1. Consider Adoption of its Spring National Meeting Minutes

Attachment One

Commissioner D.J. Bettencourt (NH)

Draft: 4/1/26

NAIC/Consumer Liaison Committee
San Diego, California
March 22, 2026

The NAIC/Consumer Liaison Committee met in San Diego, CA, March 22, 2026. The following Liaison Committee members participated: D.J. Bettencourt, Chair (NH); Marie Grant, Vice Chair (MD); Heather Carpenter (AK); Mark Fowler (AL); Charles Bassett (AZ); Ricardo Lara (CA); Michael Conway (CO); Joshua Hershman represented by Nick Gill (CT); Trinidad Navarro (DE); Dean L. Cameron represented by Weston Trexler (ID); Ann Gillespie represented by Jeff Varga (IL); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold (MN); Angela L. Nelson (MO); Mike Chaney represented by Aaron Cooper (MS); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning (NE); Alice T. Kane represented by Viara Ianakieva (NM); Judith L. French represented by Jana Jarrett (OH); Glen Mulready represented by Donna Dorr (OK); TK Keen (OR); Michael Humphreys (PA); Amanda Crawford (TX); Jon Pike (UT); Scott A. White (VA); Kaj Samson (VT); Patty Kuderer (WA); and Nathan Houdek represented by Sarah Smith (WI).

1. Adopted its 2025 Fall National Meeting Minutes

Commissioner Grant made a motion, seconded by Commissioner Conway, to adopt the Liaison Committee's Dec. 8, 2025, minutes (*see NAIC Proceedings – Fall 2025, NAIC/Consumer Liaison Committee*). The motion passed unanimously.

2. Received a Summary of the NAIC/Consumer Participation Board of Trustees Meeting

Commissioner White said the Board of Trustees met March 22. During this meeting, the Board discussed collaboration with the Center for Insurance Policy and Research (CIPR) to develop and implement a structured feedback mechanism to solicit input from current consumer representatives and NAIC Members regarding potential improvements to the NAIC Consumer Participation Program. The discussion focused on identifying opportunities to enhance participation, engagement, and overall program effectiveness. Commissioner White said the Board discussed the Consumer Participation Scholarship Program beginning in 2026. The program is intended to support participation by individuals with issue-specific expertise not currently represented among consumer representatives, particularly in emerging or underrepresented policy areas. As part of the 2026 budget, the NAIC Members approved $15,000 to fund the program in 2026.

The Board reviewed the status of three consumer representative recommendations submitted to NAIC Membership in 2025. Two recommendations were directed to the Health Insurance and Managed Care (B) Committee and one to the Property and Casualty Insurance (C) Committee. Following consultation with committee leadership, the Board noted that many health-related recommendations were incorporated into the 2026 charges of the Health Insurance and Managed Care (B)Committee. In response to the recommendation to the Property and Casualty Insurance (C) Committee, NAIC committee support will conduct research to identify state laws or regulations requiring insurers to proactively provide policy language to consumers or provide such language upon request.

3. Heard a Presentation on 2026 Consumer Representative Health Priorities

Lucy Culp (Blood Cancer United) said consumer representatives annually submit a letter to the Health Insurance and Managed Care (B) Committee outlining key consumer issues and priorities and that the presentation reflected the major themes contained in that letter. Culp said the current health insurance landscape is increasingly strained, citing rising premiums, increasing deductibles and out-of-pocket costs, and the expiration of enhanced premium tax credits as significant contributors to affordability challenges. Culp said that lower-cost plans fail to

provide meaningful coverage and do not constitute affordable care for consumers who ultimately need to access services. Culp said there is a need to address the compounding effects of Medicaid coverage losses and increased consumer migration toward non-Affordable Care Act (ACA)-compliant plans.

Carl Schmid (HIV+Hepatitis Policy Institute) discussed barriers consumers face after obtaining insurance, including insurers' utilization management and prior authorization practices. Schmid commended NAIC efforts on prior authorization, including the development of a white paper, and encouraged continued updates and transparency regarding state implementation of prior authorization laws. Schmid suggested consideration of a dedicated working group to provide sustained focus on prior authorization reform and oversight. Schmid said there is a need for improved transparency in market conduct data, noting limitations in existing NAIC Market Conduct Annual Statement (MCAS) health data and the lack of consistent state-level metrics. He also highlighted the growing use of artificial intelligence (AI) in utilization management and its impact on access to care. Schmid recognized NAIC work on pharmacy benefit managers (PBMs) and prescription drug transparency and encouraged additional examination of group purchasing organizations and vertical integration. Schmid urged state insurance regulators to continue engaging with the federal Centers for Medicare & Medicaid Services (CMS) on cost-sharing definitions, formulary practices, and consumer complaints related to access to medications.

Deborah Steinberg (Legal Action Center—LAC) discussed state enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA). Steinberg said state-level parity analyses have identified systemic barriers to care and led insurers to take corrective actions. Steinberg referenced recent enforcement actions in multiple states and encouraged continued state enforcement. Steinberg expressed concern about the continued growth of non-ACA-compliant plans that lack parity protections.

Janay Johnson (American Heart Association—AHA) discussed concerns regarding non-ACA-compliant plans, including deceptive marketing practices and their impact on ACA risk pools. Johnson discussed findings from consumer outreach and secret shopper efforts demonstrating consumer confusion and misinformation. Johnson said there are potential risks associated with Section 1333 state compacts, including legal uncertainty and potential weakening of consumer protections. Johnson urged state insurance regulators to continue to focus on disparities affecting historically marginalized communities.

Amy Killelea (Equality Arlington) discussed consumer challenges related to access to no-cost preventive services and immunizations. Killelea described recent federal actions affecting vaccine recommendations and resulting in uncertainty for consumers and insurers. Killelea encouraged continued state insurance regulatory oversight, including the use of market conduct examinations and data calls, to ensure compliance with no-cost coverage requirements.

Bonnie Burns (California Health Advocates—CHA) discussed the increasing complexity of senior issues, including Medicare Advantage, Medigap, and long-term care. Burns proposed the creation of specialized workstreams at the NAIC to address these topics and expressed concern regarding consumer understanding of complex life and annuity products used to fund long-term care (LTC). Burns said there is a need for clearer disclosures and improved consumer education. Killelea presented a newly released consumer representative report on the long-term care insurance market, highlighting disparities in access and affordability, particularly for women, people of color, and individuals with disabilities. Killela said there is a need for additional research and potential involvement of the CIPR to inform future regulatory efforts.

Wayne Turner (National Health Law Program—NHeLP) discussed the role of state insurance regulators as consumer educators. Turner said there is a need for increased consumer education due to changes in premium subsidies, Medicaid eligibility transitions, and aggressive marketing of non-compliant plans. Turner encouraged public awareness campaigns, partnerships with advocacy organizations, and continued work through the NAIC

Consumer Information (B) Working Group to ensure consumers have access to accurate, timely, and understandable insurance information.

4. Heard a Presentation on How Death Records Are Not Locating All Beneficiaries of Unclaimed Benefits

Richard Weber (Life Insurance Consumer Advocacy Center—LICAC) said insurers have historically relied heavily on the Social Security Administration's Death Master File (DMF), which has become less comprehensive over time due to statutory and administrative changes limiting the availability and accuracy of death data.

Weber discussed variability in insurer practices and state regulatory requirements, noting that gaps in death data can delay or prevent the identification of deceased policyholders and beneficiaries. Weber said these gaps disproportionately affect beneficiaries who are unaware of existing policies, particularly older policies, group life coverage, or policies issued many years ago. Weber said there are varying state unclaimed property and escheatment laws, emphasizing that differences in statutory triggers and timelines can lead to inconsistent consumer outcomes.

Weber recommended that the NAIC consider developing a model regulation requiring insurers to use multiple death data sources, establish standardized validation and review protocols, and report metrics on death matches, beneficiary outreach efforts, and benefit payments. Weber said increased transparency and uniform expectations could improve consumer outcomes while providing clarity to insurers.

5. Heard a Presentation on Affordability and Availability of Property Insurance in Wildfire-Prone Regions

Amy Bach (United Policyholders—UP) said insurance policyholders face numerous challenges after wildfire events, including delays in claims processing, disputes over the scope of loss, and inconsistencies in insurers' determinations of smoke damage. Bach said consumers frequently report difficulty obtaining clear explanations of coverage for smoke infiltration, ash contamination, and related property damage, particularly when damage is not readily visible.

Bach discussed concerns related to indoor air quality following wildfire events, noting that smoke particles and contaminants can persist within structures even after visible debris is removed. Bach said consumers face uncertainty regarding whether remediation measures, such as professional cleaning, HVAC system inspection, duct replacement, or temporary relocation, are covered under homeowners or renters policies.

Bach said there is variability in claims outcomes based on insurer guidance to adjusters and the use of third-party vendors. Bach encouraged state insurance regulators to examine whether existing claims standards and market conduct tools sufficiently address smoke and indoor air quality-related losses and to consider whether additional guidance or best practices are needed to promote consistent and fair treatment of policyholders. Bach said there is a need for clear consumer communication during catastrophic events, including timely notice of rights, transparent explanations of coverage determinations, and access to meaningful appeal or reconsideration processes.

6. Heard a Presentation on Insurer Automobile Total Loss Valuation Practices

Erica Eversman (Automotive Education and Policy Institute—AEPI) said consumers whose vehicles are declared total losses often experience confusion and dissatisfaction with settlement amounts, particularly when valuation methodologies are not clearly explained. Eversman discussed common valuation approaches used by insurers, including the use of third-party valuation reports, and noted that consumers frequently report difficulty understanding how comparable vehicles are selected and adjusted.

Eversman raised concerns about the accuracy and transparency of vehicle valuations, including issues with the condition, mileage, options, and geographic relevance of comparable vehicles used in settlement calculations.

Eversman said consumers face difficulties when disputing total loss valuations, including limited access to underlying valuation data and unclear appeal processes. Eversman also noted broader trends in the auto insurance market that may affect total-loss determinations, including rising repair costs and advances in vehicle technology. Eversman said state insurance regulators should review whether existing laws, regulations, and bulletins adequately protect consumers' ability to meaningfully contest valuations and to understand how settlement amounts are determined.

7. Discussed Other Matters

Commissioner Bettencourt recognized Brenda J. Cude (Individual Consumer Advocate) for her induction into the University of Georgia's College of Family and Consumer Sciences Honor Hall of Recognition. A video tribute was presented highlighting Cude's contributions to consumer education, insurance literacy, and academic research.

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

SharePoint/NAICSupportStaffHub/Member Meetings/Consumer CMTE/2026 Spring/Consumer Liaison Committee/Cons Liaison Min 3.22.26.docx

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

Commissioner Scott A. White (VA)

3. Long-Term Care Insurance (LTCI) Market and Consumer Challenges

Bonnie Burns (California Health Advocates)

4. State Coverage of Biomarker Testing and Defrayal Implications

Anna Schwamlein Howard (American Cancer Society Center Action Network) and Anna Hyde (Arthritis Foundation)

State Coverage of Biomarker Testing and Defrayal Implications

Anna Schwamlein Howard, American Cancer Society Cancer Action Network

Anna Hyde, Arthritis Foundation

August 11, 2026

Agenda

- Importance of state mandates
- State Mandate defrayal policy
- Recommendations for state regulators
- Additional Resources

Importance of State Mandates

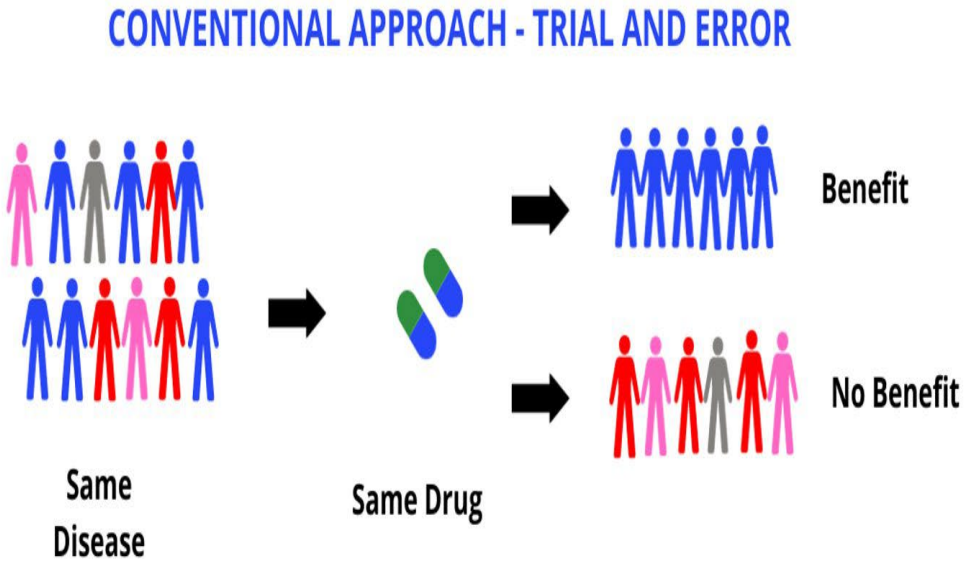
- State mandated policies helps to ensure that citizens have access to products/services that are needed to improve care.
    - Access to services otherwise not covered under Essential Health Benefit (EHB) benchmark plan
    - Expanded access to services covered under EHB benchmark plan
    - Clarification of coverage of services covered under the EHB benchmark plan

Biomarker Testing

Biomarkers - objective indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. Includes *gene mutations* or *protein expression*.

The right treatment, at the right time

- An essential component of precision medicine
- Targeted cancer therapy
- Also applies to cardiology, rheumatology, neurology, infectious, respiratory, autoimmune diseases
- Avoidance of therapies unlikely to provide clinical benefit



Biomarker Testing

Rheumatology Cost Savings

- Early treatment success prover to improve outcomes and lowe costs
- 90% of RA patients start on a TNFi, only a third meet efficacy 6 months
- Biomarker testing leads to 2-3 times greater chance of low disease activity
- For every 3 patients tested, at least 1 will avoid ineffective therapy
- Use of biomarker testing can cut wasted TNFi spending by 51%

Targeted Therapy Drug Cost Savings

$20K - 77K

annually (WAC) per patient redirected from TNFi to alternative MOA by PrismRA testing[1,2]

Medical Cost Savings

$6,091

annually per patient who responds to targeted therapy compared to an inadequate responder[3,4]

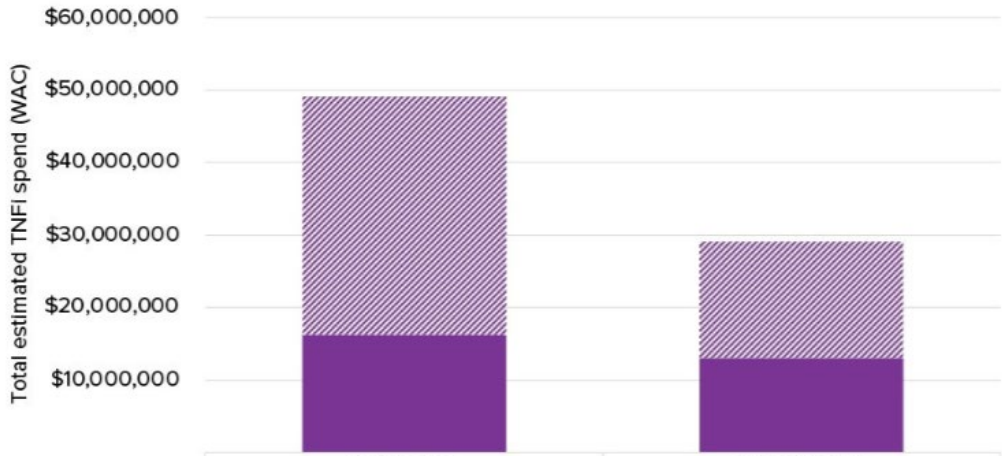
Workplace Cost Savings

$11,819

annually per employee[2-4] with reduced absenteeism (1.9 days/month)[5], improved presenteeism (4.6 days/month)[5], reduced

TNFi efficient and wasted spend

(per 1M commercially covered lives)

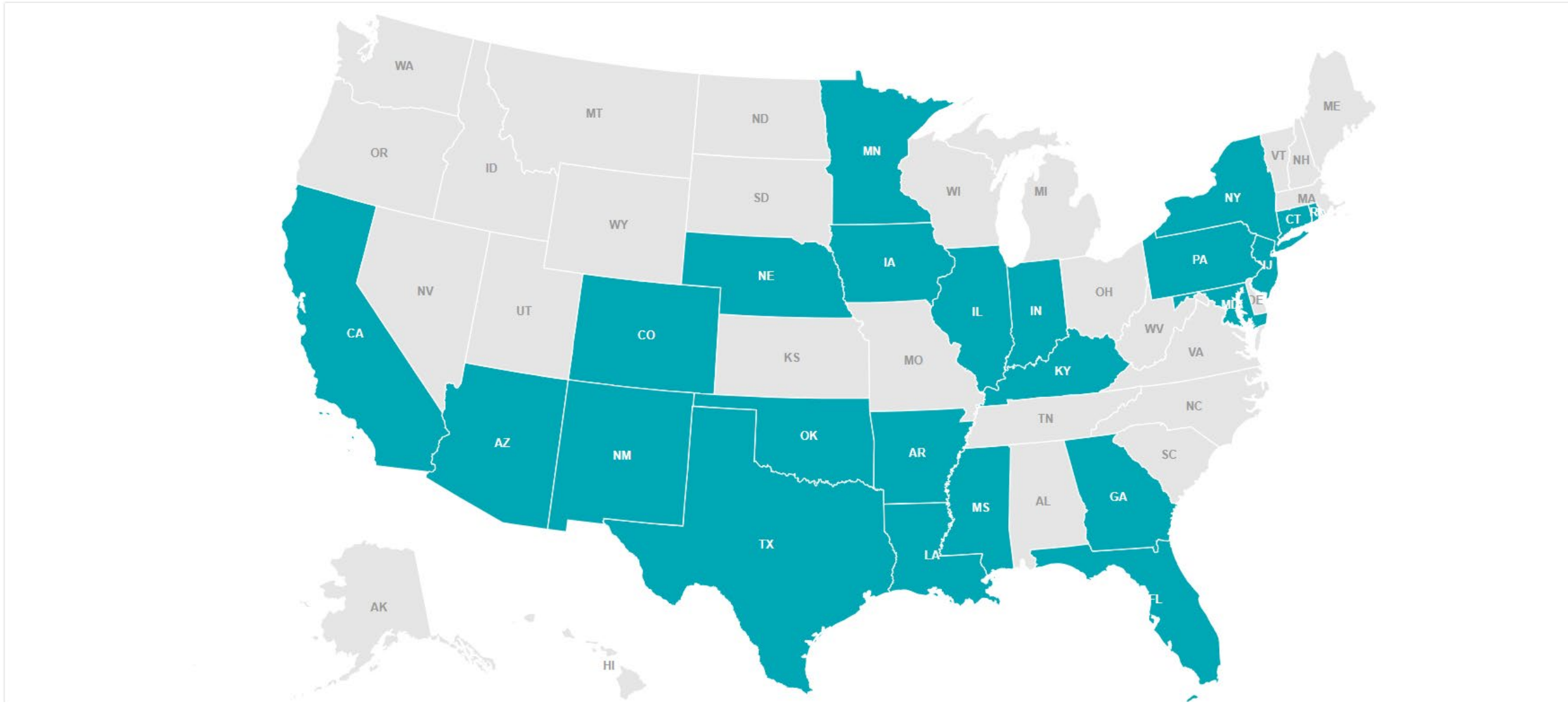


	Status quo	With PrismRA
TNFi wasted spend	$32,885,634	$16,026,054
TNFi efficient spend	$16,248,616	$13,017,721

Source: Scipher Medicine

States that have enacted biomarker testing coverage laws

Protections enacted **No protections**



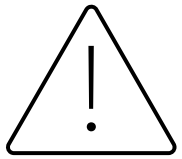
Defrayal

- **Statutory language:** Under the Affordable Care Act (ACA) a state may require a qualified health plan (QHP) to cover benefits in addition to EHB, but if a state mandates coverage in addition to EHB the state must defray the cost and make payments to the enrollee or the QHP.
- **Regulations:**
  - Only applies to benefits required by state action after December 31, 2011. (45 CFR 155.170(a)(2))
  - State will identify which benefits are in addition to EHB. (45 CFR 155.170(a)(3))
  - Determination of cost of additional benefits (45 CFR 155.170(c))
    - Each QHP in the state must quantify the cost
    - Calculation shall be: (1) based on an analysis performed in accordance with generally accepted actuarial principles and methodologies; (2) conducted by a member of the American Academy of Actuaries; and (3) reported to the State.

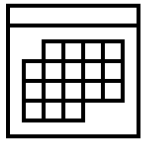
PY2027 NBPP

- Beginning plan year 2028, states will be required to defray the cost of any state mandate that meets the following criteria:
  - Required by state action that took place after December 31, 2011
  - Applicable to the individual and/or small group markets
  - Specific to required care, treatment or services, and
  - Not required for purposes of compliance with federal requirements

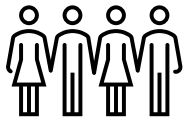
Recommendations for State Regulators



- PROCEED WITH CAUTION



- Effective date of defrayal policy is Plan Year 2028.



- Involve stakeholders

- Seek further clarification from CMS

Additional Resources

- ACS CAN report “Eye on Cancer Care: State Biomarker Coverage Laws” (August 2026) https://www.fightcancer.org/policy-resources/state-biomarker-coverage-laws

- National Health Law Program

Contact Information

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5. Marketplace Open Enrollment Outlook: QHP Rate Filings and QHP Alternatives

Brenda Claire Heyison (Center for Budget and Policy Priorities) and Lucy Culp (Blood Cancer United)

Marketplace Open Enrollment Outlook

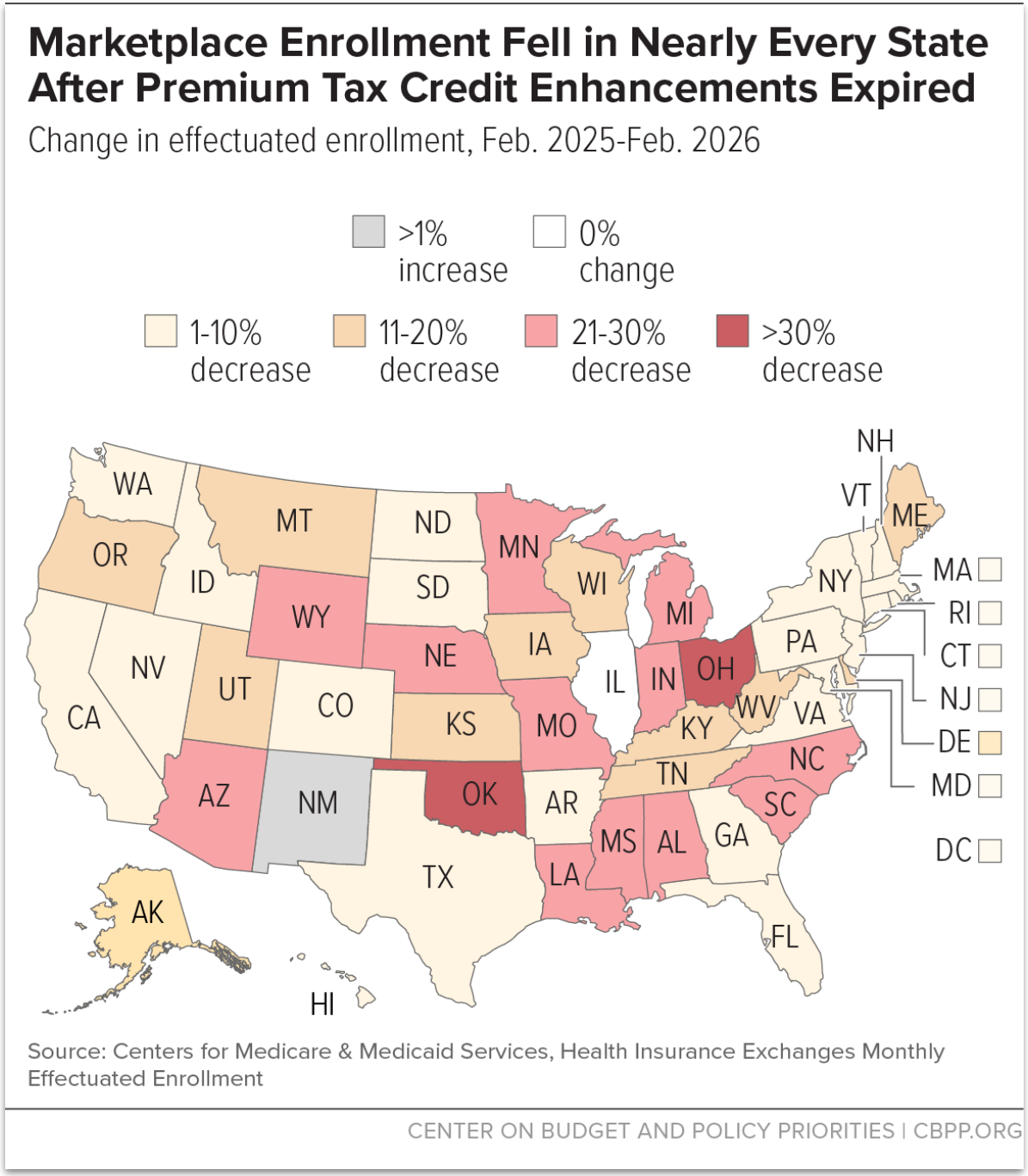
QHP Rate Filings and QHP Alternatives

CLAIRE HEYISON & LUCY CULP

NAIC SUMMER MEETING
CONSUMER LIAISON COMMITTEE
AUGUST 11, 2026

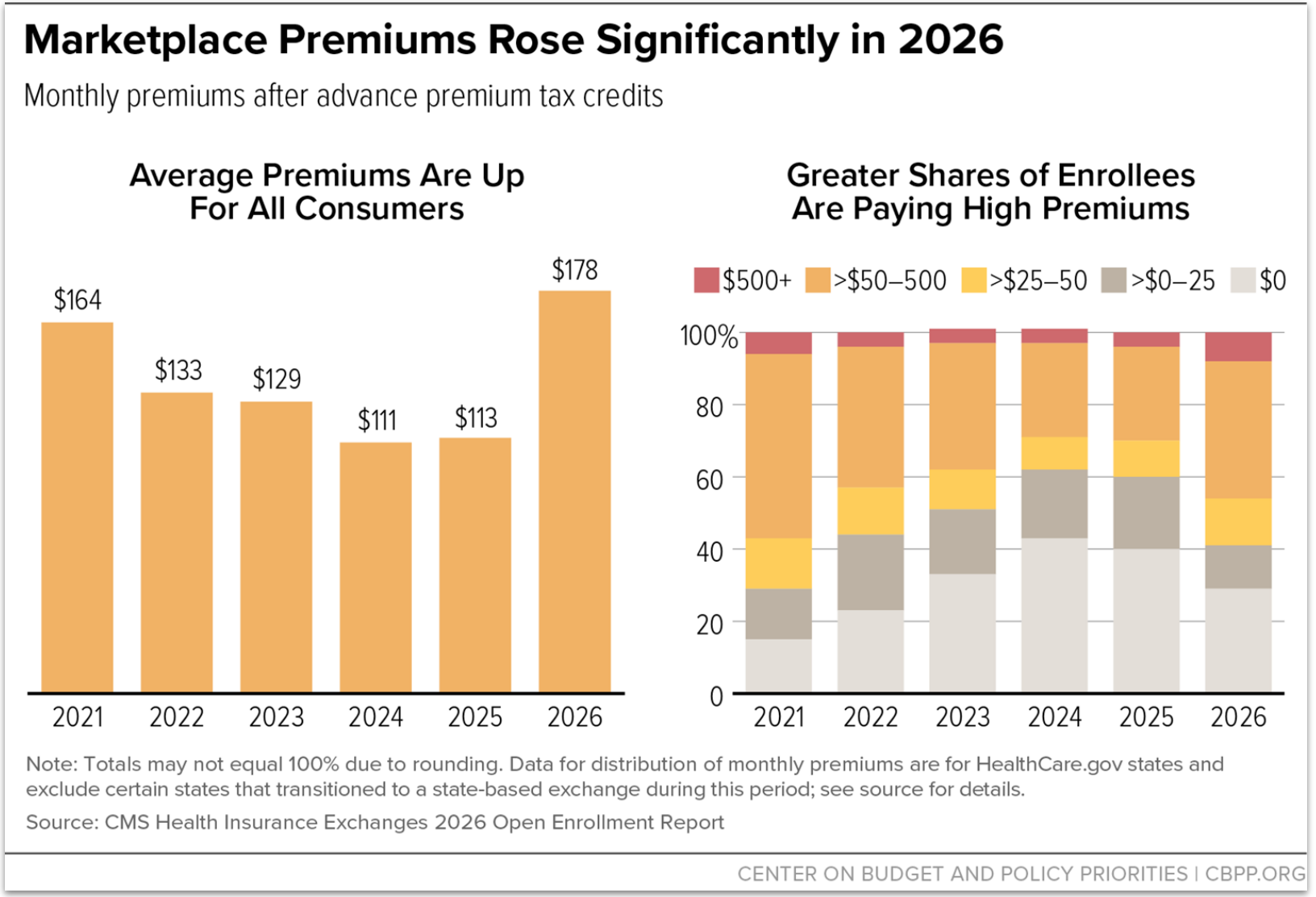
Impact of Expiration of Premium Tax Credit Enhancements

Marketplace Enrollment Fell By ~3 Million People Nationally After Premium Tax Credit Enhancements Expired



CONSUMER HEALTH ADVOCACY AT THE NAIC

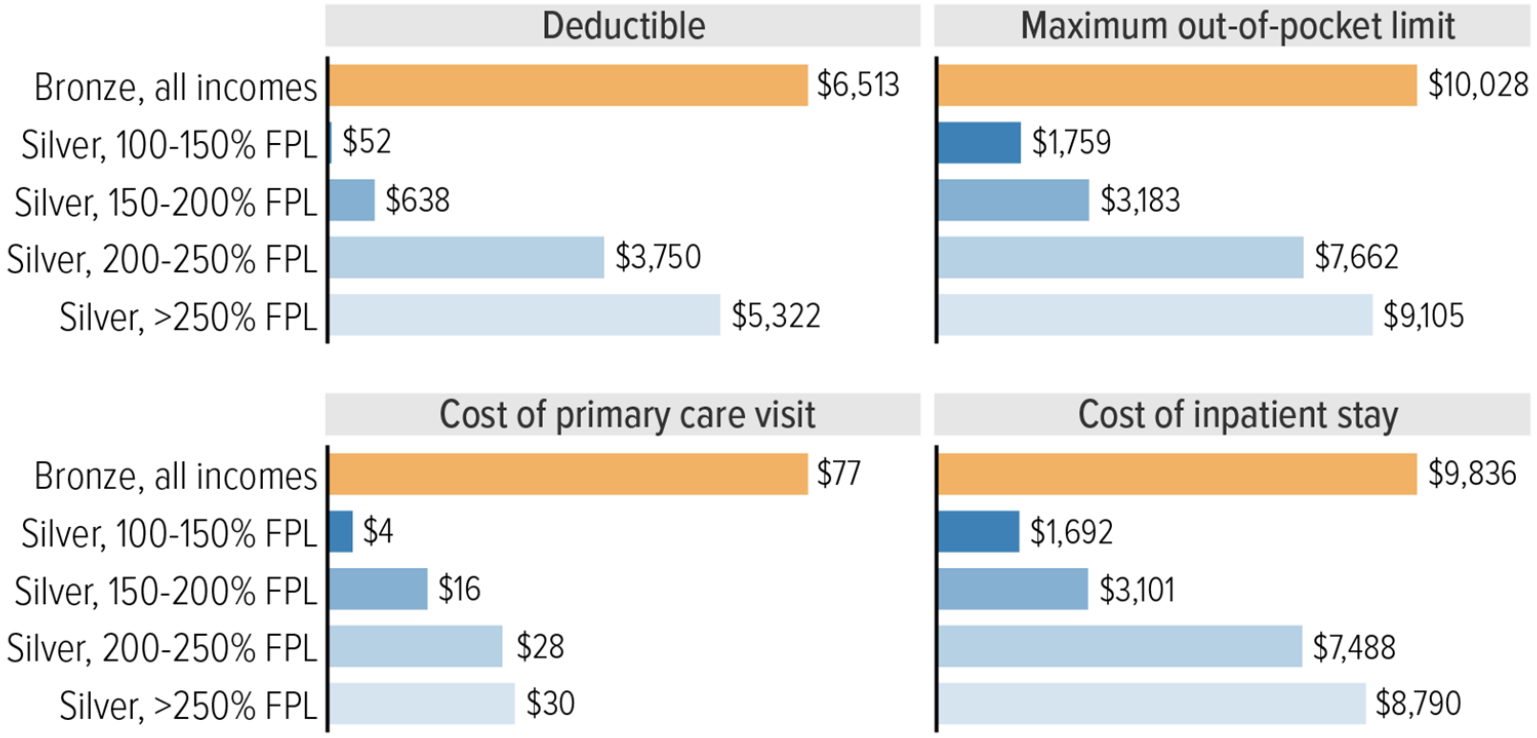
People Who Kept Marketplace Coverage Are Paying Higher Premiums…



…For Coverage with Higher Cost-Sharing

Silver Marketplace Plans Provide More Protection From High Health Care Costs Than Bronze Plans

Average plan features and example costs of care for individuals in Affordable Care Act marketplace plans, by metal level and income eligibility for silver plans with CSRs



Note: CSR = cost-sharing reduction; FPL = federal poverty level.

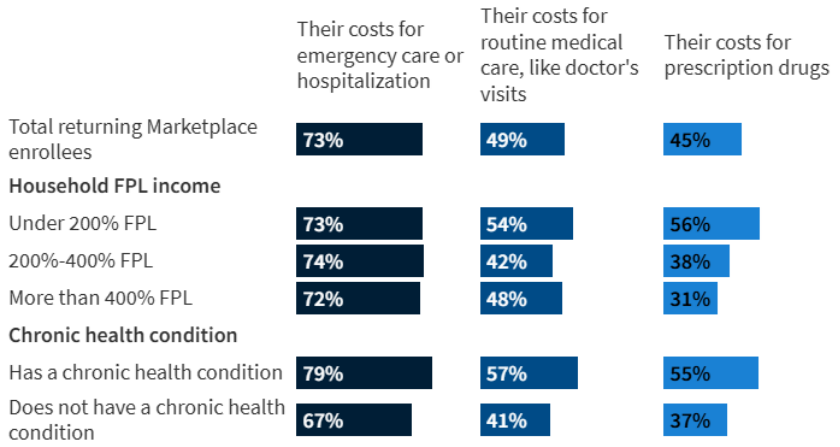
Source: CBPP analysis of the Centers for Medicare & Medicaid Services landscape files for HealthCare.gov states. Costs of care are based on the latest national averages from the Agency for Healthcare Research and Quality adjusted for health care inflation and assume enrollees have not applied other expenses toward their deductibles.

Higher Costs Force Harsh Trade-offs

Figure 8

Large Shares of Returning Marketplace Enrollees Are Worried About Being Able To Afford Emergency Care, Routine Doctor's Visits, and Prescription Drugs

Percent who say they are **very** or **somewhat worried** about being able to afford the following items:



Note: Among 2025 Marketplace enrollees who still have Marketplace coverage. See topline for full question wording.

▶ Chronic health condition details

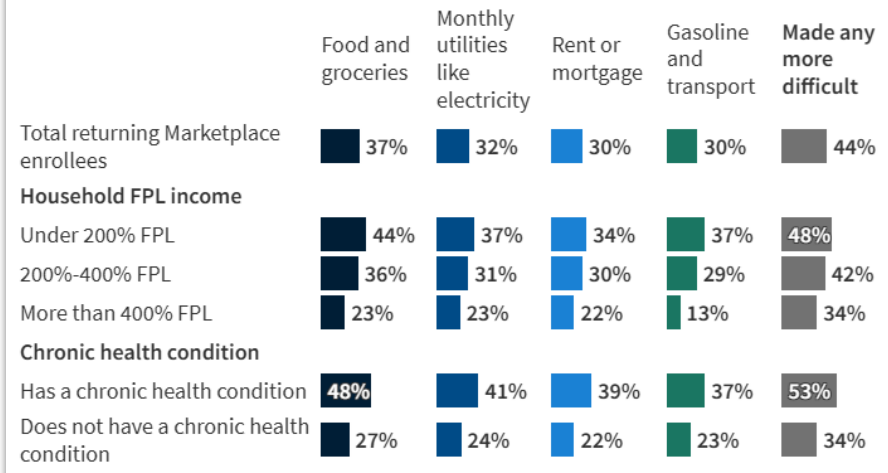
Source: KFF Follow-Up Survey of Marketplace Enrollees (February 12-March 2, 2026) • Get the data • Download PNG

KFF

Figure 9

Over Four in Ten Returning Marketplace Enrollees Say Their Current Health Care Costs Made It More Difficult To Afford Other Expenses

Percent who say their health care costs have made it more difficult to afford each of the following:



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KFF

Recent Policy Changes

Federal Marketplace Reforms

Currently in Effect

- States cannot designate gender-affirming care as an Essential Health Benefit
- People who enroll through an income-based SEP are ineligible for PTCs
- Lawfully present immigrants with income <100% FPL are ineligible for PTCs
- Paperwork requirements for people who enroll through the loss of coverage SEP
- Modified PAPI
- No APTC repayment limits

Will Take Effect PY27

- Most lawfully present immigrants will be ineligible for PTCs
- Multi-year catastrophic plans

Some Reforms Have Been Blocked or Paused

⃠ Blocked by Federal Court

- Allowing insurers to add past-due premiums to binder payments
- Charging people $5/month for passive re-enrollment into $0 net premium plans
- Expanding AV *de minimis* ranges
- Reducing time to resolve DMIs
- Shortening the Open Enrollment Period

⚠ Paused by Federal Court

- New paperwork requirements if tax data are unavailable or inconsistent with estimated income
- One-year FTR policy*
- Additional SEP verification in the FFM
- Elimination of standard plan requirements in the FFM
- Expanded eligibility for catastrophic plans
- Higher maximum out-of-pocket limit for Bronze plans
- Weakened network adequacy requirements
- No-network plans in SBMs and SBM-FPs

* In July 2026, CMS issued guidance instructing marketplaces to no longer apply FTR policies of any duration for PY 2026, and continue in this manner for PY 2027. The one-year FTR policy will still go into effect in 2028 due to the 2025 Reconciliation Law.

Immigrant Coverage Loss Due to Federal Policy Changes

- More lawfully present immigrants will lose eligibility for PTC and CSRs
- No federal Medicaid and CHIP funding for many lawfully present immigrants
- Changes to public charge determination expected to increase chilling effect

CONSUMER HEALTH ADVOCACY AT THE NAIC

The 2027 Open Enrollment Period

2027 Initial Rate Filings Suggest Further QHP Rate Increases

- Early rate filings show ~**15% median increase in gross premiums** among issuers selling ACA marketplace plans, due to:
  - Medical trend
  - Inflation
  - Risk pool deterioration resulting from federal policy changes

New "Secret Shopper" Study

- While trends continue, sales representatives are capitalizing on consumer affordability crisis
- Inaccurate product information
- Sales reps steered to fixed indemnity as a substitute for major medical coverage

Consumer Profiles	
Dani	**Jen**
Lives in WV	Lives in WV
Eligible for SEP for marketplace	Eligible for SEP for marketplace
Income = 200% FPL	Income = 440% FPL
30 years old	55 years old
No pre-existing conditions	Type 2 diabetes
Household of one	Household of one

Consumers Have Few Options

- Limited benefit products are not subject to key consumer protections: guaranteed issue, essential health benefits, community rating
- Misunderstanding of limited benefit products can result in financial risks for consumers
- Increased out-of-pocket expenses can become unaffordable, lead to more medical debt

CONSUMER HEALTH ADVOCACY AT THE NAIC

Federal Action on the Horizon

- Expected rulemaking: Short-term, limited duration plans, Association Health Plans

- Settlement expected in *Data Marketing Partnership v. Labor*

Bloomberg

A Former TV Writer Found a Health-Care Loophole That Threatens to Blow Up Obamacare

Telemarketers are selling cheap plans so bare-bones they'd normally be illegal. They're doing it by signing people up for fake jobs.

By Zachary R Mider and Zeke Faux

May 5, 2025 at 5:00 PM EDT

Corrected: May 12, 2025 at 2:20 PM EDT

CONSUMER HEALTH ADVOCACY AT THE NAIC

Opportunities for state regulators

- Marketing Regulations
- Guardrails and prohibitions on certain limited benefit products
- Premium affordability
- Enrollment supports
- Consumer outreach and engagement

2026 Consumer Rep Report

CONSUMER HEALTH ADVOCACY AT THE NAIC

Questions?

Claire Heyison - cheyison@cbpp.org

Lucy Culp - Lucy.Culp@bloodcancerunited.org

Acronyms

- APTC: advance premium tax credit
- AV: actuarial value
- DMI: data matching issue
- FFM: federally-facilitated marketplace
- FPL: federal poverty level
- FTR: failure to reconcile
- PAPI: premium adjustment percentage index
- PTC: premium tax credit
- PY: plan year
- QHP: qualified health plan
- SEP: special enrollment period
- SBM: state-based marketplace
- SBM-FP: state-based marketplace on the federal platform

CONSUMER HEALTH ADVOCACY AT THE NAIC

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

Jaclyn de Medicci Bruneau (Ceres)

Ceres' New TCFD Analysis Report

www.ceres.org/insurance

7. Unclaimed Policy Funds: Tracking and Reducing Abandoned Property Transfers

Brendan Bridgeland (Center for Insurance Research) and Brent Walker (Coalition Against Insurance Fraud)

Unclaimed Insurance Funds: Tracking and Reducing Abandoned Property Transfers

August 11, 2026

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Brent Walker
Coalition Against Insurance Fraud

Unclaimed Insurance Funds

Background

- The amount of unclaimed funds held by abandoned property funds is massive – totaling $70 billion.
- Overall, states return about one-third of this property to consumers, but in some cases states return less than 5% of the unclaimed property.
- In these difficult economic times, taking steps to help return unclaimed accounts to consumers could help millions of families.

Unclaimed Insurance Funds

- CIR became aware of the abandoned property issue working on demutualizations. During a demutualization, converting mutual insurers are required to distribute shares or cash to participating policyholders. But large life insurers found they had hundreds of thousands of "missing" policyholders.
- Because of the poor record-keeping and search procedures, billions of dollars in demutualization compensation went unclaimed.

Unclaimed Insurance Funds

I once located a demutualization payout in the name of the deceased father of a friend who had passed away while his children were in grade school, but unknown to his widow there was a life insurance policy gifted to the deceased as a newborn. When she contacted the state to claim the fund – she received both the death benefit and demutualization payment. This was money a family coping with the loss of a parent could have benefitted from long ago – over two decades after his death.

Unclaimed Insurance Funds

- Absent the demutualization, the unclaimed policy would have never been discovered. Under law in most jurisdictions, a life insurance policy will not be transferred into the abandoned property fund until three years after the insured would have reached his 100th birthday – the limiting age.
- If a person perishes at the age of 80, an unclaimed life policy won't appear in abandoned property records for another 23 years – long after the family will have ceased searching. In the interim, the insurer retains the funds and thus has little incentive to make contact with paid up policyholders.

Unclaimed Insurance Funds

- Adequate data regarding unclaimed property held by insurers are lacking. A volunteer working at the Center sent a detailed survey to the abandoned property funds of the 50 states several years ago, asking (among other things):
  - How much money the abandoned property funds held;
  - How much of these funds came from insurance companies;

Unclaimed Insurance Funds

- The identity of the 10 largest companies by amount of accounts turned over;
- The identity of the 10 largest insurance companies by the amount of accounts turned over; and
- The requirements and nature of unclaimed property reports required to be submitted by insurers.

- The response was, to say the least, underwhelming. We received only 4 responses, all of which provided only the total amount of funds held and no additional details.

Unclaimed Insurance Funds

NCOIL's Beneficiaries' Bill of Rights and Retained Asset Accounts:

- In 2010, press accounts emerged about the use of Retained Asset Accounts (RAAs) as a default settlement option for military families, and the difficulties they sometimes faced in accessing those insurance funds.
- Prudential eventually settled a class action for $39.2 million for the practice.

Unclaimed Insurance Funds

- An RAA is one of the potential options for the settlement of a death benefit – an alternative to taking a lump sum cash disbursement.
- RAA's operate like a checking account, with insurers distributing their own check-books that can be used to draw upon the funds.
- However, unlike a licensed banking institution, there is no FDIC protection for RAAs.

Unclaimed Insurance Funds

- In light of these reports, NCOIL began investigating and developing its Beneficiaries' Bill of Rights, which was adopted in 2010. (I participated in the drafting group NCOIL assembled to review the topic).
- Bill of Rights Section 5 established important new consumer protections for RAAs – including disclosures about how they differed from a bank account (i.e. no FDIC protection), interest rates, fees, and any limitations on withdrawals.

Unclaimed Insurance Funds

- Bill of Rights Section 6 also required – for the first time – data collection and disclosure about the amount of funds held in RAAs by insurers each year.
- This was accomplished via an addition to the NAIC Annual Statement Blank. (A later effort to remove it was opposed by CIR and NCOIL, as the reporting was required by law in the states that adopted the NCOIL Beneficiaries' Bill of Rights).

Unclaimed Insurance Funds

- These RAA disclosures included the number of contracts and total value of RAA accounts turned over to abandoned property funds each year.
- Transfers of RAAs to abandoned property funds appears to be the first, and only, data collection and disclosure requirement applied to unclaimed insurance benefits.
- While RAAs represent only a tiny portion of the life insurance benefits distributed each year, a review of the data shows the scope of unclaimed benefits is enormous.

Unclaimed Insurance Funds

- I requested and was granted access by the NAIC to the RAA data reported on insurer annual statements from 2020 to 2025.

- I sorted and analyzed the RAA data specifically to determine the number and value of RAAs turned over to abandoned property funds for this period (which only a small portion of life insurance proceeds).

Unclaimed Insurance Funds

RAAs Turned Over to Abandoned Property Funds from 2020 to 2025 – Key Findings:

- During this timeframe, insurers reporting data in their annual statements turned over 8,309 individual and 4,621 group insurance RAA accounts to abandoned property funds.
- The total value of accounts turned over amounted to $113,109,105 during this period.
- The average per contract was $8,748.

Unclaimed Insurance Funds

RAAs Turned Over to Abandoned Property Funds from 2020 to 2025 – Key Findings:

- One insurer accounted for 19.2% of all abandoned RAAs ($21.7 million), and a second for 14.5% ($16.4 million).
- The top 5 insurers (by RAA surrender volume) accounted for over 53% of the total abandoned RAAs.
- The top 20 insurers (again by RAA surrender volume) turned over 91% of all abandoned RAAs to unclaimed property funds during those years.

Unclaimed Insurance Funds

RAAs Turned Over to Abandoned Property Funds from 2020 to 2025 – Key Findings:

- A total of 64 insurers turned over RAA accounts to abandoned property funds, but a handful of companies accounted for much of that.
- The second biggest insurer (14.5% of RAAs) turned over accounts averaging $365,000 – and these large accounts may attract insurance fraudsters (as my colleague Brent Walker will address).

Unclaimed Insurance Funds

RAAs Turned Over to Abandoned Property Funds from 2020 to 2025 – Top States by RAA Transfer Volume:

- Indiana
- Iowa
- Michigan
- Maine
- New York
- Connecticut
- Texas

Unclaimed Insurance Funds

Abandoned Property Fraud Concerns:

Unclaimed Insurance Funds

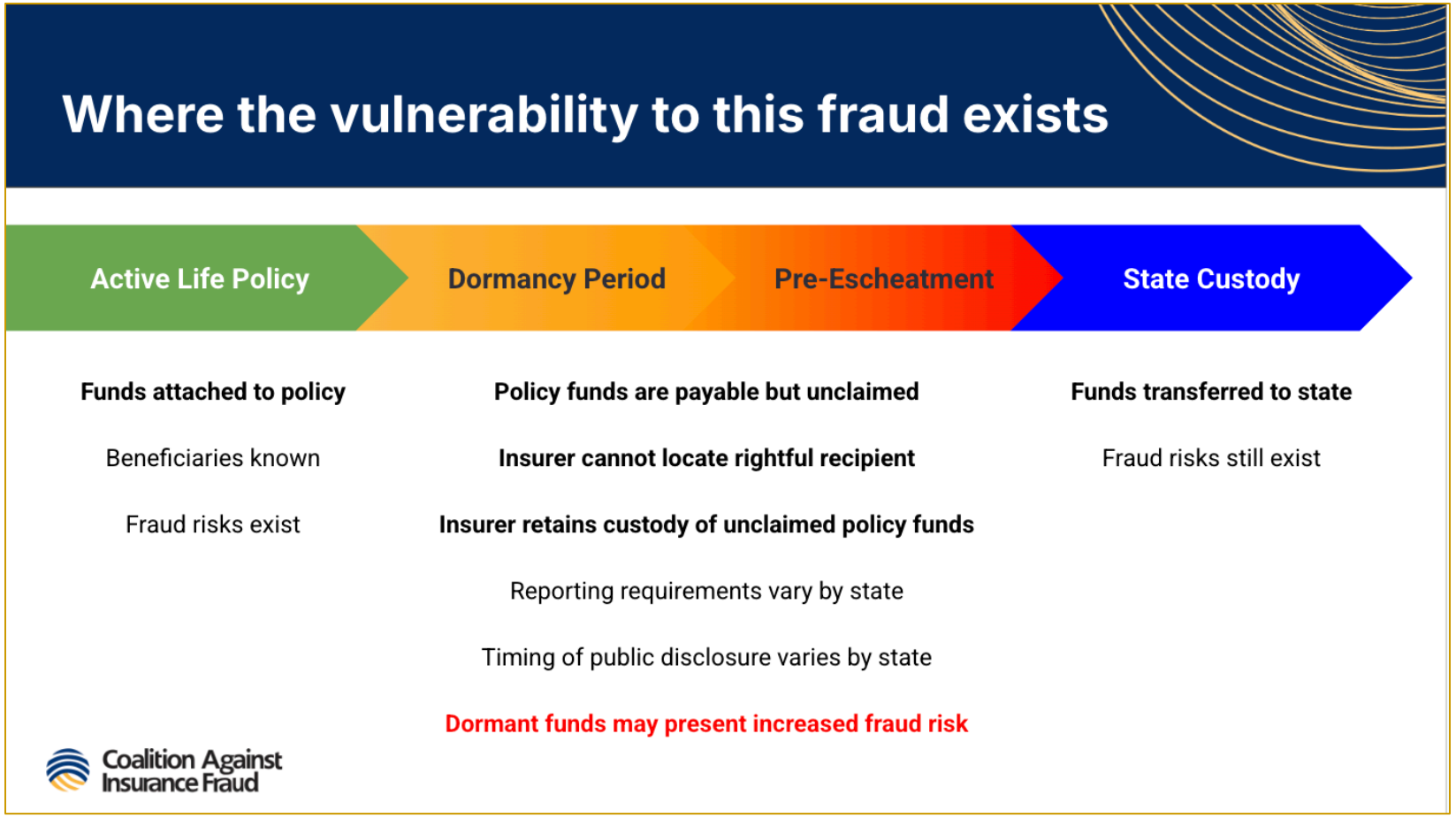
Abandoned Property Fraud Concerns:

- Unclaimed property data and forged IDs found on deep and dark web (NAUPA, 2021)
- 18 identified cases, $129K+ paid to fraudster who filed claims from overseas prison (Coalition insurer member)
- Frequent topic of discussion (Coalition Life & Disability Task Force)

The true scope is unknown.

Unclaimed Insurance Funds

Abandoned Property Fraud Concerns:



Unclaimed Insurance Funds

Abandoned Property Fraud Concerns:

Unclaimed Insurance Funds

Abandoned Property Fraud Concerns:

Unclaimed Insurance Funds

Recommendations and Next Steps

- More data collection and disclosure is necessary, as this review of RAAs shows.
- The Center for Insurance Research is requesting a charge be adopted by the Financial Condition (E) Committee and Blanks Working Group to require all insurers to report in a single line entry the amount turned over to state unclaimed property funds each year by each insurer to track the totals.

8. Strengthening Oversight: The Critical Role of Ethical Standards in Market Conduct Examinations

Richard Weber (Life Insurance Consumer Advocacy Center)

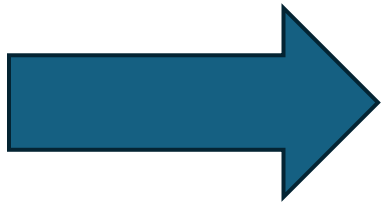
IMSA

Insurance Marketplace Standards Association

Strengthening Oversight: The Critical Role of Ethical Standards in Market Conduct Examinations

Richard M. Weber, MBA, CLU, AEP
NAIC Consumer Representative
Life Insurance Consumer Advocacy Center


ACLI




IMSA
INSURANCE MARKETPLACE
STANDARDS ASSOCIATION


valuable
confident
strength
fair
relevancy
Credibility
TRUST
honesty
compliance
ethical standards
Integrity
authoritative
substantive
living up to promises

The IMSA Principles of Ethical Market Conduct

Each life insurance company subscribing to these Principles commits itself in all matters affecting the sale of individually sold life and annuity products ...

The IMSA Principles of Ethical Market Conduct

1. To conduct business according to high standards of honest and fairness and to render that service to its customers which, in the same circumstances, it would apply to or demand for itself.

The IMSA Principles of Ethical Market Conduct

2. To provide competent and customer-focused sales and service.

The IMSA Principles of Ethical Market Conduct

3. To engage in active and fair competition.

The IMSA Principles of Ethical Market Conduct

4. To provide advertising and sales materials that are clear as to purpose and honest and fair as to content.

The IMSA Principles of Ethical Market Conduct

5. To provide for fair and expeditious handling of customer complaints and disputes.

The IMSA Principles of Ethical Market Conduct

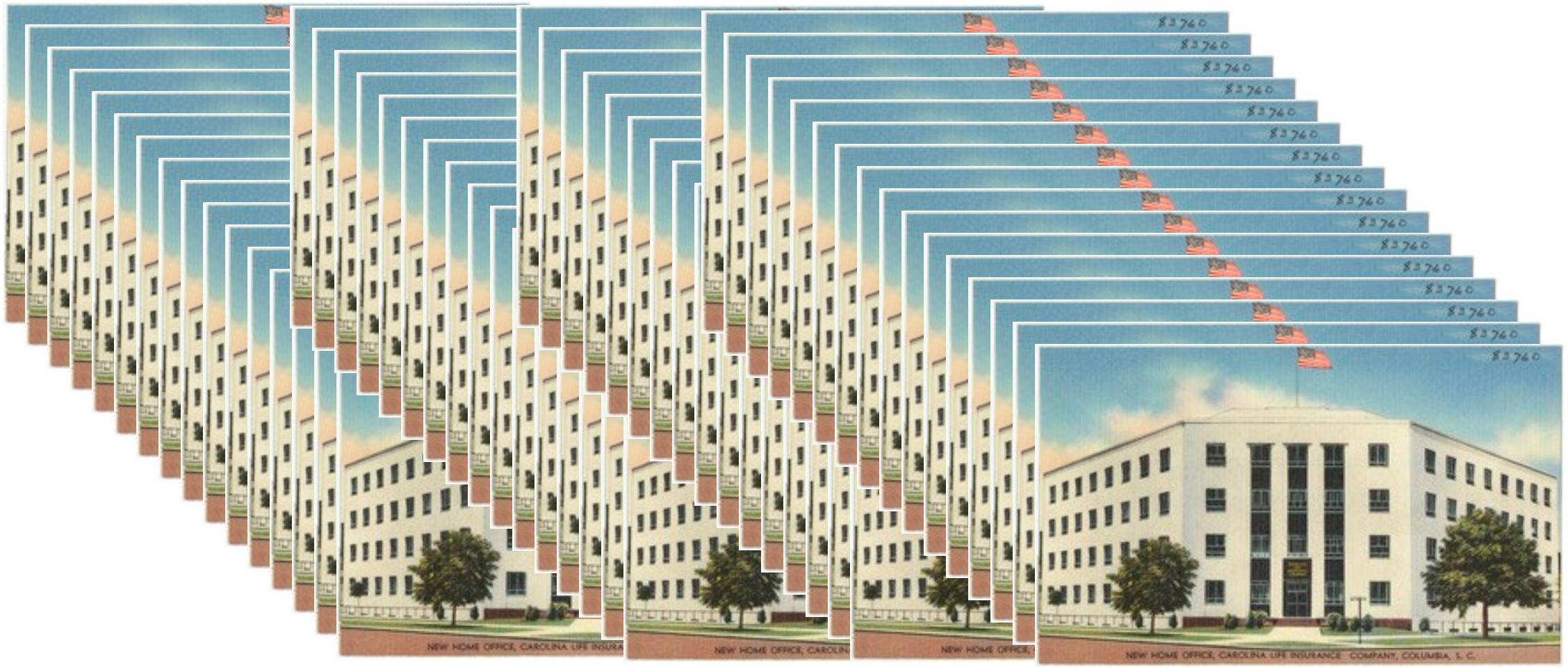
6. To maintain a system of supervision and review that is reasonably designed to achieve compliance with these Principles of Ethical Market Conduct.

The MISSING IMSA Principle

7. Marketplaces cannot be truly and fairly competitive without transparency. Consumers care about the market conduct performance of the insurers they do business with. Price is important, but not more so than trust and transparency.

First 3-year Membership Cohort (1998-2000)

219 U.S. Carriers



But by 2010 …

A concept whose time has come back?

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- Insurers are pursuing new and complex investments to generate or free up more capital and experimenting in states with fewer restrictions

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- 90% of agents fail in the first 4 years (A.M. Best)
- “Most life policies fail to terminate as a death benefit” (Gottlieb & Smetters)
- New and complex investments
- At least 37 demutualizations (1990 to early 2000s) resulted in more shareholder than policyholder focus

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- 25% of consumers buy life/annuities “online” (market.us)
- Life insurance is trending away from a focus on death benefits – moving toward “Income-tax-free RETIREMENT INCOME” – an invitation to revoke the Harken Amendment (§ 913 of the Dodd Frank legislation)

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- New and complex investments
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- 25% of consumers buy life/annuities “online” (market.us)
- Revoke the Harken Amendment (§ 913 of Dodd Frank legislation)?
- Decline in life insurance ownership – just 50% of U.S. households (rfi.global)

Specific Ask

- Establish a Working Group to reconcile the needs and concerns of the various constituents to an updated, NAIC-based IMSA – to include carriers, regulators, and CONSUMERS

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- Establish a Working Group to reconcile the needs and concerns of the various constituents to an updated, NAIC-based IMSA – to include carriers, regulators, and CONSUMERS
- Reformat and define the SEVEN principles
- Create an IMSA-like component to the introduction of the Market Conduct Examiner's Handbook as a helpful starting point for new market conduct regulators.

IMSA

Insurance Marketplace Standards Association

Strengthening Oversight: The Critical Role of Ethical Standards in Market Conduct Examinations

Richard M. Weber, MBA, CLU, AEP
NAIC Consumer Representative
Life Insurance Consumer Advocacy Center

9. The Importance of Analyzing Complete Data Related to Alleged “Nuclear" Verdicts

Amy Bach (United Policyholders), Peter R. Kochenburger (Visiting Professor, Southern University Law Center), and Kenneth Klein (Louis and Hermione Brown Professor of Law at California Western School of Law)

The importance of analyzing complete data related to alleged “nuclear" verdicts

Amy Bach, Peter Kochenburger, and Ken Klein

NAIC Consumer Representatives

Summer 2026 National Meeting

Columbus, Ohio

Insurers have cited to large jury verdicts in support of lobbying campaigns for tort reform (more recently labeled “social inflation”) for nearly 50 years, often without acknowledging:

- The vast majority of those verdicts were very significantly reduced by trial or appellate judges

- Large jury verdicts generally reflect an assessment of behavior that was egregious and needed to be punished and deterred

Two examples of why University of Wisconsin Law Professor Marc Galanter concluded, “Unfortunately, much of the debate on the civil justice system relies on anecdotes and atrocity stories and unverified assertion rather than analysis of reliable data.”

- The McDonald’s ‘Hot Coffee’ Verdict:
  - $2.7MM punitive damages verdict (the amount of net profit McDonald’s made on coffee in a single day).
  - Plaintiff suffered 3rd degree burns over 16% of her body
  - Judge reduced it to $480,000; parties then settled.
  - There was extensive front-page media coverage but only of the original verdict
- A 1986 survey conducted by the National Association for the Education of Young Children during an insurance crisis impacting day care centers concluded that:
  - ‘…our nation’s child-care programs have fallen victim to a fabricated crisis….insurers are not losing money’….nine out of 10…programs …had never had a claim….”

A single jury verdict, though drastically reduced on appeal, sparked an industry wide elimination and/or reduction in coverage to restore mold-damaged properties to pre-loss condition

By THE ASSOCIATED PRESS AUSTIN, Tex., Dec. 19 (AP) - In a prominent case involving a mold-damaged home, a state appeals court reduced a jury verdict against Farmers Insurance Group today to $4 million plus interest and lawyers' fees, from $32 million. The court, the Third District Court of Appeals, said a Farmers affiliate violated the state's Deceptive Trade Practices Act, but it rejected the jury's findings that Farmers committed fraud and did not deal fairly with the homeowner, Melinda Ballard, who had sued over water and mold damage in her 22-room house in Dripping Springs, a suburb west of Austin.

The appeals court left intact a $4 million award for actual damages but threw out $17 million for mental anguish and punitive damages. It also threw out assorted small fees and ordered that $8.9 million in lawyers' fees be recalculated and probably reduced.

The huge jury verdict sent shock waves through the homeowners insurance industry, which has cited rising claims for mold and water damage as a main reason for escalating premiums.

Farmers, which is based in Los Angeles, said it saw a measure of redemption in today's ruling. "We are pleased that the court affirmed everything that we said all along; that we did not commit fraud or knowingly act in bad faith," Michelle Levy, a spokeswoman for the insurer, said. Farmers is the second-largest home insurer in Texas, with about 700,000 customers here. Ms. Ballard said she would appeal the reduced verdict, which could take the case to the Texas Supreme Court.

The appeals court ruling means "an insurance company can rape and pillage without any form of penalty," Ms. Ballard said. "It's going to be a blood bath."

"If there are no penalties to punish bad behavior," she said, what "is going to stop them?"

My colleague Peter Kochenburger now will discuss what is not being said about nuclear verdicts.

And my colleague Ken Klein will discuss the broader holes in the argument that controlling verdicts is the key to unlock a solution to the affordability/availability insurance crisis.

Industry Data: Two Problems and a Critical Question

1. Over time, approximately 50% of ”nuclear verdicts” or high punitive damages awards arise from IP, trade secrets, breach of contract and other commercial disputes and are unrelated to bodily injury claims.

2. The case examples often used by Industry highlight the initial jury award, and do not reflect subsequent disposition where the jury award was partially or entirely overturned. This is particularly true for large punitive damages verdicts.

? The insurance industry frequently links “nuclear verdicts” to rising costs of homeowners and personal auto insurance. What is the relevance of IP, commercial disputes, products liability, commercial auto, and professional liability verdicts to the cost of homeowners and personal auto insurance? Are these claim losses included when insurers are setting rates for personal lines of insurance?

Marathon Strategies 2025 Report (reporting on 2024 verdict data)

available at: https://marathonstrategies.com/report/corporate-verdicts-go-thermonuclear-2025-edition/

- "While these cases often span a variety of topics and claims, they were largely driven in 2024 by products liability ($13.7 billion) and intellectual property ($4.4 billion), which has also been the historical trend." P. 2 [In addition to Product Liability and IP verdicts, antitrust and trade secrets cases are also in the top 10]
- "The largest settlements occurred in the same category of cases Marathon Strategies identified as the top subject of nuclear verdicts: product liability, which totaled $**23.4** billion in settlements in 2024. Antitrust ($8.41 billion), securities fraud ($2.55 billion), consumer fraud ($2.44 billion), and privacy ($1.92 billion) followed. Interestingly, intellectual property – the second-highest target of nuclear verdicts – did not rank among the top areas of settlements identified by the report." P. 9

Marathon Strategies 2025 Report (reporting on 2024 verdict data)

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- "Patent Litigation Continues To Dominate: The second-largest area of nuclear verdicts has traditionally been intellectual property, which saw $4.4 billion ordered in 25 cases in 2024. Over 70 patent infringement trials reached a jury verdict last year, half of which were a complete patent owner win. Fifteen of these verdicts were for over $100 million." P. 13

And

- "The verdicts analyzed in this report were compiled by gross award calculated by the jury, and do not reflect reductions, remittiturs, or reversals, among other case developments." P. 4

Top 10 Corporate Nuclear Verdicts — 2024

Original jury awards • Marathon Strategies (2025 Report)

#	Verdict	Defendant	Case Topic
1	**$5.23B**	AffinityLifestyles / Real Water	Products Liability
2	**$4.70B**	NFL	Antitrust
3	**$3.09B**	AffinityLifestyles / Real Water	Products Liability
4	**$2.25B**	Bayer / Monsanto	Products Liability
5	**$1.60B**	CCA Construction	Fraud.
6	**$847M**	Verizon	Intellectual Property
7	**$725M**	Exxon Mobil	Products Liability
8	**$604.9M**	Phillips 66	Trade Secrets
9	**$525M**	Amazon	Intellectual Property.
10	**$495M**	Abbott Laboratories	Products Liability

Top 10 Corporate Nuclear Verdicts — 2024

Marathon Strategies • Original jury awards

BODILY INJURY — PRODUCTS LIABILITY

#1	$5.23B	AffinityLifestyles / Real Water	Products Liability
#3	$3.09B	AffinityLifestyles / Real Water	Products Liability
#4	$2.25B	Bayer / Monsanto	Products Liability
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#10	$495M	Abbott Laboratories	Products Liability

NON-BI — ECONOMIC / COMMERCIAL

#2	$4.70B	NFL	Antitrust
#5	$1.60B	CCA Construction	Fraud
#6	$847M	Verizon	Intellectual Property
#8	$604.9M	Phillips 66	Trade Secrets
#9	$525M	Amazon	Intellectual Property

Source: Marathon Strategies, Corporate Verdicts Go Thermonuclear (2025 ed.), pp. 11–12.

Industry examples: *Legal System Abuse Costs Billions* – Insurance Thought Leadership, June 2026

Two cases cited as prime examples of legal system "abuse"

- "In 2019, an auto-liability case in Nassau County, N.Y., resulted in a jury award of $100 million to the victim's parents for pain and suffering and $900 million in punitive damages against the defendant, a trucking company." [This case was tried in Nassau County, FL in 2021].

- "Juries have issued massive punitive awards against a multinational pharmaceutical, biotechnology and medical technology company in cases that allege its talc-based products caused cancer. Some verdicts have exceeded $1 billion, and earlier cases produced punitive damages surpassing $4 billion before reductions on appeal." [The specific case is not cited, and this reference is the only time appellate review is mentioned in the article]

Misleading (inaccurate) Narrative: *Legal System Abuse Costs Billions* – Insurance Thought Leadership, June 2026

What Actually Occurred

- In 2019, an auto-liability case in Nassau County, N.Y., resulted in a jury award of $100 million to the victim's parents for pain and suffering and $900 million in punitive damages against the defendant, a trucking company.

There were several defendants; the $900 Million punitive damage was assessed against the trucking company that was unrepresented since 2019 and did not appear at trial, resulting in a default judgment of the entire punitive damage award. This award is uncollectable.

Finding the ultimate or current status of these two cases took less than 25 minutes.

Misleading (inaccurate) Narrative: *Legal System Abuse Costs Billions* – Insurance Thought Leadership, June 2026

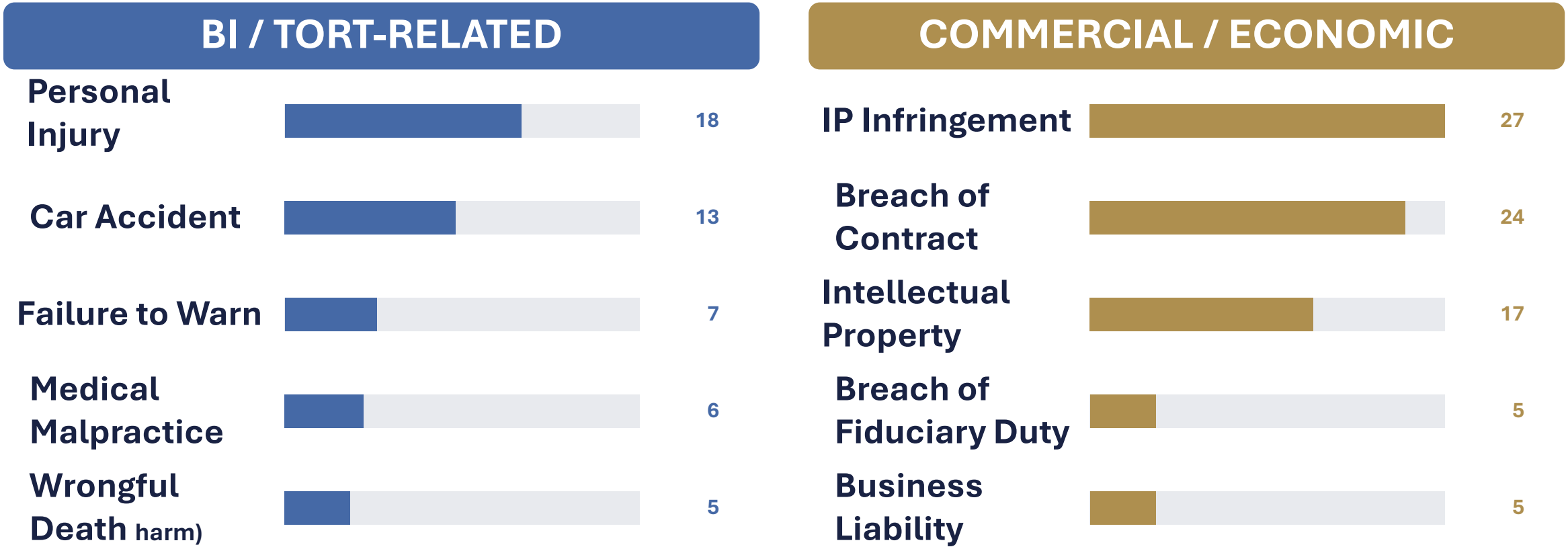
What Actually Occurred

- Juries have issued massive punitive awards against a multinational pharmaceutical, biotechnology and medical technology company in cases that allege its talc-based products caused cancer. Some verdicts . . . Likely case: Moore v. Johnson & Johnson, Los Angeles Country , where the jury awarded $950 M in punitive damages in October 2025.

The trial judge overturned the entire punitive damage award in March 2026. Both sides are appealing.

$100M+ Nuclear Verdicts Arise from Very Different Types of Litigation

CIPR / Journal of Insurance Regulation, 2012–2021 • Top 10 loss classifications (citation below)



Historically and currently, the largest reported nuclear verdicts fall principally into two broad categories: (1) IP, antitrust, trade-secret, and other commercial disputes; and (2) product-liability and other bodily-injury-related cases.

Caution: Table 2 lists the top 10 classifications, not an exhaustive mutually exclusive division of all 222 verdicts; later cases may have multiple classifications.

Source: Cole & Marzen, “Nuclear Verdicts, Tort Liability, and Legislative Responses,” Journal of Insurance Regulation, Table 2, p. 16.

The Marathon Strategies report is consistent with a recent JIR article* on nuclear verdicts, over half of the nuclear verdicts over a ten-year period were IP or contract cases

Table 2: Top 10 Types of Losses for Nuclear Verdicts

Type of Loss	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
Intellectual Property Infringement				3	2	1	4	5	6	6	27
Breach of Contract	2	1	4	2	3	4	3	2		3	24
Personal Injury			3	6	5	2		2			18
Intellectual Property	8	3	6								17
Car Accident						2	4	4		3	13
Failure to Warn						2	1	2		2	7
Medical Malpractice	5	1									6
Breach of Fiduciary Duty	2		1	1						1	5
Business Liability						1				4	5
Wrongful Death			3		2						5

Source: Information obtained from https://topverdict.com/. Includes all verdicts of $100 million between 2012 and 2021. It should be noted in later years, multiple types are often listed for each case. Type used in summary information presented here is based on first type listed.

*Cole & Marzen, "Nuclear Verdicts, Tort Liability, and Legislative Responses," Journal of Insurance Regulation, Table 2, p. 16.

Concerns about the "*nuclear verdicts cause insurance issues*" thesis are not only anecdotal but also systemic:

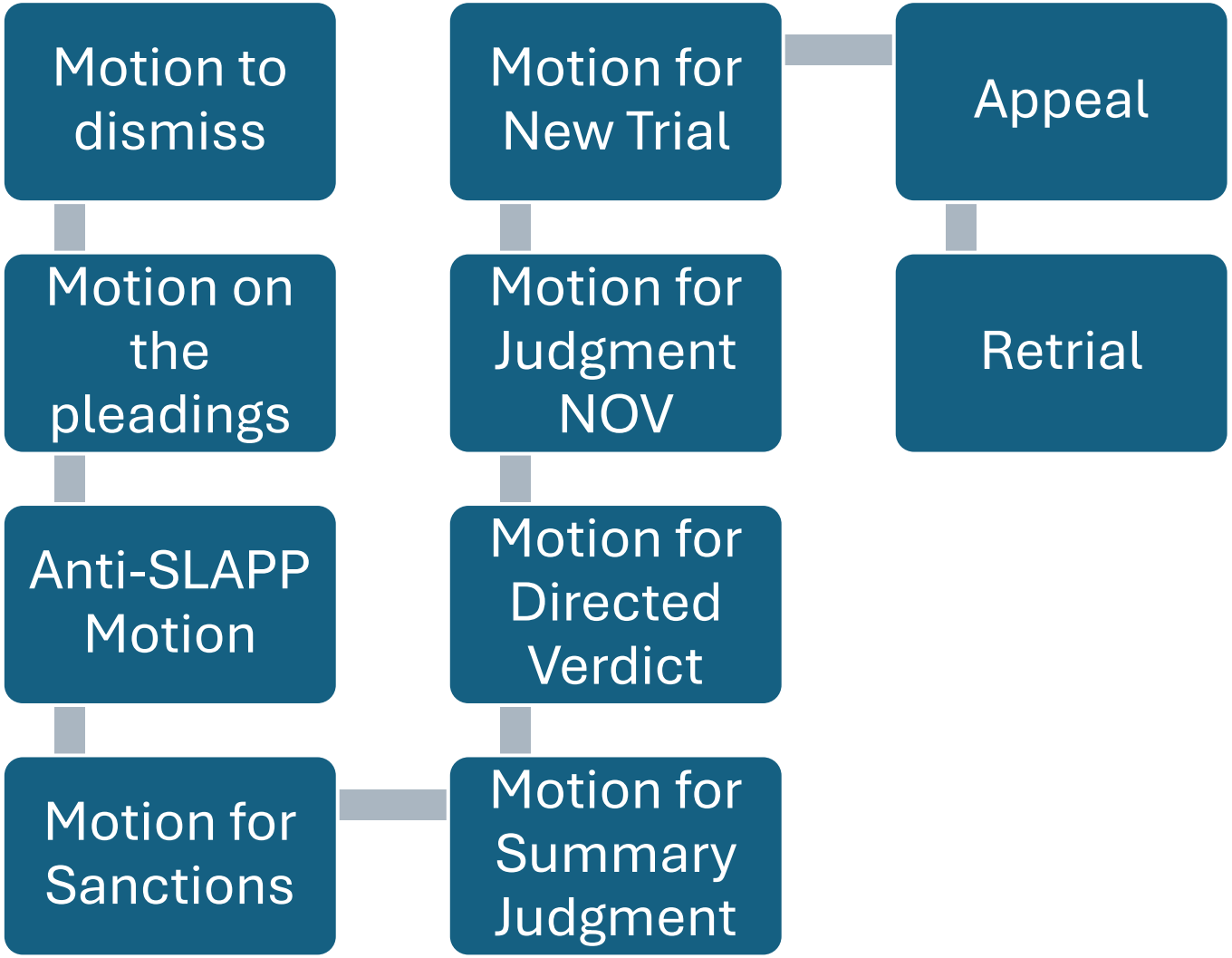
- Inconsistent threshold $$ amounts for what is a "Nuclear Verdict."
- Lack of rigorous data establishing an increase in either the frequency of 'nuclear' verdicts or the average size of the verdicts.
- Limited empirical engagement isolating the relative causal contribution of other possible explanations of rising premiums or declining insurance availability.
- Mismatching of litigation verdicts to insurance lines (for example, home damage verdicts with homeowner insurance premiums, or commercial trucking verdicts with commercial vehicle insurance premiums).
- And, arguably most importantly, failing to account for the fact that…

Systemic concerns about the "*nuclear verdicts cause insurance issues*" thesis :

- Inconsistent threshold $$ amounts for what is a "Nuclear Verdict."
- Lack of rigorous data establishing an increase in either the frequency of 'nuclear' verdicts or the average size of the verdicts.
- Limited empirical engagement isolating the relative causal contribution of other possible explanations of (ex// increased climate risk and rising costs of repairs).
- Mismatching of litigation verdicts to insurance lines (for example, IP or contracts verdicts with homeowner or personal auto insurance premiums).

It is wrong to assume that Large Verdicts = Frivolous Verdicts

Existing court mechanisms to eliminate frivolous litigation



Litigation reform in the name of reducing frivolous lawsuits can harm policyholders:

- Litigation simply is the market mechanism providing an incentive for insurers to be more careful and fairer in adjusting claims.
- Litigation reform makes all litigation harder to file and harder to win.
- Litigation reform puts a thumb on the scales balancing incentives for insurers to fairly and accurately adjust claims, and so can improperly impede recovery by innocent victims.

Litigation reform poorly addresses insurance adequacy and affordability issues:

- Liability insurance for day care centers is getting more expensive and harder to get at all.
- Last month, the NAIC Child Care Insurance Working Group was shown a slide entitled, "WHAT IS DRIVING CARRIERS OUT OF THE MARKET," arguing that a $24.8 verdict against a California foster family agency explained why the NIAC dropped ~90% of its insured California FFAs.
- On appeal, the appellate court ruled : "**Denying liability to foster children** wronged by negligent FFAs **would be a blunt and morally fraught approach** to addressing the lack of liability coverage."

Conclusions

- As NAIC members and staff examine the merits of claims of litigation abuse and nuclear verdicts and potentially limiting judicial remedies as a strategy for reducing homeowners and personal auto premiums, we urge careful fact-finding and data analysis both on the underlying facts in large verdict cases and potential effects of weakening private enforcement of insurance consumer protection standards that complement regulator actions.

- We urge the NAIC to convene a full or half day session on this topic, serving as a neutral forum with balanced representation of the full range of stakeholder perspectives.

10. Discuss Any Other Matters Brought Before the Liaison Committee

Commissioner D.J. Bettencourt (NH)