2021. During this meeting, the Task Force:

1. Adopted its Spring National Meeting minutes, which included the following action:
   A. Discussed its 2021 charges.
   B. Adopted the report of the Market Information Systems Research and Development (D) Working Group. The Working Group adopted the Regulatory Information Retrieval System (RIRS) Coding Changes Proposal. The Task Force agreed to expose the proposal and consider adoption during its Summer National Meeting.
   C. Adopted the Market Information Systems (MIS) Metrics and Recommendations.
   D. Heard a report on the outstanding Uniform System Enhancement Requests (USER).

2. Adopted the report of the Market Information Systems Research and Development (D) Working Group, which included the following action:
   A. Heard presentations from NAIC staff regarding the testing of the use of artificial intelligence (AI) to construct predictive models of insolvency risk and the Center for Economic Justice (CEJ) regarding how AI can be used in market analysis. The Working Group agreed to form a subject matter expert (SME) group to develop recommendations for incorporating AI into the NAIC MIS.
   B. Reviewed outstanding USER forms.
   C. Reviewed comments received on the RIRS Coding Changes Proposal.
   D. Reviewed the progress of the implementation of the MIS data analysis recommendations.

3. Adopted the RIRS Coding Changes Proposal.

4. Heard a report on the outstanding USER forms.

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NAIC National Association of Insurance Commissioners

Regulatory Information Retrieval System (RIRS)
Proposed Coding Structure Changes

Overview

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

In brief, this proposal consists of:

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

Record Type (New)

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

Modification Indicator (New)

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

Line of Business (New)

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

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

Origin of Action (Revised)

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

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

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

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

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

Reason for Action (Revised)

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

Claims

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

Complaint Handling

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

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

Escrow/Settlement, Closing or Security Deposit Funds

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

Marketing & Sales

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

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

Operations & Management

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

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

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

Policyholder Service

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

Producer Licensing

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

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

Underwriting & Rating

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

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

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

Miscellaneous

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

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

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

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

Disposition for Action (Revised)

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

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

NAIC National Association of Insurance Commissioners

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

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

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

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

NAIC NATIONAL MEETING SUMMER 2021

Virtual Meeting
(in lieu of meeting at the 2021 Summer National Meeting)

PRODUCER LICENSING (D) TASK FORCE
Wednesday, August 4, 2021
2:30 – 3:30 p.m. ET / 1:30 – 2:30 p.m. CT / 12:30 – 1:30 p.m. MT / 11:30 a.m. – 12:30 p.m. PT

Meeting Summary Report

The Producer Licensing (D) Task Force met Aug. 4, 2021. During this meeting, the Task Force:

1. Adopted its March 21 minutes.

2. Heard an update on state implementation of online examinations. Forty jurisdictions offer online examinations for producer licensing.

3. Discussed the anticipated referral from the Special (EX) Committee on Race and Insurance, which directs the Task Force to provide a report on the availability of producer licensing exams in foreign languages, the steps exam vendors have taken to mitigate cultural bias, and the number and location of producers by company compared to demographics in the area.

4. Discussed the review of the NAIC's *Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994*, with a focus on how to simplify the guidelines for use by state insurance regulators as they access the impact of criminal convictions and work toward greater consistency in the review of "1033 Waiver" requests.

5. Discussed an announcement in June from the Pennsylvania Department of Insurance (DOI) on a new pilot program for prospective insurance agents with criminal records. Under Pennsylvania's Preliminary Licensing Determination program, the DOI provides guidance to applicants with criminal records on how their specific convictions, history, and background may affect their ability to successfully apply for an insurance producer license. The DOI is offering this service to individuals working towards rehabilitating themselves and securing a career in the insurance industry.

6. Discussed draft procedures for amending the NAIC's Uniform Producer Licensing Applications. The purpose of the procedures is to provide guidance on the Task Force's consideration of proposed changes to the uniform applications in support of the NAIC members' goal of providing stable applications that encourage the use of electronic technology. The Task Force is exposing the draft procedures for a 30-day public comment period.

7. Received reports from the Producer Licensing (D) Working Group and the Uniform Education (D) Working Group. These groups have not met since the last Task Force meeting due to a vacancy in the chair of the Producer Licensing Uniformity (D) Working Group. A new chair and vice chair will be selected for this group.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

MARKET CONDUCT EXAMINATION GUIDELINES (D) WORKING GROUP
June 10, 2021

Summary Report

The Market Conduct Examination Guidelines (D) Working Group met June 10, 2021. During this meeting, the Working Group:

1. Reviewed its 2021 charges.

2. Discussed and prioritized its potential tasks for 2021.

3. Identified models adopted in 2020 and asked for state insurance regulator volunteers to begin a review of the models and report at the next Working Group meeting, if applicable revisions to corresponding sections of the *Market Regulation Handbook* are warranted.

4. Discussed new title insurance standardized data requests (SDRs) to address in force policies and claims for inclusion in the reference documents of the *Market Regulation Handbook.*

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NAIC NATIONAL MEETING SUMMER 2021

Virtual Meeting
(in lieu of meeting at the 2021 Summer National Meeting)

MARKET ANALYSIS PROCEDURES (D) WORKING GROUP
Thursday, July 1, 2021

Meeting Summary Report

The Market Analysis Procedures (D) Working Group met July 1, 2021. During this meeting, the Working Group:

1. Adopted its March 19 minutes, which included the following action:
   A. Adopted revisions to the *Market Conduct Annual Statement (MCAS) Best Practices Guide.*
   B. Adopted a requirement that companies identify their MCAS attesters by line of business and jurisdiction.
   C. Adopted revisions to the NAIC *Market Regulation Handbook* training opportunities for market regulation analysts.

2. Discussed market analysis training needs for state insurance regulators.

3. Opened discussions on the next line of business to be included in the MCAS.

4. Discussed initial aggregate analysis of MCAS data with an April 30 due date. This discussion will continue once the validation of the data is completed.

5. Discussed MCAS reporting by jurisdiction of residency or jurisdiction of issuance. The Working Group will make no recommendations to change the current instructions in the data calls and definitions for the various MCAS blanks. It was agreed that additional training on reporting requirements will be helpful for market analysts.

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NAIC NATIONAL MEETING SUMMER 2021

Virtual Meeting
(in lieu of meeting at the 2021 Summer National Meeting)

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Wednesday, July 28, 2021
2:00 – 3:00 p.m. ET / 1:00 – 2:00 p.m. CT / 12:00 – 1:00 p.m. MT / 11:00 a.m. – 12:00 p.m. PT

Meeting Summary Report

The Market Conduct Annual Statement Blanks (D) Working Group met July 28, 2021. During this meeting the Working Group:

1. Adopted its June 30 minutes, which included the following action:
   A. Adopted it May 26 and May 25 minutes, which included the following action:
      1. Adopted its April 28 minutes, which included the following action:
         a. Adopted its March 23 minutes.
         b. Agreed to collect non-claims lawsuit data in the Private Passenger Auto (PPA) and Homeowners (HO) Market Conduct Annual Statement (MCAS) blanks.
      2. Adopted the Travel MCAS data call and definitions.
      3. Adopted the Short-Term Limited-Duration (STLD) MCAS data call and definitions.
      4. Discussed the addition of digital claims MCAS data elements to the HO and PPA MCAS data call and definitions.
      5. Discussed the draft edits to the Life MCAS data call and definitions to include reporting for accelerated underwriting.
      6. Adopted revisions to the definition of "lawsuit."
   B. Agreed to wait for the Accelerated Underwriting (A) Working Group to adopt its definition of "accelerated underwriting" before proceeding with the MCAS definition of "accelerated underwriting."
   C. Adopted the digital claims data elements and definitions for the PPA and HO MCAS data call and definitions.
   D. Agreed to postpone the collection of non-claims lawsuit data until the 2023 data year reported in 2024.

2. Heard an update on the addition of accelerated underwriting data elements in the Life and Annuity MCAS data call and definitions. The subject matter expert (SME) drafting group continues to wait for the Accelerated Underwriting (A) Working Group to adopt a definition of "accelerated underwriting."

3. Heard an update on the Other Health MCAS data call and definitions. The drafting group plans to resume meeting to begin drafting the remainder of the other health products.

4. Agreed to form an SME group to draft a proposal for incorporating non-claims-related lawsuits in the PPA and HO MCAS blanks and revise the definition of "lawsuit," as necessary. The group will also consider the best way to collect digital claims vendor information in the interrogatories for the PPA and HO MCAS blanks.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

PRIVACY PROTECTIONS (D) WORKING GROUP
May 10, 2021 / June 14, 2021 / July 12, 2021

Summary Report

The Privacy Protections (D) Working Group met May 10, June 14, and July 12.

1. During the May 10 meeting, the Working Group:
   A. Adopted its March 29 minutes, which included the following action:
      1. Reviewed the 2021 NAIC member-adopted strategy for consumer data privacy protections.
      2. Discussed the 2020 Fall National Meeting verbal gap analysis of consumer issues.
   B. Discussed the draft of the initial privacy policy statement.
   C. Requested comments in the form of parameters and examples on the initial privacy policy statement by June 7 for discussion during the next Working Group meeting scheduled for June 14.

2. During the June 14 meeting, the Working Group:
   A. Adopted its May 10 minutes, which included the following action:
      1. Discussed the initial draft of the privacy policy statement.
      2. Requested comments in the form of parameters and examples on the initial privacy policy statement by June 7.
   B. Discussed the comments received by June 7 from America's Health Insurance Plans (AHIP), the Blue Cross Blue Shield Association (BCBSA), and the Coalition of Health Companies in the form of parameters and examples on the initial privacy policy statement for discussion during the next Working Group meeting scheduled for July 12.

3. During the July 12 meeting, the Working Group:
   A. Adopted its June 14 minutes, which included the following action:
      1. Discussed comments received from health insurers received on the six consumer privacy rights identified by the 2021 NAIC member-adopted strategy for consumer data privacy protections to be discussed by the Working Group as part of its gap analysis in its 2019 work plan.
   B. Received comments from the American Council of Life Insurers (ACLI) about the six consumer privacy rights.
   C. Heard a presentation from NAIC consumer representatives on the consumer perspective of data privacy and consumer privacy rights.
   D. Requested comments in the form of parameters and examples on the revised draft of the privacy policy statement by July 29 for discussion during the next Working Group meeting scheduled for Aug. 30.

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