

Draft Pending Adoption

Draft: 8/28/23

NAIC/Consumer Liaison Committee
Seattle, Washington
August 12, 2023

The NAIC/Consumer Liaison Committee met in Seattle, WA, Aug. 12, 2023. The following Liaison Committee members participated: Andrew R. Stolfi, Chair (OR); Grace Arnold, Vice Chair (MN); Lori K. Wing-Heier represented by Heather Carpenter (AK); Mark Fowler (AL); Ricardo Lara (CA); Michael Conway (CO); Andrew N. Mais represented by Kurt Swan (CT); Michael Yaworsky (FL); Dean L. Cameron represented by Randy Pipal (ID); Dana Popish-Severinghaus represented by KC Stralka (IL); Vicki Schmidt represented by LeAnn Crow (KS); James J. Donelon represented by Ron Henderson (LA); Kathleen A. Birrane represented by Jamie Sexton (MD); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by Jacob Just (ND); Eric Dunning represented by Martin Swanson (NE); Scott Kipper represented by David Cassetty (NV); Judith L. French represented by Jana Jarrett (OH); Michael Humphreys represented by Jodi Frantz (PA); Cassie Brown represented by Randall Evans (TX); Jon Pike represented by Tanji Northup (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler (WA); Nathan Houdek represented by Sarah Smith (WI); and Allan L. McVey represented by Erin K. Hunter (WV). Also participating was Paige Duhamel (NM).

1. Adopted its Spring National Meeting Minutes

Commissioner Lara made a motion, seconded by Ron Henderson, to adopt the Committee's March 21 minutes (see *NAIC Proceedings – Spring 2023, NAIC/Consumer Liaison Committee*). The motion passed unanimously.

2. Heard a Report on the Consumer Board of Trustees Meeting

Commissioner Stolfi said the Consumer Board of Trustees is combining the different applications for the NAIC Consumer Participation Program into one application. He said there have been different applications, depending on whether a person is applying as a funded or unfunded consumer representative and whether a person is in the first or second year as a consumer representative. He said the combined application will be used for individuals applying to participate in the NAIC Consumer Participation Program in 2024. He said the Board discussed a request for action submitted by Erica Eversman (Automotive Education & Policy Institute—AEPI) for the NAIC to amend the NAIC *After Market Parts Model Regulation* (#891) to redefine “aftermarket” parts and establish criteria for insurers to inform consumers about the use of aftermarket parts. He said the Board discussed a potential conflict of interest submitted by a consumer representative.

3. Heard a Presentation from the CEJ on “A Meaningful Framework for Supervision of Insurer’s Use of Big Data and Artificial Intelligence”

Birny Birnbaum (Center for Economic Justice—CEJ) said the purpose of market conduct regulation is to ensure the fair treatment of consumers. He said unfair discrimination, from an actuarial perspective, is treating similarly situated consumers differently in rating or claims. He said this is defined as an unfair trade practice. He said unfair discrimination is also defined as discriminating against a person because of their race, religion, or national origin. He said discriminating against an individual is unfair and prohibited even if the treatment is actuarially fair. He said insurers may use data that is racially biased, which indirectly causes unfair discrimination based on race. He said industry claims a risk classification and scoring algorithm that is predictive is fair and that protected class discrimination can only mean explicit and intentional discrimination against a protected class.

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Birnbaum said state insurance regulators in 2020 acknowledged the increased potential for the use of racially biased data and algorithms to result in the unfair discrimination of protected classes when the NAIC adopted the Principles on Artificial Intelligence (AI). He said following the adoption of the principles, George Floyd was murdered by police in Minneapolis, and the U.S. was confronted with the fact that structural racism persists throughout the country. State insurance regulators recognized this watershed moment to declare action against racism in insurance, which led to the appointment of the Special (EX) Committee on Race and Insurance. Since that time, Birnbaum said the NAIC has made great strides in diversity, equity, and inclusion (DE&I) education and initiatives, but he questioned the progress the NAIC has made in addressing structural racism in insurance..

Birnbaum said the Innovation, Cybersecurity, and Technology (H) Committee's draft AI Model Bulletin fails to respond to the challenges and promises made by the NAIC in 2020. He said the bulletin does not expand on the AI Principles or offer guidance on how state insurance regulators should implement the principles. He said the bulletin tells insurers what they already know, which is that the use of AI must comply with the law and insurers should have oversight of their AI. He said the bulletin fails to provide essential definitions and does not define proxy discrimination.

Birnbaum said state insurance regulators should focus on consumer outcomes and not the process. He said AI governance and risk management procedures are necessary and important but not sufficient. He said insurers should be testing to ensure their data, algorithms, and applications do not result in unfair discrimination on both an actuarial basis and a protected class basis in all phases of the insurance life cycle. He said regulatory guidance is needed to define proxy discrimination and disparate impact to help establish at least one uniform testing methodology. He said this should include the reporting of test results by insurers.

Birnbaum said a governance requirement should include a requirement that insurers' AI outcomes are disputable, which is a broader requirement than transparency. He said the governance- only approach, which is called principles-based, does not make sense for addressing the regulatory oversight of AI. He said state insurance regulators can obtain the data and ability to ensure good consumer outcomes and compliance with state laws through testing for unfair discrimination, and that testing should be a central feature of state insurance regulatory oversight of AI.

Birnbaum said state insurance regulators need to define proxy discrimination and establish thresholds for testing results that would be considered proxy discrimination. He said the CEJ has proposed guidance for these. He said insurers should be able to identify and explain why a consumer outcome occurred and trace the outcome to a particular characteristic of the consumer. This would provide consumers with the ability to dispute the outcome, which is a broader requirement that an insurer explain how a model or algorithm works.

In response to a question from Commissioner Stolfi about the difference between governance and testing, Birnbaum said financial regulators use risk-based capital (RBC) with specific guidance on how insurers should measure their capital to produce an RBC ratio. Without this type of testing and guidance, insurers would have only a governance approach, and each insurer could define risk in any way they want. Birnbaum said the framework for RBC is the framework needed for the oversight of AI. This framework sets common metrics for testing and goes beyond pure governance.

Commissioner Lara asked about testing for unfair discrimination based on sexual orientation. Birnbaum suggested a phase-in approach and starting testing for unfair racial discrimination since data on race is available. Insurers, at some point, should be willing to ask policyholders for protective class characteristics on a voluntary basis.

4. Heard a Presentation from the UP and the AEPI on the Appraisal Process for Automotive and Property Damage Claims

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Amy Bach (United Policyholders—UP) said the UP has a Roadmap to Recovery Program to help consumers after a catastrophe and a Roadmap to Preparedness Program to help eliminate protection gaps and engage in consumer advocacy and action. She said the UP is working to restore confidence and fairness to the property claims appraisal process. She said disputes between insurers and insureds over the extent of damage and repair costs are extremely common. This leads to wasted time and judicial resources since appraisals can be completed without attorneys and litigation.

Bach provided an overview of how the insurance appraisal process is supposed to work, which is intended to be a faster and cheaper process than litigation in resolving a valuation dispute between an insurance company and a policyholder. She said each side picks their appraiser, and then the two appraisers are supposed to agree on an umpire to resolve any discrepancies in the valuation. For example, she said the appraisal process should resolve issues, such as how many square feet of lumber are needed or the grade of lumber needed, by engaging with experts in construction and labor costs rather than taking these types of disputes to court.

Bach said some insurers have removed appraisal clauses from their policies in states that do not require an appraisal clause. This means disputes have a higher likelihood of ending up in litigation. Bach said there are some variations in appraisal clauses. She provided an example of an appraisal clause that specifies that each party must select their appraiser within 20 days after the demand is received, and then an umpire is to be selected. She said not every company or state needs to have the exact same rules.

Bach said there are a lot of points of contention around initiating appraisals. For example, she said parties may be working to resolve a dispute, and then either the insurer or insurance company may demand to initiate an appraisal process. The parties can then face disputes about what umpire to select, which is when courts often need to get involved. Bach said there may also be questions about whether an appeal is binding, the effect of the appraisal process in a lawsuit, and whether the use of the appraisal process precludes a bad faith case. She encouraged the Property and Casualty Insurance (C) Committee to review this issue and work to reform the appraisal process.

Eversman said the appraisal clause is intended to be an alternative dispute resolution mechanism used to determine property loss claim value. She said it is not intended to determine liability. She said some appraisal clauses are more definitive, but they are usually not very detailed in private passenger automobile (PPA) policies. She said typical auto appraisal disputes arise with partial losses and focus on the types of parts to be used, the cost of parts, and whether a part should be repaired or replaced. She said there are new parts, aftermarket parts, and salvage parts. She said total loss values can also be contentious. She said insurers use appraisals as a shield by which an insurer will not use an appraisal until an insured sues in court to demand an appraisal. Insurers will also use appraisals as a sword to try to resolve non-monetary issues.

Eversman recommended that state insurance regulators mandate appraisal clauses in automobile policies for both full and partial property losses; require insurers to notify consumers that the right to an appraisal exists if they disagree with an offer; require insurers to use independent umpires; and establish a time frame for the right to an appraisal, along with a maximum consumer expense permitted. She said appraisal requirements must also have details, such as who may serve an appraiser and penalties for failure to comply with the appraisal requirements.

Eversman requested that the Property and Casualty Insurance (C) Committee establish a workstream to address the appraisal process for auto losses. Crow asked what the recommended maximum a consumer should pay for an appraisal is. Bach said the cost is a deterrent for consumers, and she suggested that insurers should advance the cost of the appraisal and then deduct half the cost of the appraisal from the final settlement. Eversman suggested a maximum cost of between \$500 to \$800 for auto claim appraisals. She said states should mandate appraisal clauses in policies, and either the insurer or insured should have the right to request an appraisal.

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5. Heard a Presentation from the DREDF, the Whitman-Walker Institute, and the LLS on Federal Health Updates

Kellan Baker (Whitman-Walker Institute) said the Consolidated Appropriations Act of 2023 delinked continuous enrollment in Medicaid and the public health emergency (PHE), which ended continuous Medicaid enrollment on March 31. He said Medicaid enrollment grew by an estimated 23 million (32%) to 95 million individuals between 2020 and 2023. He said this stopped the churn between Medicaid coverage and private marketplace coverage. He said 7.8 to 24.4 million individuals will lose Medicaid coverage during the PHE unwinding, and states are moving at different speeds to complete PHE unwinding and Medicaid eligibility redeterminations. He said 74% of people who dropped from Medicaid coverage were disenrolled for procedural reasons during the unwinding, and many disenrolled beneficiaries are likely still eligible for Medicaid coverage.

Baker said state insurance regulators can help mitigate the impact of disenrollment from Medicaid by enhancing in-person assistance; working with insurers and state Medicaid agencies to develop outreach toolkits; ensuring that accurate information is available to consumers about inexpensive but potentially insufficient coverage alternatives; and monitoring qualified health plans (QHPs) for marketing, enrollment, and network adequacy. He said states should also consider an “unwinding” open enrollment period, expand continuity of care protections, and require pro-rating of out-of-pocket costs for mid-year transitions.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applies to fully insured and self-insured health plans, as well as non-federal governmental group plans. She said enforcement authority is held by the U.S. Department of Labor (DOL), the federal Centers for Medicare & Medicaid Services (CMS), and state insurance regulators. She said racial and ethnic minorities often have worse mental health outcomes due to inaccessibility to quality mental health care services. There is also discrimination and a lack of awareness about mental health. Yee said there was a proposed rule issued on July 25 addressing non-quantitative treatment limitations (NQTLs) under the MHPAEA. This guidance provides 13 factual examples for review. One key change is that the proposed rule would classify certain benefits, conditions, and disorders based on “generally recognized independent standards of current medical practice.” Yee encouraged state insurance regulators to comment on the proposed rule to provide insights on how state and federal cooperation can best be operationalized to ensure consumer access to care for mental health and substance use disorder (MH/SUD).

Lucy Culp (Leukemia & Lymphoma Society—LLS) said Georgetown University has completed several “secret shopper” studies, and there is a trend of misleading marketing as people lose their Medicaid coverage. She said the proposed rule on short-term, limited-duration (STLD) insurance defines STLD insurance as being no more than a three-month contract term and no more than four months with the same insurer within a 12-month period. The rule prohibits stacking by issuers and applies to new policies. For on-coordinate excepted benefits, she said the proposed rule requires individual market indemnity products to be paid on a per-period basis, and hospital or other fixed indemnity products must be paid as a fixed dollar amount, regardless of expenses incurred. She recommended that state insurance regulators support the definition of STLD insurance in the proposed rule, support the proposal for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit, and offer additional insights regarding products sold across state lines through association plans.

Commissioner Stolfi said Oregon passed a law that required three free primary care visits, and consumers could pick whether the three free visits would be for medical or mental health purposes. Due to established federal methodology requiring insurers to estimate which costs would be for medical care versus mental health care, Oregon had to amend the law to require a \$5 copay for these visits. Commissioner Stolfi said Oregon would be submitting comments about this since the implementation of a \$5 copay is not something Oregon wanted to impose on consumers.

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6. Heard a Presentation from the Consumers' Checkbook, Georgians for a Healthy Future, and the United States of Care on Preventative Health Services

Caitlin Westerson (United States of Care) said the federal Affordable Care Act (ACA) requires most private health plans (e.g., non-grandfathered individual, group, and self-funded) to cover more than 100 preventive health services without cost sharing. She said the decision in the case of *Braidwood Management Inc. v. Becerra*, while temporarily stayed, puts access to critical preventive care at risk for more than 150 million people, including approximately 37 million children. If the decision is upheld and applies nationwide, she said two in five adults would skip necessary preventive care, and historically underserved communities will be disproportionately affected. She said even a small copay could deter those with low incomes from receiving preventive care. She said the following key preventive services, if eliminated, would disproportionately affect consumers with limited access to health care: 1) smoking cessation; 2) pre-exposure prophylaxis for the prevention of HIV; 3) colorectal cancer screening; and 4) postpartum depression screening. The communities most affected would be Native Americans, African Americans, Hispanic individuals, and rural populations.

Eric Ellsworth (Consumers' Checkbook) said documentation for providers and consumers regarding preventive services and payer guidance documents is extremely burdensome to search on insurers' websites. He said consumers equate not finding information on a benefit with that benefit not being available. He said plan formularies often do not distinguish coverage from preventive and non-preventive drugs. He said payer guidance documents that inform claims adjudication policies were often incomplete. He said it is especially hard for consumers to get complete information when an intervention includes both a medical and pharmacy benefit.

Yosha Dotson (Georgians for a Healthy Future) provided the following six recommendations for state insurance regulators: 1) utilize data calls and market conduct exams to assess compliance with preventive and cost-sharing requirements; 2) ensure continued preventive protections with state legislative and regulatory action; 3) enforce appeals protections for mis-adjudicated or denied preventive services claims; 4) ensure that QHP certification assesses formularies and other plan documents; 5) hold plans accountable for educating consumers and providers on preventive services requirements; and 6) establish uniform billing and coding standards.

7. Heard a Presentation from the AKF and the HIV+Hepatitis Policy Institute on Healthcare Appeals and Denials

Deb Darcy (American Kidney Fund—AKF) said the number of health care denials is a concern, and she referenced a ProPublica report that stated that one health insurer denied 60,000 claims in one month without a human reviewing the claims. She said health insurers must follow the laws, and doctors are expected to examine a patient's medical records before a health insurer can reject a claim for not being medically necessary. She said the U.S. House of Representatives (House) Committee on Energy and Commerce is looking into the activities of this company. In addition, she said a class action lawsuit was filed against the insurance company in the Eastern District of California. The class action lawsuit notes that the insurer rejected 300,000 claims over a two-month period, which indicates that the insurer spent an average of 1.2 seconds on each claim.

Darcy said the Kaiser Family Foundation (KFF) released a survey on consumer experience with health insurance and whether consumers understand what services will and will not be covered. She said the KFF survey reflects that 17% of health claims were denied for ACA plans, and less than 1% of denied claims were appeals. She said the survey reflected that 16% of consumers said their insurance company delayed or denied needed care and prior authorizations; 27% of consumers said their health insurance paid less than what they expected; 18% of consumers said insurance did not cover any of the care they received; and 23% said their insurance did not cover a needed prescription. She said the survey reflected that 40% of adults surveyed did not know they have the right to appeal a claim denial, and 24% of the consumers surveyed did not know who to contact when they have a problem with their health insurance.

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Carl Schmid (HIV+Hepatitis Policy Institute) said there are 20 consumer representatives focusing on health insurance issues, and he suggested that state insurance regulators review existing data collected on health insurer denials. He suggested that state insurance regulators meet with representatives of the KFF, the federal Center for Consumer Information and Insurance Oversight (CCIIO), and the DOL. Regarding prior authorization, he suggested that states have a better understanding of individual state actions and proposed federal regulations through state presentations, federal presentations, and presentations by consumer groups and the American Medical Association (AMA). He also suggested that the NAIC update its models to address prior authorization. Regarding appeals and denials, he suggested that state insurance regulators better understand the reasons for denials, better understand why a low number of appeals are approved, and work to shift provider behaviors around appeals. He said state insurance regulators should work to encourage consumer knowledge of their rights to appeal a denial. He said state insurance regulators should investigate new ways in which to communicate with consumers and engage with each other to exchange ideas on how to enhance communication with consumers. He said state insurance regulators should review the use of AI for health claims, and he encouraged state insurance regulators to invite insurers to present on their use of AI. He also encouraged state insurance regulators with expertise in health insurance to work with the Innovation, Cybersecurity, and Technology (H) Committee to develop guidance on the use of AI.

Schmid said consumer representatives have submitted formal requests for action for an additional review of these issues by the Health Insurance and Managed Care (B) Committee; the Market Regulation and Consumer Affairs (D) Committee; and the Innovation, Cybersecurity, and Technology (H) Committee. Duhamel suggested that the denial of health claims would be a good topic for NAIC Zone meetings. Crow said the Consumer Information (B) Subgroup is working on how to increase consumers' knowledge regarding their rights to appeal a health claim denial.

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

SharePoint/NAIC Support Staff Hub/Committees/Consumer Cmte/2023 Summer/Consumer_08 Min

Draft: 10/13/23

Adopted by the Executive (EX) Committee and Plenary, Dec. XX, 2023

Reaffirmed by the NAIC/Consumer Liaison Committee, Oct. 13, 2023

2024 Reaffirmed Mission Statement

NAIC/CONSUMER LIAISON COMMITTEE

The mission of the NAIC/Consumer Liaison Committee is to assist the NAIC in its mission to support state insurance regulation by providing consumer views on insurance regulatory issues. The Liaison Committee provides a forum for ongoing dialogue between NAIC members and NAIC consumer representatives. The Liaison Committee's activities in 2024 will be closely aligned with the priorities of the NAIC Consumer Participation Board of Trustees.

NAIC Support Staff: Lois E. Alexander

**NAIC CONSUMER LIAISON
REPRESENTATIVE RECOMMENDATION
TO THE EXECUTIVE COMMITTEE**

(Please send completed form to Lois Alexander for processing)

RECOMMENDED BY: Brendan Bridgeland

DATE: November 20, 2023

ISSUE: Pet Insurance Complaint Collection and Classification

COMMITTEE REFERRAL RECOMMENDATION:

(A)_____ (B)_____ (C)_____ (D) X (E)_____ (F)_____ (G)_____

ACTION REQUESTED/CHARGE RECOMMENDED:

Adding pet insurance as a category in the NAIC's complaint database.

NAIC ACTION:

Develop a classification for pet insurance complaints in the State Based Systems (SBS) complaint tracking database. This would make it far easier for regulators, consumer groups and consumers to monitor developments in the pet insurance marketplace through the NAIC's Consumer Information Source. It would also support the NAIC's other pet insurance data collection initiatives – in the P/C financial statements and MCAS reports and provide states with the ability to evaluate this rapidly growing line of business.

RECOMMENDATION ACCEPTED: _____

RECOMMENDATION DECLINED: _____

Not Much of the Life Insurance Purchased in the U.S. Winds Up As a Death Claim

Richard M. Weber, MBA, CLU
Consumer Representative



This presentation is based on a paper entitled

Lapse-Based Insurance

David Gottlieb - London School of Economics and Wharton School, University of Pennsylvania

Kent Smetters - Wharton School, University of Pennsylvania

June 6, 2016, and updated in 2021

“Most individual life insurance policies lapse before expiration. Insurers sell front-loaded policies, make money on lapsers, and lose money on non-lapsers. Policyholders who lapse cross-subsidize those who do not.”

Why is this important?

- Over 70 percent of US families own life insurance and annual premiums exceed \$110 billion
- Annualized lapse rates lead to substantial lapses over the multi-year life of the policies.

Why is this important?

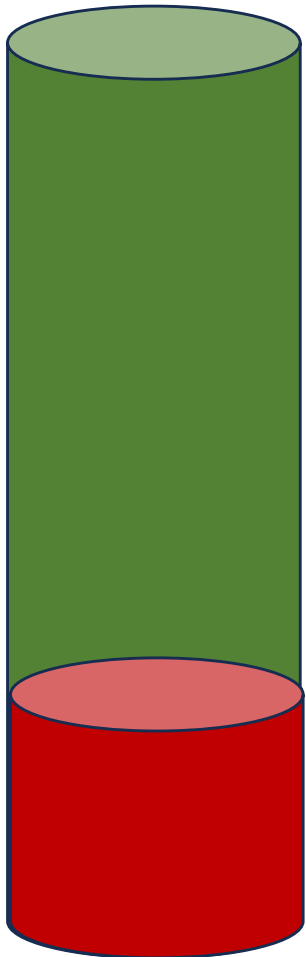


1990 - 2010



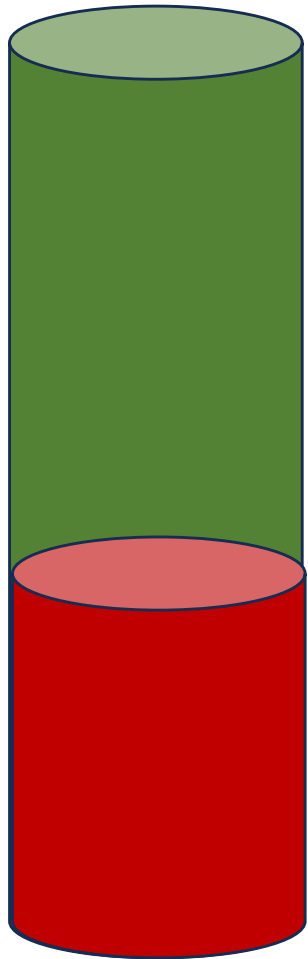
1990 - 2010

Why is this important?



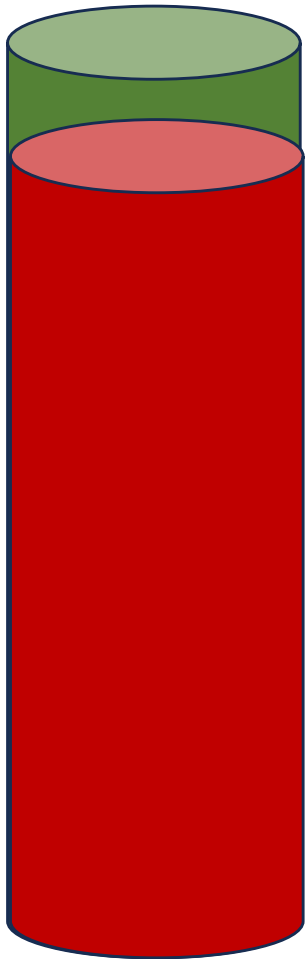
- **25% of permanent insurance** policyholders lapse within just three years of first purchasing their policies;

Why is this important?



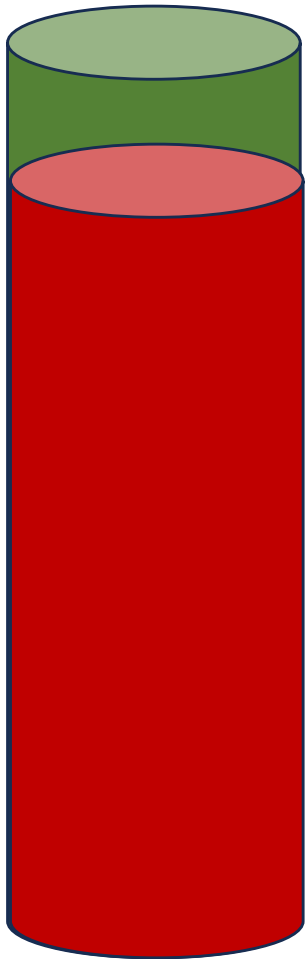
- Within 10 years, **40%** have lapsed.

Why is this important?



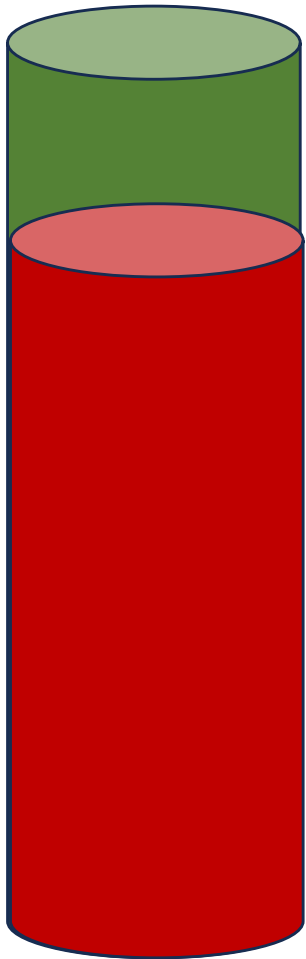
- **Nearly 88% of universal life policies ultimately do not terminate with a death benefit claim.**

Why is this important?



- Almost 85% of term policies fail to pay a death claim;

Why is this important?



- In fact, 74% of term policies and 76% of universal life policies sold to seniors at age 65 never pay a claim.

Why people lapse - G&S

“Lapsers”

- “Lapses are more prevalent for smaller policies, and more exposed to ‘background’ shocks, including unemployment, medical expenses, new consumption opportunities, etc.”
- “Forgetting to pay.”

Why people lapse - G&S

Insurers

- “There is substantial evidence that insurers take profits from lapses into account when setting their premiums.”
- Note: NAIC’s 1995 Life Insurance Illustration Model Regulation prohibits this activity, known as Lapse Supported Pricing (Section 6-B-9)

Why people lapse - G&S

Insurers

- “What companies were doing to get a competitive advantage was taking into account these higher projected future lapses to essentially discount the premiums to arrive at a much more competitive premium initially because of all the profits that would occur later when people lapsed.”

(Society of Actuaries 1998, p. 12)

Additional G&S Findings

Insurers

- Insurance agents receive most of the sales commission in the first or second year
- Anecdotally, consumers are more likely to lapse their policies when they are not in contact with their sales agent.

Additional G&S Findings

Insurers

- Wealth managers typically earn fees based on the market value of accounts “...thereby encouraging the wealth manager to keep the relationship active.”
- The paper observes: “Our model suggests that front-loaded commissions may be used to incentivize insurance brokers to find clients without concern for whether they will hold their policies for very long.”

Why people lapse - Real World

Lapsers

- When policies are sold primarily based on the illustration, misalignment of regulations and the way many policies actually “work” often create customer dissatisfaction when they later see lower results than initially illustrated.

Why people lapse - Real World

Lapsers

- Another agent may suggest they can offer a “better deal” and use a *new* policy illustration suggesting it will meet the client’s expectations. Rarely does this turn out to be true - and the second policy is lapsed.

Why people lapse - Real World

Insurers

- While regulations have attempted to reign in the “Wild Wild West” of Indexed UL (AG49, AG49A, and AG49B), carriers have successfully found ways to counteract regulatory intent after the introduction of each AG revision to make their illustrations “look attractive.”

Why people lapse - Real World

Insurers

- Anecdotally, commissions continue to be the “driver” of sales behavior in a number of cases, and lapses (and indeed lawsuits) often follow a failure to consider the client’s best interests - and the suitability of the recommendation.

Who is affected by these “**Best Interest**” and “**Suitability**” rules?

Legislated fiduciary obligations of care

360,000 Investment Advisor Representatives (many of whom may also be regulated by FINRA as Registered Representatives), and their **14,800** Registered Investment Advisory firms.

Regulated fiduciary obligations of care

624,000 Registered Representatives,
including those dually licensed as IARs.

Regulated fiduciary obligations of care

There are approximately **332,000** licensed insurance agents in the U.S, **20,500** of whom sell insurance products in New York.

Regulated fiduciary obligations of care

All licensed agents would be subject to the updated fiduciary rules of the **Department of Labor** - when recommending an annuity to an IRA or Roth plan.

Regulated fiduciary obligations of care

5,065 CPAs certified as Personal Financial Specialist (PFS).

Professionally required fiduciary obligations of care

5,000 members of the Society of Financial Service Professionals are subject to a standard similar to that of a fiduciary duty: to place the client's interests ahead of the member's and to only provide planning and/or product recommendations that are suitable for the client.

Professionally required fiduciary obligations of care

100,000 CFP financial planners who are obligated to Fiduciary Standards promulgated by the CFP Board of Standards and required as a condition of biannual membership renewal.

No matter how you count 'em ...
there are a lot of advisers, advisors,
and agents affected by these fast-
evolving rules!



That said, we would like to point out that industry trade groups such as Finseca, ACLI, IRI and NAIFA seeking to expand “financial security for all” *cannot reach this goal when 88% of what’s placed fails to pay death claims.*

In conclusion, noting ...

Most consumers are not keeping their life insurance until death. This has an adverse effect on families and is contrary to sensible public policy, and ...

In conclusion, noting ...

ONE reason more policies are not retained is due to a failure to match appropriate policies to the resources and circumstances of the consumer.

Our “Ask” of the NAIC

1. How should we be presenting policy illustrations – prepared under current, strict state regulation but terribly flawed in terms of the expectations they create for the client – when the mandate in New York (and likely to “cross the Hudson”) is serving “the client’s best interest?”

Our “Ask” of the NAIC

2. We urge the NAIC to evaluate the experience of the New York Department’s **Insurance Regulation 187** and move toward requiring insurance carriers and agents/brokers to only make policy recommendations that are suitable to the consumer’s circumstances - and accomplished with the client’s interest held above that of the agent.

Not Much of the Life Insurance Purchased in the U.S. Winds Up As a Death Claim

Richard M. Weber, MBA, CLU

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