

Draft: 8/22/23

Market Regulation and Consumer Affairs (D) Committee  
Seattle, Washington  
August 15, 2023

The Market Regulation and Consumer Affairs (D) Committee met in Seattle, WA, Aug. 15, 2023. The following Committee members participated: Jon Pike, Chair (UT); Mike Causey, Co-Vice Chair, represented by Jackie Obusek (NC); Michael Humphreys, Co-Vice Chair, and David Buono (PA); Peni Itula Sapini Teo (AS); Karima M. Woods (DC); Trinidad Navarro and Susan Jennette (DE); Dean L. Cameron (ID); Sharon P. Clark (KY); Chlora Lindley-Myers represented by Cynthia Amann and Jo LeDuc (MO); Jon Godfread represented by John Arnold (ND); Michael Wise (SC); Cassie Brown, Matthew Tarpley, and Jamie Walker (TX); Kevin Gaffney represented by Karla Nuisl (VT); and Jeff Rude (WY). Also participating were: Dana Popish Severinghaus and Erica Weyhenmeyer (IL); Larry D. Deiter (SD); Rebecca Nichols (VA); and Mike Kreidler and John Haworth (WA).

1. Adopted its July 27 Minutes

Commissioner Pike said the Committee met July 27 and took the following action: 1) adopted the pet insurance Market Conduct Annual Statement (MCAS) data call and definitions; 2) adopted a new charge for the Producer Licensing (D) Task Force to amend the NAIC's *Public Adjuster Licensing Model Act* (#228); and 3) received the Voluntary Market Regulation Certification Program from the Market Regulation Certification (D) Working Group.

Commissioner Clark made a motion, seconded by Commissioner Navarro, to adopt the Committee's July 27 minutes (Attachment One). The motion passed unanimously.

2. Adopted Revisions to the *Market Regulation Handbook*

Tarpley said revisions to the NAIC *Market Regulation Handbook*, Chapter 4—Collaborative Actions, Section E. Conclusion of Collaborative Enforcement Actions are meant to provide non-regulators with transparency and insight regarding the multistate settlement process that occurs in the Market Actions (D) Working Group. The revisions were adopted by the Market Conduct Examination Guidelines (D) Working Group on July 18.

Director Cameron made a motion, seconded by Commissioner Humphreys, to adopt the revisions to Chapter 4 of the *Market Regulation Handbook* (Attachment Two). The motion passed unanimously.

3. Adopted the Voluntary Market Regulation Certification Program

Commissioner Pike said during the Committee's call, the Market Regulation Certification (D) Working Group reported that it had completed its work, and the final draft of the Voluntary Market Regulation Certification Program, guidelines, checklist, and implementation plan have been exposed on its web page since May 9.

Commissioner Kreidler said the completed Voluntary Market Regulation Certification Program consists of 11 requirements; checklists and guidelines for each requirement; a scoring matrix; and the implementation plan. He said the program is a long-needed response to the federal government's critiques of market conduct regulation in the separate states and territories of the U.S. It is also a step forward to promoting best practices and consistency for all NAIC members' market regulation activities, and it promotes collaboration among the NAIC members.

Haworth presented an overview of the contents of the program to the Committee. He said the program has 11 requirements that are broken into five major categories, including: 1) the appropriate statutory authorities for

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market regulation departments to conduct market regulation activities and maintain the confidentiality of information obtained from their own activities and received from other NAIC jurisdictions; 2) staffing resources and qualifications to conduct market regulation activities and/or to oversee contractors; 3) the use of the *Market Regulation Handbook*; 4) the reporting of timely, accurate, and complete data to NAIC databases and participation MCAS; and 5) collaboration with other jurisdictions through NAIC working groups.

Haworth said in the first three years of the program, jurisdictions will have the ability to self-certify themselves using the program checklist and scoring matrix. After three years, jurisdictions will have the option to either self-certify or be fully certified by an independent panel of state insurance regulators. Re-certification would occur every five years.

Commissioner Clark made a motion, seconded by Director Cameron, to adopt the Voluntary Market Regulation Certification Program and Scoring Definitions (Attachment Three). The motion passed unanimously.

### 4. Adopted its Task Force and Working Group Reports

#### A. Antifraud (D) Task Force

Commissioner Navarro said the Antifraud (D) Task Force met Aug. 14. The Task Force discussed its current charges in preparation for developing its 2024 charges, and he requested that suggestions be submitted by Sept. 22. He said the Task Force will meet in October to adopt its 2024 proposed charges.

Commissioner Navarro said the Task Force heard a presentation concerning Workers' Compensation Premium Fraud from the United Brotherhood of Carpenters and Joiners of America (UBC). He said the Task Force discussed the importance of workers' compensation insurance fraud related to the construction industry and agreed that additional discussions in regulator-to-regulator and open meetings are necessary to further address this type of insurance fraud.

Commissioner Navarro said the Task Force received a report from the Improper Marketing of Health Insurance (D) Working Group. The Working Group met July 27 to discuss the revised draft amendments to the NAIC's *Unfair Trade Practices Act* (#880). He said the Working Group also met Aug. 14 to discuss the revised draft and comments and adopt the amendments to Model #880. He said the Task Force will expose the adopted amendments for comment and meet in September to consider them for adoption.

Commissioner Navarro said the Task Force received an update from the Antifraud Technology (D) Working Group. He said the Working Group chair is working with NAIC staff concerning the redesign of the NAIC's Online Fraud Reporting System (OFRS). The Working Group will be holding conference calls to discuss necessary enhancements to the OFRS to include fields provided from the National Insurance Crime Bureau (NICB) data.

Commissioner Navarro also said the Task Force heard a presentation from the Coalition Against Insurance Fraud (CAIF) regarding a research study on who commits insurance fraud and why. The study showed how different generations across the nation view insurance fraud. He said the Task Force also received reports on matters of interest from the CAIF and the NICB.

#### B. Market Information Systems (D) Task Force

Director Severinghaus said the Market Information Systems (D) Task Force met July 31. She said this year, the Task Force is beginning work on implementing the recommendations contained in the Artificial Intelligence (AI) report it adopted last year. She said the Market Information Systems Research and Development (D) Working Group is working on the first recommendation to develop methods to ensure better MIS data quality, and the Market

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Analysis Procedures (D) Working Group is working on the second recommendation to assess MIS data and scoring methodologies for its effectiveness and make suggestions for needed improvements. The Task Force heard reports from both working groups on their progress with their charges related to the AI report.

Director Severinghaus said the Task Force also heard a report from NAIC staff regarding the progress on a variety of projects that affect the MIS, including those that are incorporated into the *State Connected* strategic plan and those prioritized through the Uniform System Enhancement Request (USER) forms.

### C. Producer Licensing (D) Task Force

Director Deiter said the Producer Licensing (D) Task Force met May 31 and adopted a new charge to review and amend, as needed, Model #228 to enhance consumer protections in the property/casualty (P/C) claims process. He said the Task Force also adopted new Continuing Education Recommended Guidelines for Instructor Approval to create a more uniform process for the approval of continuing education (CE) instructors and a quicker process for such approval. He said these items were adopted by the Committee during its July 27 meeting.

Director Deiter said if the new charge is adopted by the Committee, the Task Force will move forward with drafting proposed revisions to Model #228. He said the model will be amended to strengthen regulatory standards for the following four issues: 1) individuals acting as unlicensed public adjusters; 2) contractors who are also acting as public adjusters on the same claim; 3) limiting the assignment of benefit rights to the contractor; and 4) limits on public adjuster compensation. He said Commissioner Navarro has agreed to lead this effort due to recent legislative changes regarding public adjusters in Delaware. He also said because some of the issues to be discussed on potential fraudulent practices, it will be helpful to have Commissioner Navarro, who chairs the Antifraud (D) Task Force, lead this effort.

Director Deiter said during its May 31 meeting, the Task Force continued its discussion of the template for the review of 1033 requests, which are required by the federal Violent Crime Control and Law Enforcement Act of 1994. He said the Task Force discussed the following three issues: 1) whether the definition of “conviction” should include pleas of abeyance and expungements should be excluded from this definition; 2) whether states use the long-form or short-form for requests and why one form is preferred; and 3) the factors a jurisdiction may consider when evaluating a 1033 waiver request and how states inform individuals about the 1033 waiver application process. He said NAIC staff are working with a small group of subject matter experts (SMEs), and the Task Force will continue its discussions in the coming months.

Director Deiter said the Task Force also received a report from the National Insurance Producer Registry (NIPR) Board of Directors. He said NIPR’s year-to-date (YTD) revenue was \$24 million, which is 3.7% over budget. The NIPR senior team and Board of Directors have begun work on the NIPR strategic plan for 2024–2026, and a vote on the final plan is scheduled for the end of the year. Director Deiter said NAIC staff are coordinating with NIPR and states, including any back-office system support vendors, to conduct an analysis of how long it will take to implement proposed changes and the cost to implement. The Task Force will be discussing the time and cost estimates in the coming months to determine the next steps.

Director Deiter said the Task Force also adopted the reports for the Adjuster Licensing (D) Working Group and the Uniform Education (D) Working Group.

### D. Market Analysis Procedures (D) Working Group

LeDuc said the Market Analysis Procedures (D) Working Group will meet July 17. She said the Working Group was assigned a new charge to “assess current market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing

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the data.” She said in considering this charge, the Working Group began by compiling a list of what data market analysts use. She said the list is not exhaustive, but it is extensive and covers data provided through the NAIC MIS, data available within the states, and data obtained from sources outside the NAIC and states. She said the Working Group will continue to add to the list as data sources continue to be identified, but it will also begin identifying how market analysts use the data and discuss the data’s effectiveness.

LeDuc said the Working Group will also begin its assessments of the scoring systems that are in the NAIC MIS, which includes the Market Analysis Prioritization Tool (MAPT) and the MCAS-MAPT rankings.

LeDuc said the Working Group also adopted the Other Health MCAS standard ratios (Attachment Four) to be posted publicly after each annual filing. She said they will be effective for the 2023 data year collected in 2024.

LeDuc said the Working Group is also discussing the inclusion of fraternal insurance organizations in the MCAS. She said fraternal are exempted from filing the MCAS, and the Working Group is discussing whether the exemption should remain.

LeDuc said the Working Group is also putting together a plan to provide regulator-only training on market analysis tools and methods using the tools for market analysis. She said the training sessions will be informal and address topics most in demand. She noted that there are quite a few new market analysts that will benefit from informal sessions with more experienced market analysts.

### E. Market Conduct Annual Statement Blanks (D) Working Group

Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group met July 19. She said the Working Group is discussing revisions to the homeowners and private passenger auto (PPA) blanks to clarify to companies which closed claims to report and how to report them. She said a proposal will be considered for adoption during the Working Group’s next meeting.

Weyhenmeyer said the Working Group also received a request to permanently move the MCAS filing deadline for the short-term limited-duration (STLD) and other health MCAS blanks to May 31 to match the deadline already established for the health MCAS blank.

Weyhenmeyer also said in the last couple years, the Working Group adopted two MCAS blanks with less than 30 days of exposure after the final draft was complete. She said to avoid this in the future, the Working Group is working on adding guidelines to the written process for adopting new blanks and revising data elements. She said the guidelines will encourage a 60-day exposure prior to the June 1 deadline date for adoption.

### F. Market Conduct Examination Guidelines (D) Working Group

Tarpley said the Market Conduct Examination Guidelines (D) Working Group met March 28 and July 18.

Tarpley said during its March 28 meeting, the Working Group discussed its 2023 charges and items to be carried forward from 2023 to 2024, including the travel insurance in-force policy standardized data request (SDR), the travel insurance claims SDR, and an exposure draft of the *Market Regulation Handbook’s* Chapter 23—Conducting the Life and Annuity Examination.

Tarpley said during its July 18 meeting, the Working Group adopted revisions to the *Market Regulation Handbook’s* Chapter 4, Section E. He said the revisions provide non-regulators with insight on the multistate settlement process that occurs in the Market Actions (D) Working Group. He said the Working Group also discussed a June 6 draft of Chapter 23 and reviewed comments received on the draft. The comment period was

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extended to Sept. 4. Tarpley said revisions to Chapter 23 arise from the changes recently made to the *Suitability in Annuity Transactions Model Regulation* (#275). He said the Working Group also received updates on the SDRs for travel insurance in-force policies and claims.

### G. Market Regulation Certification (D) Working Group

Commissioner Kreidler said the Market Regulation Certification (D) Working Group met June 6 and adopted the Voluntary Market Regulation Certification Program. He said the Working Group is on hold until further instruction from the Committee.

### H. Speed to Market (D) Working Group

Nichols said the Speed to Market (D) Working met July 25. She said the Working Group reviewed suggested changes to the uniform product coding matrices (PCMs). She said three suggestions for additional types of insurance (TOIs)/sub-TOIs were submitted for the P/C matrix and the Life, Health, and Annuity matrix. She said the Working Group adopted new sub-TOIs for paid family medical leave products for the Life, Health, and Annuity matrix. She said alternative solutions, such as new filing types were also discussed for a couple of the suggestions. She said two suggestions for the P/C matrix were tabled to see if a solution can be provided by the System for Electronic Rates & Forms Filings (SERFF) Modernization project.

Nichols said the Working Group's revisions to the *Product Filing Review Handbook* are nearly complete. She said the next steps are to expose the revisions and ask for Working Group member volunteers to review a few of the chapters for any technical gaps or inaccuracies. She expressed appreciation to Petra Wallace (NAIC) for her support, hard work, and commitment to the work on the *Product Filing Review Handbook*.

LeDuc made a motion, seconded by Commissioner Navarro, to adopt the other health MCAS standardized ratios and the following reports: 1) the Antifraud (D) Task Force; 2) the Market Information Systems (D) Task Force; 3) Producer Licensing (D) Task Force; 4) the Market Analysis Procedures (D) Working Group (Attachment Five); 5) the Market Conduct Annual Statement Blanks (D) Working Group (Attachment Six); 6) the Market Conduct Examination Guidelines (D) Working Group (Attachment Seven); 7) the Market Regulation Certification (D) Working Group (Attachment Eight); and 6) the Speed to Market (D) Working Group (Attachment Nine). The motion passed unanimously.

### 5. Heard an Update on International Issues Regarding Market Regulation

Commissioner Pike said the Committee has a standing charge to coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) or other related groups on issues regarding market regulation concepts.

Nikhail Nigam (NAIC) said the NAIC is a member of the IAIS and serves on its Market Conduct Working Group (MCWG). He said the MCWG is tasked with developing and enhancing high-level principles-based supervisory and supporting material in relation to market conduct supervision. He said the MCWG coordinates with other international bodies dealing with the market conduct of insurers and intermediaries and financial consumer protection. The MCWG reports to the IAIS Policy Development Committee, and it is composed of representatives of IAIS members with experience in market conduct supervision and regulation.

Nigam said in June, the MCWG finalized a Members Report on the Use of Conduct Indicators in Insurance Supervision. He said the report provides members with guidance on the identification, assessment, and appropriateness of specific types of indicators and data-gathering techniques. He said the report puts an emphasis on adopting more outcomes-based approaches to conduct supervision in many jurisdictions. He said the MCWG

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believes the ability to draw informative, actionable, and well-targeted “indicators” from data is central to achieving this objective. He said the report follows a member survey conducted in 2021 and 2022 focusing on current supervisory approaches and challenges regarding the use of data and key indicators to assess conduct-related outcomes. He said the NAIC provided two examples. The first focused on claims handling and a review of the NAIC MCAS and the data it collects on claims and underwriting for various lines of business. The second NAIC example reviewed the use complaints index.

Nigam said another project the MCWG has been focusing on is related to Diversity, Equity, and Inclusion (DE&I), and the NAIC has been involved in these efforts at both the MCWG, as well as the Governance Working Group (GWG) of the IAIS. He said the project focuses on the link between DE&I and insurers’ governance, risk management, and corporate culture. He said the project is exploring the hypothesis that applying a DE&I paradigm to the Insurance Core Principle (ICP) 19 requirement of fair treatment of customers can result in better outcomes and fairer treatment for diverse consumers. He said the NAIC has regularly updated the IAIS on the work of the Special (EX) Committee on Race and Insurance, and it held a special session where the NAIC’s DE&I Director, Evelyn Boswell, presented on the work of her team and the assistance they provide to NAIC members.

Nigam said a few other initiatives being worked on at the MCWG include work to incorporate climate risk into ICP 19. He said the IAIS’s Climate Risk Steering Group and the MCWG are working on an application paper for supervisors that will focus on instances when sustainability-related risks and considerations can lead to the unfair treatment of consumers.

Nigam said the MCWG is focused on supporting the parent committees and secretariat at the IAIS in developing its strategic plan for the next five years. He said one initiative has been proposed by the MCWG to share Suptech tools and initiatives.

### 6. Heard a Presentation on the Use of Visualization in Market Analysis

Commissioner Pike said the Market Analysis Procedures (D) Working Group has a charge this year to assess the effectiveness of data used by market analysts. He said to provide some background on this work, he asked LeDuc to provide the Committee with an overview of the current state of market analysis techniques, especially regarding the use of tools to provide visualizations of the data used by analysts.

LeDuc said the visualization of data leverages human perception skills to allow the analyst to absorb more information and remember it more easily. She said this allows analysts to analyze a large quantity of data more quickly and identify more complex issues. The analyst can identify new trends, patterns and anomalies when they are able to visualize data using visualizations incorporating graphs, charts, and the deliberate use of color instead of viewing a mere dataset of numbers. LeDuc said this gives analysts a better understanding of the data, removes subjectivity, and creates repeatable outcomes for verification. Additionally, LeDuc noted that this is further enhanced when incorporating text analytics, machine learning, predictive analytics, and network analysis. She said to fully utilize visualizations and advanced analytics, the data needs to be available, accessible, usable, consumable, reliable, consistent, and complete.

LeDuc provided examples illustrating how to create effective visualizations used to provide comparisons of data over time, the relationships between different categories and data points, the composition of data over multiple periods of time, and the distribution of data points. She gave examples of the best ways to create visualizations to answer the different questions that can be asked about the data.

LeDuc said there are best practices to keep in mind when creating data visualizations. She said the visualization should be kept as simple as possible to answer the question being asked. It should direct the focus of the user to the most relevant points in the data. The data and visualization should be clearly explained and identified to the

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user reviewing the visualization. LeDuc also emphasized that the use of color must be intentional and with the purpose of clearly bringing out the meaning in the data.

LeDuc showed how the MAPT and the MCAS data can be made more useful by presenting the data into visualizations.

LeDuc concluded with things to consider: 1) the visualization should add value; 2) it is important to consider the cost and benefits of obtaining and creating new data sources; 3) visualizations change both the process and mindset in the analysis of data; and 4) using visualizations moves market analysis from an examiner's skillset to an analyst's skillset.

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

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## 2024 Proposed Charges

### MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

The mission of the Market Regulation and Consumer Affairs (D) Committee is to monitor all aspects of the market regulatory process for continuous improvement. This includes market analysis, regulatory interventions with companies, and multi-jurisdictional collaboration. The Committee will also review and make recommendations regarding the underwriting and market practices of insurers and producers, as those practices affect insurance consumers, including the availability and affordability of insurance.

#### Ongoing Support of NAIC Programs, Products, or Services

1. The **Market Regulation and Consumer Affairs (D) Committee** will:
  - A. Monitor the centralized collection and storage of market conduct data, national analysis, and reporting at the NAIC, including issues regarding the public availability of data.
  - B. Monitor and assess the current process for multi-jurisdictional market conduct activities, and provide appropriate recommendations for enhancement, as necessary.
  - C. Oversee the activities of the Antifraud (D) Task Force.
  - D. Oversee the activities of the Market Information Systems (D) Task Force.
  - E. Oversee the activities of the Producer Licensing (D) Task Force.
  - F. Monitor the underwriting and market practices of insurers and producers, as well as the conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
  - G. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
  - H. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
  - I. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).
2. The **Advisory Organization (D) Working Group** will:
  - A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (including rating organizations and statistical agents) to be more comprehensive, efficient, and possibly less frequent than the current system of single-state exams. Solicit input and collaboration from other interested and affected committees and task forces.
  - B. Monitor the data reporting and data collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge, as needed.
  - C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).
3. The **Market Actions (D) Working Group** will:
  - A. Facilitate interstate communication and coordinate collaborative state regulatory actions.



## MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE *(Continued)*

4. The **Market Analysis Procedures (D) Working Group** will:
  - A. Recommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions.
  - B. In accordance with the second recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, assess currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data.
  - C. Discuss other market data collection issues, and make recommendations, as necessary.
  - D. Consider recommendations for new lines of business for the Market Conduct Annual Statement (MCAS).
5. The **Market Conduct Annual Statement Blanks (D) Working Group** will:
  - A. Review the MCAS data elements and the “Data Call and Definitions” for those lines of business that have been in effect for longer than three years and update them, as necessary.
  - B. Develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate.
6. The **Market Conduct Examination Guidelines (D) Working Group** will:
  - A. Develop market conduct examination standards, as necessary, for inclusion in the *Market Regulation Handbook*.
  - B. Monitor the adoption and revision of NAIC models, and develop market conduct examination standards to correspond with adopted NAIC models.
  - C. Develop updated standardized data requests, as necessary, for inclusion in the *Market Regulation Handbook*.
  - D. Discuss the development of uniform market conduct procedural guidance (e.g., a library, repository, or shared collaborative space with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook*.
  - E. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee to develop market conduct examiner guidance for the oversight of regulated entities’ use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).
7. The **Market Regulation Certification (D) Working Group** will:
  - A. Implement the *Voluntary Market Regulation Certification Program* by: i) provisionally certifying each jurisdiction that submits a self-certification report; ii) assessing the submission and monitoring the progress of each provisionally certified jurisdiction towards compliance to each certification standard; and iii) providing peer-review and guidance for any participating jurisdiction that requests guidance.
  - B. Develop a mechanism for enabling participating jurisdictions to apply for full certification. This will include: i) forming an NAIC Review Team; and ii) developing methods for assessing and auditing full-certification requests.
  - C. Review feedback from jurisdictions concerning any issues or recommended changes to the *Voluntary Market Regulation Certification Program* requirements and the *Market Regulation Certification Program Self-Assessment Guidelines* and *Checklist Tool*.
  - D. Consider new standards to be incorporated into the *Voluntary Market Regulation Certification Program*.
8. The **Speed to Market (D) Working Group** will:
  - A. Consider proposed System for Electronic Rates & Forms Filing (SERFF) features or functionality presented to the Working Group by the Product Steering Committee (PSC). Review periodic reports from the PSC, as needed.

## MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE *(Continued)*

- B. Provide feedback and recommendations concerning the SERFF modernization when requested by the Executive (EX) Committee and any group assigned oversight of the SERFF modernization by the Executive (EX) Committee.
- C. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed to market operational efficiencies related to product filing needs, efficiencies, and effective consumer protection. This includes the following activities:
  - i. Provide a forum to gather information from the states and the industry regarding tools, policies, and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly regarding uniformity.
  - ii. Use SERFF data to develop, refine, implement, collect, and distribute common filing metrics that provide a tool to measure the success of the speed to market modernization efforts, as measured by nationwide and individual state speed to market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
  - iii. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval, and notification of changes. Monitor, assist with, and report on state implementation of any PCM changes.
  - iv. Facilitate the review and revision of the *Product Filing Review Handbook*, which contains an overview of all the operational efficiency tools and describes best practices for industry filers and state reviewers regarding the rate and form filing and review process. Develop and implement a communication plan to inform the states about the *Product Filing Review Handbook*.
- D. Provide direction to NAIC staff regarding SERFF functionality, implementation, development, and enhancements. Receive periodic reports from NAIC staff, as needed.
- E. Conduct the following activities, as desired, by the Interstate Insurance Product Regulation Commission (Compact):
  - i. Provide support to the Compact as the speed-to-market vehicle for asset-based insurance products, encouraging the states' participation in, and the industry's usage of, the Compact.
  - ii. Receive periodic reports from the Compact, as needed.

NAIC Support Staff: Tim Mullen/Randy Helder

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Committee%20Charges/2024/03\\_ToBeAdoptedByCmte\\_Plenary/018\\_DCMte.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Committee%20Charges/2024/03_ToBeAdoptedByCmte_Plenary/018_DCMte.docx)

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

*Adopted by the Market Regulation and Consumer Affairs (D) Committee, XX, 2023*

*Adopted by the Antifraud (D) Task Force, Oct. 23, 2022*

## **2024 Charges**

### **ANTIFRAUD (D) TASK FORCE**

The mission of the Antifraud (D) Task Force is to serve the public interest by assisting the state insurance supervisory officials, individually and collectively, through the detection, monitoring, and appropriate referral for the investigation of insurance crime, both by and against consumers. The Task Force will assist the insurance regulatory community by conducting the following activities: 1) maintaining and improving electronic databases regarding fraudulent insurance activities; 2) disseminating the results of research and analysis of insurance fraud trends, as well as case-specific analysis, to the insurance regulatory community; and 3) providing a liaison function between state insurance regulators, law enforcement—i.e., federal, state, local, and international—and other specific antifraud organizations. The Task Force will also serve as a liaison with the NAIC Information Technology Group (ITG) and other NAIC committees, task forces, and/or working groups to develop technological solutions for data collection and information sharing. The Task Force will monitor all aspects of antifraud activities by its working groups on the following charges.

#### **Ongoing Support of NAIC Programs, Products or Services**

1. The **Antifraud (D) Task Force** will:
  - A. Work with NAIC committees, task forces, and working groups (e.g., Title Insurance (C) Task Force, etc.) to review issues and concerns related to fraud activities and schemes related to insurance fraud.
  - B. Coordinate efforts to address national concerns related to agent fraud and activities of unauthorized agents related to insurance sales.
  - C. Coordinate the enforcement and investigation efforts of state and federal securities regulators with state insurance fraud bureaus.
  - D. Coordinate with state, federal, and international law enforcement agencies in addressing antifraud issues relating to the insurance industry.
  - E. Review and provide comments to the International Association of Insurance Supervisors (IAIS) on its Insurance Core Principles (ICPs) related to insurance fraud.
  - F. Coordinate activities and information from national antifraud organizations and provide information to state insurance fraud bureaus.
  - G. Coordinate activities and information with state and federal fraud divisions to determine guidelines that will assist with reciprocal involvement concerning antifraud issues resulting from natural disasters and catastrophes.
  - H. Coordinate efforts with the insurance industry to address antifraud issues and concerns.
  - I. Evaluate and recommend methods to track national fraud trends.
  - J. Develop seminars, trainings, and webinars regarding insurance fraud. Provide three webinars by the 2024 Fall National Meeting.
  
2. The **Antifraud Technology (D) Working Group** will:
  - A. Work with the NAIC to develop an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions. Complete by the 2024 Fall National Meeting.
  - B. Evaluate sources of antifraud data and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2024 Fall National Meeting.

**ANTIFRAUD (D) TASK FORCE** *(Continued)*

3. The **Improper Marketing of Health Insurance (D) Working Group** will:
  - A. Coordinate with state insurance 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.
  - B. Review existing NAIC models and guidelines that address the use of lead generators for sales of health insurance products and identify models and guidelines that need to be updated or developed to address current marketplace activities.

NAIC Support Staff: Greg Welker/Lois E. Alexander

*Adopted by the Executive (EX) Committee and Plenary,  
Adopted by the Market Regulation and Consumer Affairs (D) Committee,  
Adopted by the Market Information Systems (D) Task Force, Oct. 20, 2023*

## **2024 Charges**

### **MARKET INFORMATION SYSTEMS (D) TASK FORCE**

The mission of the Market Information Systems (D) Task Force is to provide business expertise regarding the desired functionality of the NAIC Market Information Systems (MIS) and the prioritization of regulatory requests for the development and enhancement of the MIS.

#### **Ongoing Support of NAIC Programs, Products, or Services**

1. The **Market Information Systems (D) Task Force** will:
  - A. Ensure that the MIS support the strategic direction set forth by the Market Regulation and Consumer Affairs (D) Committee.
  - B. Analyze the data in the MIS. In accordance with the first recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, recommend methods to ensure better data quality.
  - C. In conjunction with the Market Analysis Procedures (D) Working Group and in accordance with the second recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, assess currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data.
  - D. Provide guidance on the appropriate use of the MIS and the data entered in them.
    - i. Complaints Database System (CDS).
    - ii. Electronic Forums.
    - iii. Market Actions Tracking System (MATS).
    - iv. Market Analysis Profile.
    - v. Market Analysis Prioritization Tool (MAPT).
    - vi. Market Analysis Review System (MARS).
    - vii. Market Conduct Annual Statement (MCAS).
    - viii. Regulatory Information Retrieval System (RIRS).
    - ix. 1033 State Decision Repository (SDR1033) (in conjunction with the Antifraud (D) Task Force).
2. The **Market Information Systems Research and Development (D) Working Group** will:
  - A. Serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.
  - B. Assist the Task Force with tasks as assigned, such as:
    - i. Analyze MIS data.
    - ii. Provide state users with query access to MIS data.
    - iii. Provide guidance on the appropriate use of the MIS.

NAIC Support Staff: Randy Helder

Draft: 10/23/23

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

Adopted by the Market Regulation and Consumer Affairs (D) Committee, XX, 2023

Adopted by the Producer Licensing (D) Task Force, Oct. 23, 2023

## **2024 Proposed Charges PRODUCER LICENSING (D) TASK FORCE**

The mission of the Producer Licensing (D) Task Force is to 1) develop and implement uniform license applications, standards, interpretations, and treatment of producer and adjuster licensees and licensing terminology; 2) monitor and respond to developments related to licensing reciprocity; 3) coordinate with industry and consumer groups regarding priorities for licensing reforms; and 4) provide direction based on NAIC membership initiatives to the National Insurance Producer Registry (NIPR) Board of Directors regarding the development and implementation of uniform producer licensing initiatives, with a primary emphasis on encouraging the use of electronic technology.

### **Ongoing Support of NAIC Programs, Products, or Services**

1. The **Producer Licensing (D) Task Force** will:
  - A. Work closely with NIPR to encourage the full utilization of NIPR products and services by all the states and producers, and encourage accurate and timely reporting of state administrative actions to the NAIC's Regulatory Information Retrieval System (RIRS) to ensure that this data is properly reflected in the State Producer Licensing Database (SPLD) and the Producer Database (PDB).
  - B. Facilitate roundtable discussions, as needed, with the state producer licensing directors for the exchange of views, opinions, and ideas on producer licensing activities in the states and at the NAIC.
  - C. Discuss, as necessary, state perspectives regarding the regulation and benefit of the activities of the federal Affordable Care Act (ACA), established enrollment assisters (including navigators and non-navigator assisters and certified application counselors), and the activities of producers in assisting individuals and businesses purchasing in the health insurance marketplaces. Coordinate with the Health Insurance and Managed Care (B) Committee and the Antifraud (D) Task Force, as necessary.
  - D. Monitor the activities of the National Association of Registered Agents and Brokers (NARAB) in the development and enforcement of the NARAB membership rules, including the criteria for successfully passing a background check.
  - E. Coordinate through NAIC staff to provide guidance to NIPR on producer licensing-related electronic initiatives. Hear a report from NIPR at each national meeting.
  - F. Coordinate with the Market Information Systems (D) Task Force and the Antifraud (D) Task Force to evaluate and make recommendations regarding the entry, retention, and use of data in the NAIC's Market Information Systems (MIS).
  - G. Coordinate with the Special (EX) Committee on Race and Insurance on referrals affecting insurance producers.
  - H. Discuss how criminal convictions may affect producer licensing applicants, review, and amend the NAIC's *Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994* as needed to create a more simplified and consistent approach in how states review 1033 waiver requests.
  
2. The **Adjuster Licensing (D) Working Group** will:
  - A. Monitor state implementation of adjuster licensing and reciprocity; update the NAIC adjuster licensing standards, as necessary.

3. The **Producer Licensing Uniformity (D) Working Group** will:
  - A. Work closely with state producer licensing directors and exam vendors to ensure that 1) the states achieve full compliance with the standards in order to achieve greater uniformity and 2) the exams test the qualifications for an entry-level position as a producer.
  - B. Provide oversight and ongoing updates to the *State Licensing Handbook*, as needed.
  - C. Monitor and assess the state implementation of the Uniform Licensing Standards (ULS) and update the standards, as needed.
  - D. Review and update the NAIC's uniform producer licensing applications and uniform appointment form, as needed. Provide any recommended updates to the Producer Licensing (D) Task Force by the NAIC Summer National Meeting.
  
4. The **Public Adjuster Licensing (D) Working Group** will:
  - A. Review and amend the *Public Adjuster Licensing Model Act* (#228) as needed to enhance consumer protections in the property/casualty (P/C) claims process.
  
5. The **Uniform Education (D) Working Group** will:
  - A. Update the reciprocity guidelines, the uniform application forms for continuing education (CE) providers, and the process for state review and approval of instructors and courses, as needed. Provide any recommended updates to the Producer Licensing (D) Task Force by the Fall National Meeting.
  - B. Coordinate with NAIC parent committees, task forces, and/or working groups to review and provide recommendations on prelicensing education and CE requirements that are included in NAIC model acts, regulations, and/or standards, as necessary.

NAIC Support Staff: Tim Mullen/Greg Welker

## UNFAIR TRADE PRACTICES ACT

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

### Section 1. Purpose

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

### Section 2. Definitions

When used in this Act:

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

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

- C. “Customer” means an individual who purchases, applies to purchase, or is solicited to purchase insurance products primarily for personal, family or household purposes.
- D. “Depository institution” means a bank or savings association. The term depository institution does not include an insurance company.
- E. “Health Insurance Lead Generator” means a[n]y person that utilizes a lead-generating device to:engages in any of the following activities:.
  - (1) Publicizes the availability of what is, or what purports to be, an health insurance product or service that the person is not licensed to sell directly to consumers-customer;
  - (2) Identifies consumer customer who may want to learn more about an health insurance product; or



(3) Sells or transmits ~~consumer~~ customer information to insurers or producers for follow-up contact and sales activity.

F. “Lead-generating device” means any communication directed to the public that, regardless of form, content, or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this State for the purchase of ~~[accident and sickness/Medicare supplement] insurance.~~what is or what purports to be a health insurance product or service.

Drafting Note: Public means all the general public and any person.

G. “Insured” means the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy.

H. “Insurer” means any person, reciprocal exchange, interinsurer, Lloyd’s insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including producers, adjusters and third- party administrators. Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health service plans as defined in Sections [insert applicable section]. For purposes of this Act, these foregoing entities shall be deemed to be engaged in the business of insurance.

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

I. “Person” means a natural or artificial entity, including but not limited to, individuals, partnerships, associations, trusts, or corporations. For purposes of this act, “person” includes a health insurance lead generator operating as any such natural or artificial entity.

J. “Policy” or “certificate” means a contract of insurance, indemnity, medical, health or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer.

K. “Producer” means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

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

### Section 3. Unfair Trade Practices Prohibited

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

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

### Section 4. Unfair Trade Practices Defined

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

- A. Misrepresentations and False Advertising of Insurance Policies. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison that:
  - (1) Misrepresents the benefits, advantages, conditions, or terms of any policy; or
  - (2) Misrepresents the dividends or share of the surplus to be received on any policy; or

- (3) Makes a false or misleading statement as to the dividends or share of surplus previously paid on any policy; or
  - (4) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates; or
  - (5) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof; or
  - (6) Is a misrepresentation, including any intentional misquote of premium rate, for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion or surrender of any policy; or
  - (7) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or
  - (8) Misrepresents any policy as being shares of stock.
- B.** False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, [electronic mail](#), [internet advertisement or posting](#), or other publication, or in the form of a notice, circular, pamphlet, letter, [electronic posting of any kind](#), or poster, or over any radio or television station, [or via the internet or other electronic means](#), or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the conduct of its insurance business, which is untrue, deceptive or misleading.
- C.** [Failure to Maintain Marketing and Performance Records. Failure of a health insurance lead generator to maintain its books, records, documents and other business records in such an order that data regarding complaints and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two \(2\) preceding years shall be maintained. Failure to do so shall constitute a violation of \(INSERT STATE STATUTE\).](#)
- D.** Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure such insurer.
- E.** Boycott, Coercion and Intimidation. Entering into any agreement to commit, or by any concerted action committing any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.
- F.** False Statements and Entries.
- (1) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of an insurer.
  - (2) Knowingly making any false entry of a material fact in any book, report or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer, or knowingly making any false material statement to any insurance department official.
- G.** Stock Operations and Advisory Board Contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to purchase insurance.

**H. Unfair Discrimination.**

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

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

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

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

**I. Rebates.**

- (1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any life insurance policy or annuity, or accident and health insurance or other insurance, or agreement as to such contract other than as plainly expressed in the policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such policy, any rebate of premiums payable on the policy, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such policy or annuity or in connection therewith, any stocks, bonds or other securities of any company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the policy.
- (2) Nothing in Subsection G, or Paragraph (1) of Subsection H shall be construed as including within

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the definition of discrimination or rebates any of the following practices:

- (a) In the case of life insurance policies or annuities, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;
- (b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;
- (c) Readjusting the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; or
- (d) Engaging in an arrangement that would not violate Section 106 of the Bank Holding Company Act Amendments of 1972 (12 U.S.C. 1972), as interpreted by the Board of Governors of the Federal Reserve System, or Section 5(q) of the Home Owners' Loan Act, 12 U.S.C. 1464(q).
- (e) The offer or provision by insurers or producers, by or through employees, affiliates or third-party representatives, of value-added products or services at no or reduced cost when such products or services are not specified in the policy of insurance if the product or service:
  - (i) Relates to the insurance coverage; and
  - (ii) Is primarily designed to satisfy one or more of the following:
    - (I) Provide loss mitigation or loss control;
    - (II) Reduce claim costs or claim settlement costs;
    - (III) Provide education about liability risks or risk of loss to persons or property;
    - (IV) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;
    - (V) Enhance health;
    - (VI) Enhance financial wellness through items such as education or financial planning services;
    - (VII) Provide post-loss services;
    - (VIII) Incent behavioral changes to improve the health or reduce the risk of death or disability of a customer (defined for purposes of this subsection as policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured or applicant); or
    - (IX) Assist in the administration of the employee or retiree benefit insurance coverage.
  - (iii) The cost to the insurer or producer offering the product or service to any given customer must be reasonable in comparison to that customer's premiums or insurance coverage for the policy class.
  - (iv) If the insurer or producer is providing the product or service offered, the insurer or producer must ensure that the customer is provided with contact information to

assist the customer with questions regarding the product or service.

- (v) The commissioner may adopt regulations when implementing the permitted practices set forth in this statute to ensure consumer protection. Such regulations, consistent with applicable law, may address, among other issues, consumer data protections and privacy, consumer disclosure and unfair discrimination.
- (vi) The availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory. The documented criteria must be maintained by the insurer or producer and produced upon request by the Department.

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

- (vii) If an insurer or producer does not have sufficient evidence but has a good-faith belief that the product or service meets the criteria in H(2)(e)(ii), the insurer or producer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year.

An insurer or producer must notify the Department of such a pilot or testing program offered to consumers in this state prior to launching and may proceed with the program unless the Department objects within twenty-one days of notice.

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

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

**Drafting Note:** If a state wishes to limit (f) to a stated monetary limit the committee would suggest that, at the time of the drafting of this model, the lesser of 5% of the current or projected policyholder premium or \$250 would be an appropriate limit, however specific prohibitions may exist related to transactions governed by the Real Estate Settlement Procedures Act of 1974 and the laws and regulations governing the Federal Crop Insurance Corporation Risk Management Agency. States may want to consider a limit for commercial or institutional customers.

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

**Drafting Note:** Section 104 (d)(2)(B)(viii) of the Gramm-Leach-Bliley Act provides that any state restrictions on anti-tying may not prevent a depository institution or affiliate from engaging in any activity that would not violate Section 106 of the Bank Holding Company Act Amendments of 1970, as interpreted by the Board of Governors of the Federal Reserve System. The Board of Governors of the Federal Reserve System has stated that nothing in its interpretation on combined-balance discount arrangements is intended to override any other applicable state and federal law. FRB SR 95-32 (SUP). Section 5(q) of the Home Owners' Loan Act is the analogous provision to Section 106 for thrift institutions. The Office of Thrift Supervision has a regulation 12 C.F.R. 563.36 that allows combined-balance discounts if certain requirements are met.

**Drafting Note:** Each state may wish to examine its rating laws to ensure that it contains sufficient provisions against rebating. If a state does not, this section may be expanded to cover all lines of insurance.

- J. Prohibited Group Enrollments. No insurer shall offer more than one group policy of insurance through any person unless such person is licensed, at a minimum, as a limited insurance representative. However, this prohibition shall not apply to employer/employee relationships, nor to any such enrollments.
- K. Failure to Maintain Marketing and Performance Records. Failure ~~of an insurer~~ to maintain its books, records, documents and other business records, including any recordings, in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two (2) preceding years (or STATE REQUIREMENT) shall be maintained
- L. Failure to Maintain Complaint Handling Procedures. Failure of any insurer to maintain a complete record of all the complaints it received since the date of its last examination under Section [insert applicable section]. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this subsection, “complaint” shall mean any written communication primarily expressing a grievance.
- M. Misrepresentation in Insurance Applications. Making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money or other benefit from any provider or individual person.
- N. Unfair Financial Planning Practices. An insurance producer:
  - (1) Holding himself or herself out, directly or indirectly, to the public as a “financial planner,” “investment adviser,” “consultant,” “financial counselor,” or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters or trust and estate matters when such person is in fact engaged only in the sale of policies. This provision does not preclude persons who hold some form of formal recognized financial planning or consultant certification or designation from using this certification or designation when they are only selling insurance. This does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.
  - (2)
    - (a) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in Paragraph 3, or solicitation of the sale of a product or service that
      - (i) He or she is also an insurance salesperson, and
      - (ii) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case.
    - (b) The disclosure requirement under this subsection may be met by including it in any disclosure required by federal or state securities law.
  - (3)
    - (a) Charging fees other than commissions for financial planning by insurance producer, unless such fees are based upon a written agreement, signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the party to be charged at the time the agreement is signed by the party.
      - (i) The services for which the fee is to be charged must be specifically stated in the agreement.

- (ii) The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement.
- (iii) The agreement must state that the client is under no obligation to purchase any insurance product through the insurance producer or consultant.

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

- (b) The insurance producer shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the commissioner upon request.
- O. Failure to file or to certify information regarding the endorsement or sale of long-term care insurance. Failure of any insurer to:
- (1) File with the insurance department the following material:
    - (a) The policy and certificate;
    - (b) A corresponding outline of coverage; and
    - (c) All advertisements requested by the insurance department; or
  - (2) Certify annually that the association has complied with the responsibilities for disclosure, advertising, compensation arrangements, or other information required by the commissioner, as set forth by regulation.
- P. Failure to Provide Claims History
- (1) Loss Information—Property and Casualty. Failure of a company issuing property and casualty insurance to provide the following loss information for the three (3) previous policy years to the first named insured within thirty (30) days of receipt of the first named insured’s written request:
    - (a) On all claims, date and description of occurrence, and total amount of payments; and
    - (b) For any occurrence not included in Subparagraph (a) of this paragraph, the date and description of occurrence.
  - (2) Should the first named insured be requested by a prospective insurer to provide detailed loss information in addition to that required under Paragraph (1), the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than reasonably required to underwrite the same line or class of insurance. The insurer shall provide information under this subparagraph to the first named insured as soon as possible, but in no event later than twenty (20) days of receipt of the written request. Notwithstanding any other provision of this section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information.
  - (3) The commissioner may promulgate regulations to exclude the providing of the loss information as outlined in Paragraph (1) for any line or class of insurance where it can be shown that the information is not needed for that line or class of insurance, or where the provision of loss information otherwise is required by law.

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

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

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

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

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

**Section 5. Favored Agent or Insurer; Coercion of Debtors**

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



- (8) Pay or receive any commission, brokerage fee or other compensation as a producer, unless the person holds a valid producer's license for the applicable class of insurance. However, an unlicensed person may make a referral to a licensed producer provided that the person does not discuss specific insurance policy terms and conditions. The unlicensed person may be compensated for the referral; however, in the case of a referral of a customer, the unlicensed person may be compensated only if the compensation is a fixed dollar amount for each referral that does not depend on whether the customer purchases the insurance product from the licensed producer. Furthermore, any person who accepts deposits from the public in an area where such transactions are routinely conducted in the depository institution may receive for each customer referral no more than a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a transaction;

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

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

**Drafting Note:** The Gramm-Leach-Bliley Act contains two "safe harbors" that relate to information sharing. Section 104(d)(2)(B)(vi) describes the circumstances surrounding the release of a customer's insurance information. Section 104(d)(2)(B)(vii) describes the circumstances surrounding the use of a customer's health information obtained from the insurance records of the customer. If a state has adopted the NAIC's Privacy of Consumer Financial and Health Information Model Regulation, no further action is needed. If not, language implementing the two safe harbors should be considered. It should be noted, however, that during the drafting process, there were concerns expressed about the application of the preemption provisions of the Fair Credit Reporting Act (FCRA) in circumstances involving the sharing of information with affiliates. Nothing in this Act shall be construed to modify, limit or supersede the operation of the FCRA (15 U.S.C. 1681 *et seq.*). In addition, no inference shall be drawn on the basis of the provisions of this Act regarding whether information is transaction or experience information under Section 603 of FCRA.

- C. Every person or depository institution, or affiliate of a depository institution that lends money or extends credit and who solicits insurance primarily for personal, family or household purposes shall disclose to the customer in writing that the insurance related to the credit extension may be purchased from an insurer or producer of the customer's choice, subject only to the lender's right to reject a given insurer or agent as provided in Subsection B(2). Further, the disclosure shall inform the customer that the customer's choice of insurer or producer will not affect the credit decision or credit terms in any way, except that the depository institution may impose reasonable requirements concerning the creditworthiness of the insurer and the scope of coverage chosen as provided in Subsection B(2).
- D. (1) A depository institution that solicits, sells, advertises or offers insurance, and any person who solicits, sells, advertises or offers insurance on behalf of a depository institution or on the premises of a depository institution shall disclose to the customer in writing, where practicable and in a clear and conspicuous manner, prior to a sale, that the insurance:
- (a) Is not a deposit;
- (b) Is not insured by the Federal Deposit Insurance Corporation or any other federal government agency;
- (c) Is not guaranteed by the depository institution, its affiliate (if applicable) or any person that is soliciting, selling, advertising or offering insurance (if applicable); and

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

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

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

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

**Section 6. Power of Commissioner**

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

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

- A. Whenever the commissioner shall have reason to believe that any insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution has been engaged or is engaging in this state in any unfair trade practice whether or not defined in this Act, and that a proceeding by the commissioner in respect thereto would be in the interest of the public, the commissioner shall issue and serve upon such insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution, a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than [insert number] days after the date of the service thereof. With respect to a depository institution, the commissioner's authority to call a hearing is limited to the depository institution's insurance underwriting, sales, solicitation and cross marketing activities. The commissioner shall provide a copy of the notice of hearing to the appropriate federal banking agency when a depository institution is involved.
- B. At the time and place fixed for the hearing, the insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner requiring the insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution to cease and desist from the acts, methods or practices so complained of. Upon good cause shown, the commissioner shall permit any person to intervene, appear and be heard at the hearing by counsel or in person.
- C. Nothing contained in this Act shall require the observance at the hearing of formal rules of pleading or evidence.
- D. The commissioner, at the hearing, may administer oaths, examine and cross examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence or other documents the commissioner deems relevant to the inquiry, provided, however, that in the case of depository institutions, the commissioner shall have the power to require the production of books, papers, records, correspondence or other documents that the commissioner deems relevant to the inquiry only on the insurance activities of the depository institution. The commissioner, may, and upon the request of any party, shall cause to be made a stenographic record of all the evidence and all the proceedings at the hearing. If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena or to testify with respect to any matter concerning which he may be lawfully interrogated, the [insert title] Court of [insert county] County or the county where the person resides, on application of the commissioner, may issue an order requiring such person to comply with the subpoena and to testify; and any failure to obey any order of the court may be punished by the court as contempt.
- E. Statements of charges, notices, orders and other processes of the commissioner under this Act may be served by anyone duly authorized by the commissioner, either in the manner provided by law for service of process in civil actions, or by registering and mailing a copy thereof to the person affected by the statement, notice, order or other process at the person's residence or principal office or place of business. The verified return by the person so serving the statement, notice, order, or other process, setting forth the manner of service, shall be proof of the same, and the return postcard receipt for the statement, notice, order or other process, registered and mailed as specified, shall be proof of the service of the same.

**Section 8. Cease and Desist and Penalty Orders**

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

**Section 9. Judicial Review of Orders**

- A. An insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution subject to an order of the commissioner under Section 8 or Section 11 may obtain a review of the order by filing in the [insert title] Court of [insert county] County, within [insert number] days from the date of the service of the order, a written petition praying that the order of the commissioner be set aside. A copy of the petition shall be served upon the commissioner, and thereupon the commissioner shall certify and file in the court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the commissioner. Upon filing of the petition and transcript, the court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of the petition shall operate as a stay of the order of the commissioner, and shall have power to make and enter upon the pleadings, evidence and proceedings set forth in the transcript a decree modifying, affirming or reversing the order of the commissioner, in whole or in part. The findings of the commissioner as to the facts, if supported by [insert type] evidence, shall be conclusive.

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

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

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

- C. An order issued by the commissioner under Section 8 shall become final:
- (1) Upon the expiration of the time allowed for filing a petition for review if no such petition has been duly filed within such time; except that the commissioner may thereafter modify or set aside the order to the extent provided in Section 9B; or
  - (2) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed

or the petition for review dismissed.

- D. No order of the commissioner under this Act or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

#### **Section 10. Judicial Review by Intervenor**

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

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

#### **Section 11. Penalty for Violation of Cease and Desist Orders**

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

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

#### **Section 12. Regulations**

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

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

#### **Section 13. Provisions of Act Additional to Existing Law**

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

#### **Section 14. Immunity from Prosecution**

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

**Section 15. Separability Provision**

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

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

1947 Proc. 383, 392-400, 413 (adopted).  
1960 Proc. II 485-487, 509-515, 516 (reprinted).  
1972 Proc. I 15, 16, 443-444, 491, 493-501 (amended and reprinted).  
1977 Proc. I 26, 28, 211, 226-227 (amended).  
1979 Proc. II 31, 34, 38, 39, 525 (amended).  
1985 Proc. I 19, 39, 85-86 (amended).  
1989 Proc. II 13, 21, 129-130, 132, 133-140 (amended and reprinted).  
1990 Proc. I 6, 25, 122, 146 (changed name of model).  
1990 Proc. II 7, 13-14, 160, 169-177 (amended and reprinted).  
1991 Proc. I 9, 16, 192-193, 196-203 (amended and reprinted).  
1993 Proc. I 8, 136, 242, 246-254 (amended and reprinted).  
1993 Proc. 1<sup>st</sup> Quarter 3, 34, 267, 274, 276 (amended).  
2001 Proc. 2<sup>nd</sup> Quarter 7, 9, 836, 843-853 (amended and reprinted).  
2021 Spring National Meeting (amended).



## UNFAIR TRADE PRACTICES ACT

### What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

### How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

### Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at [jneuerburg@naic.org](mailto:jneuerburg@naic.org).

**Disclaimer:** *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*



**UNFAIR TRADE PRACTICES ACT****STATE PAGE KEY:**

**MODEL ADOPTION:** States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

**PREVIOUS VERSION:** States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

**RELATED ACTIVITY:** Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

**NO CURRENT ACTIVITY:** No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-12-1 to 27-12-24 (1971/1994).
Alaska		ALASKA STAT. §§ 21.36.010 to 21.36.350 (1976/2009).	ALASKA STAT. § 21.36.500 (1992) (financial planners); § 45.50.471 (1970/2009); ALASKA ADMIN. CODE tit. 3, § 26.110 (2015); BULLETIN 2007-6 (2007).
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. §§ 20-441 to 20-461 (1954/2008).	
Arkansas		ARK. CODE ANN. §§ 23-66-201 to 23-66-316 (1959/2011).	CODE ARK. R. 054.00.4 (1985/2005); BULLETIN 8-2014 (2014).
California		CAL. INS. CODE §§ 790 to 790.10 (1959/2000).	CAL. INS. CODE §§ 759 to 764 (2002).
Colorado		COLO. REV. STAT. §§ 10-3-1101 to 10-3-1113 (1963/2015).	B-5.32 (2013); BULLETIN B-4.72 (2014).
Connecticut		CONN. GEN. STAT. §§ 38a-815 to 38a-819 (1955/2013).	CONN. GEN. STAT. §§ 38a-824 to 38a-832 (1949/1980); BULLETIN HC-69-010 (2008); BULLETIN IC-35 (2013).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware		DEL. CODE ANN. tit. 18, §§ 2301 to 2314 (1953/2013).	
District of Columbia		D.C. CODE §§ 31-2231.01 to 31-2231.25 (2000/2012).	
Florida		FLA. STAT. §§ 626.951 to 626.9641 (1982/2014).	FLA. STAT. § 626.572 (1990/2005) (rebating).
Georgia		GA. CODE ANN. §§ 33-6-1 to 33-6-14 (1972/2005).	GA. COMP. R. & REGS. 120-2-20-.03 to 120-2-20-.04 (2012).
Guam			5 GUAM CODE ANN. § 32201 (1993/2007).
Hawaii		HAW. REV. STAT. §§ 431:13-101 to 431:13-204 (1988/2014).	
Idaho		IDAHO CODE ANN. §§ 41-1301 to 41-1331 (1961/2005).	BULLETIN 88-2 (1988).
Illinois			215 ILL. COMP. STAT. 5/421 to 5/434 (1959/2015); 5/236 (1937/2004).
Indiana		IND. CODE §§ 27-4-1-1 to 27-4-1-18 (1947/2009).	
Iowa		IOWA CODE §§ 507B.1 to 507B.14 (1955/2010).	IOWA ADMIN. CODE r. 191-15.11 (2011); BULLETIN 13-07 (2013); BULLETIN 2014-2 (2014).
Kansas		KAN. STAT. ANN. §§ 40-2401 to 40-2421 (1955/2007).	
Kentucky		KY. REV. STAT. ANN. §§ 304.12-010 to 304.12-230 (1970/2010).	KY. REV. STAT. ANN. § 304.17A-150 (1994/2012) (health benefit plans); ADVISORY OPINION 2014-1 (2014).

**UNFAIR TRADE PRACTICES ACT**

<b>NAIC MEMBER</b>	<b>MODEL ADOPTION</b>	<b>PREVIOUS VERSION</b>	<b>RELATED ACTIVITY</b>
Louisiana		LA. REV. STAT. ANN. §§ 22:1961 to 22:1973 (1966/2014).	
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 2151 to 2182 (1970/2001).	BULLETIN 384 (2012).
Maryland		MD. CODE ANN., INS. §§ 27-101 to 27-219 (1957/2014).	MD. CODE REGS. 31.15.01.01 to 31.15.14.9999 (1970/2014); BULLETIN 2014-23 (2014).
Massachusetts		MASS. GEN. LAWS ch. 176D, §§ 1 to 14 (1972/2012).	BULLETIN B-2010-10 (2010).
Michigan		MICH. COMP. LAWS §§ 500.2001 to 500.2093 (1957/2011).	BULLETIN 2006-07 (2006).
Minnesota		MINN. STAT. §§ 72A.17 to 72A.32 (1967/2013).	BULLETIN 2013-3 (2013).
Mississippi		MISS. CODE ANN. §§ 83-5-29 to 83-5-51 (1956/2009).	
Missouri		MO. REV. STAT. §§ 375.930 to 375.948 (1978/2004).	MO. REV. STAT. § 376.502 (2009); MO. CODE REGS. ANN. tit. 20, § 100-2.100 (2008) (financial planners).
Montana		MONT. CODE ANN. §§ 33-18-101 to 33-18-1006 (1959/2015).	MEMORANDUM 1-29-2014 (2014).
Nebraska		NEB. REV. STAT. §§ 44-1522 to 44-1535 (1973/2003).	
Nevada		NEV. REV. STAT. §§ 686A.010 to 686A.280 (1971/2013).	BULLETIN 2014-009 (2014).
New Hampshire		N.H. REV. STAT. ANN §§ 417:1 to 417:17 (1947/2010).	
New Jersey		N.J. REV. STAT. §§ 17:29B-1 to 17:29B-14 (1947/2001).	

**UNFAIR TRADE PRACTICES ACT**

<b>NAIC MEMBER</b>	<b>MODEL ADOPTION</b>	<b>PREVIOUS VERSION</b>	<b>RELATED ACTIVITY</b>
New Mexico		N.M. STAT. ANN. §§ 59A-16-1 to 59A-16-30 (1985/1999).	
New York		N.Y. INS. LAW §§ 2401 to 2409; §§ 2602 to 2612 (1984/2013).	
North Carolina		N.C. GEN. STAT. §§ 58-63-1 to 58-63-60 (1949/1999).	
North Dakota		N.D. CENT. CODE §§ 26.1-04-01 to 26.1-04-19 (1983/2011).	
Northern Marianas		4 N. MAR. ISLAND CODE § 7302 (1984).	
Ohio		OHIO REV. CODE ANN. §§ 3901.19 to 3901.26 (1955-1956/2013); OHIO ADMIN. CODE § 3901-1-07 (1975/2011).	
Oklahoma		OKLA. STAT. tit. 36, §§ 1201 to 1220 (1957/2012); § 1250.5 (2012).	
Oregon			OR. REV. STAT. §§ 746.005 to 746.270 (1967/2010); OR. ADMIN. R. 836-080-0235 (1980/2010).
Pennsylvania		40 PA. CONS. STAT. §§ 1171.1 to 1171.15 (1974/2014).	40 PA. CONS. STAT. §§ 1171.3 to 1171.5 (2014).
Rhode Island		R.I. GEN. LAWS §§ 27-29-1 to 27-29-13 (1958/2015).	HEALTH BULLETIN 2013-5 (REVISED) (2014).
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 2701 to 2740 (1974/1987).	
South Carolina		S.C. CODE ANN. §§ 38-57-10 to 38-57-310; §§ 38-59-10 to 38-59-50 (1988/1999).	S.C. CODE ANN. § 38-55-50 (1987/2004) (rebating).

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South Dakota		S.D. CODIFIED LAWS §§ 58-33-1 to 58-33-46.1 (1966/2000); §§ 58-33-66 to 58-33-69 (1986/1989).	
Tennessee		TENN. CODE ANN. 56-8-104 (2012).	
Texas		TEX. INS. CODE ANN. §§ 541.001 to 541.454 (2005/2013).	28 TEX. ADMIN. CODE §§ 21.1 to 21.122 (1981/2010).
Utah			UTAH ADMIN. CODE r. 590-154 (1993/2013) (unfair marketing practices); BULLETIN 2013-5 (2013); BULLETIN 2015-8 (2015).
Vermont		VT. STAT. ANN. tit. 8, §§ 4721 to 4726 (1974/2007).	
Virgin Islands			V.I. CODE ANN. tit. 22, §§ 1201 to 1228 (1968).
Virginia		VA. CODE ANN. §§ 38.2-500 to 38.2-516 (1986/2013).	
Washington		WASH. REV. CODE ANN. §§ 48.30.010 to 48.30.270 (1947/2015).	
West Virginia		W. VA. CODE §§ 33-11-1 to 33-11-10 (1957/2005).	
Wisconsin			WIS. STAT. §§ 628.31 to 628.46 (1975/1998); WIS. ADMIN. CODE INS. § 6.68 (1979/1984).
Wyoming		WYO. STAT. ANN. §§ 26-13-101 to 26-13-124 (1967/1986).	33 WYO. CODE R. §§ 1 to 5 (1980/1997).

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On June 5, 1944, the Supreme Court handed down the decision in the *Southeastern Underwriters* case, (*United States v. Southeastern Underwriters Association* 64 U.S. 1162) which reversed the fundamental basis underlying state regulation of the business of insurance by holding that insurance was commerce. One of the immediate effects of this decision was to make applicable to the insurance business a number of federal acts which were, in many cases, in direct conflict with the provision of state laws. **1945 Proceedings 26.**

Immediately after *Southeastern Underwriters*, proposals were considered by Congress to put insurance regulation back in the hands of the states. One suggestion was an amendment to the Federal Trade Commission Act eliminating insurance business from the scope of that act. **1945 Proceedings 28.**

Public Law 15 of the 79th Congress (known as the McCarran-Ferguson Act) was adopted to specifically declare that Congress felt continued regulation of insurance by the states was in the public interest. The Federal Trade Commission Act would not apply to the business of insurance or to acts in the conduct thereof. The Sherman Act provision regarding boycott, coercion or intimidation would continue to apply. **1946 Proceedings 132-133.**

P.L. 15 contained a moratorium from the application of federal laws to permit the states time to develop laws. After that period federal law would apply to the extent states had not assumed the responsibility. **1946 Proceeding 134.**

One of the initial efforts at developing state legislation in response to McCarran-Ferguson was the development of trade practices legislation. Among the considerations in developing a model law was the view that it was impractical to give each commissioner the power to determine what constituted unfair trade practices. It was contended such a plan would lead to lack of uniformity in administration and conflicting interpretations of the same practices in different jurisdiction. On the other hand it was asserted that if individual trade practices acts were not enacted in each state, the field would not be covered completely, thereby creating dual jurisdiction with its attendant problems. **1946 Proceedings 142-143.**

At the time it was first developed, the drafters gave the model the title “An Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance.” The task force considering market conduct activities recommended changing the title to “Unfair Trade Practices Act” as it was commonly known. There was no intent that the change should imply any change in concept. **1990 Proc. IA 146.**

The prefatory note was added in 1990 when provisions regarding claims settlement practices were deleted from the Unfair Trade Practices Act and incorporated in a freestanding model. **1990 Proc. II 169.** [See proceeding citations for Model 900 for further information.]

After passage of the Gramm-Leach-Bliley Act of 1999 (known as “GLBA” or the Financial Services Modernization Act), a new working group was appointed to consider ways for states to enforce adequate consumer safeguards related to bank sales of insurance. The new federal law affirmed the McCarran-Ferguson Act, the 1945 law that authorized the states to regulate the business of insurance, and provided for “functional regulation” of insurance activities by state insurance regulators. State law would be subject to preemption only if it “prevents or significantly interferes” with a bank’s insurance sales activities. **2000 Proc. 1<sup>st</sup> Quarter 984-985.**

GLBA provided 13 “safe harbors” from preemption for state regulatory authority over bank sales activities. State laws that imposed restrictions that are substantially the same as the safe harbors, but not more restrictive, were protected from federal preemption. **2000 Proc. 1<sup>st</sup> Quarter 985.**

The working group discussed the form of state adoption of the safe harbors. Some interested parties urged adoption of a model law. Others said there was no need for legislation, since the safe harbors were outlined in GLBA and legislative remedies were only needed if problems were identified. **2000 Proc. 2<sup>nd</sup> Quarter 1016.**

An interested party said that legislation about the 13 safe harbors would promote uniformity among the states. It was important for public policy reasons, because if states did not act, they faced federal preemption. A consumer representative also spoke in favor of a proactive rather than a reactive approach. **2000 Proc. 2<sup>nd</sup> Quarter 1017.**

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A trade association representative noted that the NAIC's Unfair Trade Practices Act already contained many of the safe harbors within it, and she believed another layer of regulation would be confusing for consumers. A commissioner opined that, if states do not have the safe harbors codified in state law, they may have abdicated their regulatory reach to a federal agency. She expressed surprise that the trade associations were not advocating uniformity in this instance, given the uniformity mantra they had been espousing. **2000 Proc. 2<sup>nd</sup> Quarter 1017.**

A commissioner urged the group to develop model legislation as soon as possible. The chair noted that the group has not yet reached consensus on that issue. Some favored development of a whole model law, some favored developing model language by section, and some favored doing nothing. He suggested that if federal regulators did not take action on the pending preemption requests, the working group could decide a model was unnecessary. If the federal regulators took an aggressive stance toward preemption, the working group should develop more precise language for states to follow to avoid preemption requests. **2000 Proc. 3<sup>rd</sup> Quarter 1003.**

By the next meeting of the working group, a decision had been made to draft amendments to the NAIC Unfair Trade Practices Act to incorporate the safe harbors and rules from Section 305 of the Gramm-Leach-Bliley Act. Federal banking regulators were supportive of the idea, hoping that having a uniform model law available that has been reviewed by all parties would minimize the number of individual preemption requests received. **2000 Proc. 4<sup>th</sup> Quarter 851.**

The Unfair Trade Practices Act already contained a section on coercion of debtors. For that reason, the working group decided to amend the Unfair Trade Practices Act to address the 13 safe harbors. **2000 Proc. 4<sup>th</sup> Quarter 852.**

A regulator opined that it was preferable for states to create consistent public policy through development of model laws rather than leaving interpretation of dissimilar laws to the courts. The chair agreed that, even with the model law approach, there will be some litigation; however, the model law approach at least provided a framework. **2000 Proc. 4<sup>th</sup> Quarter 853.**

During development of the 2001 amendments, regulators addressed 11 of the 13 safe harbors in the proposed amendments to the Unfair Trade Practices Act. They decided not to address the two safe harbors related to privacy, as the NAIC's privacy regulations adequately addressed privacy disclosures. **2001 Proc. 2<sup>nd</sup> Quarter 836.**

### Section 1. Purpose

A committee was appointed to draft model legislation to attempt to cover the field through state legislation with respect to matters covered by Section 5 of the Federal Trade Commission Act. The committee expressed the opinion that state laws must be strengthened if insurance commissioners were to be in a position to demonstrate that the states were adequately covering the field. **1946 Proc. 145.**

The committee reported, after review of various alternatives, that there was doubt whether existing state statutes would sustain the argument that insurance business was subject to state control in the field of unfair trade practices. After continued study they recommended a pattern of legislation for strengthening state laws bearing on unfair trade practices. **1946 Proc. 148.**

Section 1 was, on its face, a declaration on the part of the adopting state of the state legislature's intention to cover the field previously occupied by the Federal Trade Commission. The legislation served as an answer to the invitation by Congress for the states to act if federal laws are not to apply. The drafters considered it to be of legal and practical importance to unmistakably establish the intention of state legislatures to act under P.L. 15 and to occupy the field. **1946 Proc. 148.**

When amendments were being considered, it was suggested that a consumer class action suit might be authorized for commission of unfair trade practices. The proposals included: (1) creating unlimited class action rights; (2) creating a right to a class action triggered only by a finding by the commissioner that an unfair trade practice had been committed; and (3) empowering the commissioner to sue on behalf of injured members of a class for damages sustained. **1971 Proc. II 344.**

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#### Section 1 (cont.)

The advisory committee spoke out against inclusion of consumer class action suits for damages resulting from violations of the Act. They felt such a provision was unnecessary and undesirable for several reasons: (1) the common law in all states recognizes the principle of representative actions, so the consumer is not without remedy; (2) there is less reason for such legislation as applied to such a heavily regulated industry as insurance; (3) the regulator has the practical power to accomplish on behalf of the consumer what consumer class actions are designed to accomplish; (4) insurers would not then be able to rely on the decision of the regulator; (5) consumer class actions would result in “judicial” regulation of the insurance business; (6) the class action principle has been abused, with the principle beneficiaries being lawyers; (7) class actions impact on the entire industry and are not restricted to isolated acts by one insurer; (8) class actions tend to encourage champerty; (9) the insurer would not be able to rely on the opinion of counsel, or even the decision of the regulator, regarding interpretation of unclear laws because of the fear of class actions; and (10) the costs of the defense of class action suits are prohibitive. **1971 Proc. II 350-351.**

When revisions were adopted in late 1971, the final decision of the subcommittee was that a provision related to class actions was inappropriate. The remedies in the model bill provided broad relief, thus affording the consumer the complete protection of the insurance department, including complaint handling mechanisms, which had proved most effective. **1972 Proc. I 491.**

In 1989 the subgroup considering amendments to the model discussed what the NAIC position was regarding whether a private cause of action was intended to be created by the Unfair Trade Practices Act. They decided no private cause of action was intended and added proposed draft language to that effect. **1989 Proc. II 204.**

The amendment adopted in 1990 included a new final sentence to this section to clarify the private cause of action issue. **1990 Proc. II 169.**

The amendments developed in 2000-2001 in response to the Gramm-Leach-Bliley Act (GLBA) included a direct reference to that act in the purpose section. An insurance association commented that the proposal to identify GLBA expressly illustrated the harm that would be perpetuated by adoption of unnecessary model laws. They opined that any state that identified GLBA in its statute would be limiting rather than expanding the Unfair Trade Practices Act. They argued that the proposed amendment would surrender the states’ most valuable tool in regulating insurance trade practices. **2000 Proc. 4<sup>th</sup> Quarter 846.**

#### Section 2. Definitions

A. The definition of affiliate was included in the 2001 amendments. **2001 Proc. 2<sup>nd</sup> Quarter 844.**

C. One interested party commented that the definition of “customer” was overly simplistic and broad. The definition of customer could be interpreted to apply to corporate entities, expanding the reach of the consumer protections beyond natural persons. The draft that was the subject of this comment used the term “person” in the definition. **2000 Proc. 4<sup>th</sup> Quarter 847.**

Another interested party argued that the protections of the Unfair Trade Practices Act should extend to all customers. Like individuals, corporate entities could also be the victim of unfair or deceptive practices or be harmed by inequalities in bargaining power. **2000 Proc. 4<sup>th</sup> Quarter 847.**

A comment on the first draft suggested that the definition of customer should not extend to persons who were solicited to obtain insurance because soliciting has little to do with being a customer. Another interested party responded that this misperceives the nature of the protections of the Unfair Trade Practices Act. These protections were designed to prevent unfair or deceptive trade practices to anyone that could be a victim of such practices, whether he was a policyholder, applicant, or just being solicited to commence the purchasing process. **2000 Proc. 4<sup>th</sup> Quarter 847.**



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#### Section 2C (cont.)

After review of a later draft of the model, an industry trade association again urged the working group to redefine customer more narrowly to apply solely to individuals. The suggested language was incorporated into the draft of the model. **2001 Proc. 1<sup>st</sup> Quarter 753.**

The federal consumer protection rules were drafted to apply solely to individuals and insurance regulators expressed no objection to using the same definition in the NAIC model. **2001 Proc. 2<sup>nd</sup> Quarter 838.**

D. The definition of “depository institution” was added with the amendments adopted in 2001. An interested party commented that the definition was too simplistic, potentially building controversial extraterritorial authority, for example, expanding the act to cover depository institutions outside the state. **2000 Proc. 4<sup>th</sup> Quarter 846.**

Another interested party countered that the first comment misunderstood the nature of insurance regulation. Whereas banks were regulated according to where the bank was located, insurance was regulated according to where the customer was located. The fact that the Unfair Trade Practices Act did not specify that it applied to institutions within the regulating state was fully consistent with other insurance regulation. Persons doing business in the regulating state were subject to the state’s restrictions regardless of where they were located. **2000 Proc. 4<sup>th</sup> Quarter 847.**

Later in the drafting process the chair pointed out that the definition of depository institution was clarified by adding that a depository institution does not include an insurance company. **2001 Proc. 1<sup>st</sup> Quarter 752.**

An insurance trade association continued to urge adoption of a more extensive definition of depository institution, arguing that the definition in the model was too simplistic. **2001 Proc. 1<sup>st</sup> Quarter 754.**

E. This subsection was added when technical amendments were adopted in December 1990. **1991 Proc. IA 197.**

F. The amended model adopted in 1971 included a provision to bring Blue Cross and Blue Shield plans under its terms. **1972 Proc. I 491.**

The amendments adopted in 1990 included revisions to this section. The entities that had been referenced in the drafting note were defined as insurers and the drafting note eliminated. In addition, the model was changed throughout to replace “person” with “insurer” where appropriate. **1990 Proc. II 170.**

I. When considering amendments to the model in 1991 and 1992, the drafters agreed to add a definition of producer to make the Act consistent with recent amendments to other NAIC models. It recognized the producer concept to include not just agents, but anyone involved in the production of insurance business. **1992 Proc. IA 226.**

#### **Section 3. Unfair Trade Practices Prohibited**

The subgroup drafting model amendments in 1989 held extensive discussions as to whether it was appropriate to broaden the scope of the model act regarding the long-standing “general business practice” standards. **1989 Proc. II 204.**

#### **Section 4. Unfair Trade Practices Defined**

The drafters of the model cautioned that no statute of this character could specify every act or practice that might meet the concept of what is unfair or deceptive. The initial adopted model included the following unfair trade practices: misrepresentation and false advertising of policy contracts, false information, defamation, boycott and coercion, false financial statements, stock operations and advisory committee contracts, discrimination and rebates. **1946 Proceedings 145- 146.**

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#### Section 4 (cont.)

A member of other subjects were considered by the committee for inclusion, but after consideration were excluded. Fraud, barratry, bribery, and making of political contributions were excluded, as preferably being dealt with as unfair trade practices generally, and not as unfair trade practices confined to the insurance business. **1946 Proc. 146.**

At the time the model was adopted, the drafters again cautioned that no statute could specify every act, method or practice which might be unfair or deceptive. All that can be expected is a reasonably adequate coverage of sufficient extent to reflect a considered exercise of legislative judgment and declaration of policy. **1946 Proc. 149.**

When considering amendments to propose to regulators, the advisory committee had to determine what “trade practices” were for the purposes of the Act. In order to determine what prohibitions might be appropriate under the model act, they recommended against inclusion of practices which might, in the general scheme of statutory enactments, be found in other portions of the insurance law. For example, a practice relating to unfair discrimination in fire and casualty rates should appear in the rating laws rather than in an unfair trade practices act. They suggested the model act should not become a repository for specific acts which the commissioner can reach through existing law. **1971 Proc. II 345-346.**

A. One of the unfair practices identified was lowballing: purposely quoting a lower rate. The phrase added to Paragraph (6) was designed to address this concern. **1991 Proc. IA 219.**

When the drafters were considering the addition of language to Paragraph (5) to refer to race, religion and national origin, there was extensive debate about whether to add similar language to Paragraphs (1) and (2). On one side were those who asserted that broadened nondiscrimination language would assure that discrimination would be dealt with effectively no matter how it might manifest itself. The responsive argument was advanced that discrimination was already dealt with effectively in the state rating law and that adding a provision to Paragraphs (1) and (2) would be redundant, unnecessary, and potentially would lead one to falsely conclude that the language was actually necessary for a state to deal effectively with discrimination on the basis of race, religion or national origin. **1992 Proc. IIA 150.**

B. After the decision in *Federal Trade Commissioner v. Traveler's Insurance Co.* 362 U.S. 293 (1960) was handed down, the committee looked at ways to provide a method for the commissioner to proceed against a nonadmitted insurer for commission of any unfair trade practice. Since the concern of the committee was not limited to the area of false advertising, but reached all unlawful activities of nonadmitted insurers, a more comprehensive solution was needed. **1960 Proc. II 486-487.**

E. It was proposed that Section 4E(2) be amended by adding the last phrase. It was the intent of the drafters to hold companies responsible for oral statements made to department officials or contract examiners. **1992 Proc. IA 227.**

G. When amendments were being considered in 1971, it was suggested that specific language be added dealing with refusal to insure risks solely because of age, residence, race, color, creed, marital status, ancestry, lawful occupation; or solely because the insured would not agree to place collateral business with a particular insurer, if such practices are performed with such frequency as to constitute a general business practice. **1971 Proc. II 342.**

The subcommittee reviewed several drafts which would have restricted the right of insurers to reject persons as risks solely because of race, color, creed, marital status, sex, national origin, residence, age, lawful occupation, failure to place collateral insurance, or previous refusal by another insurer. They decided not to incorporate the provisions because some of the matters were covered in civil rights laws, some were covered in special laws related to auto insurance, and the broad philosophical issues would appear to be more appropriate for a separate bill. **1972 Proc. I 491.**

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#### Section 4G (cont.)

While considering amendments to the Unfair Trade Practices Act dealing with redlining and similar discriminatory practices, the task force also recommended addition of a provision to prohibit discrimination based on the sex or marital status of an individual. Although the initial thought was to adopt a provision related to auto insurance, the paragraph drafted covers all lines of insurance. **1979 Proc. II 552-554.**

In 1977 a task force was appointed to consider the issue of “redlining,” especially with respect to personal lines insurance. More specifically, the committee was charged to develop a definition of redlining and consider its relationship to the unfair trade practices laws in the states. **1977 Proc. II 627.**

A statement of principles and objectives adopted by the Availability of Essential Insurance Subcommittee stated there was evidence that some insurers were refusing to insure, refusing to renew, or limiting the amount or type of property and automobile insurance coverage available to individuals because of the geographic location of a particular risk. The availability of insurance should not be dependent on the geographic location of a particular risk. It is the position of the NAIC that the insurance industry has been perceived to be redlining, and the perception can only be altered by implementing such practices as stating exact reasons for rejections, cancellations and nonrenewals. The insurance industry should also abandon underwriting “short-cuts” such as refusing to accept an application solely because the applicant was refused coverage by another carrier. **1978 Proc. I 628.**

The first draft of an amendment to prevent redlining was simply to define as an unfair trade practice “refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to a risk because of the geographic location of the risk.” An accompanying drafting note stated the language was intended to have broad application to all lines of insurance where unfair discrimination is practiced with regard to the geographic location of the risk. However, the drafters recognized that some states might want to limit the application of the proposed language to certain lines or classes of insurance. **1978 Proc. I 629.**

A nonprofit public interest organization presented a report on redlining to the committee considering amendments to the Unfair Trade Practices Act. **1978 Proc. I 642-644.** Their definition of redlining included arbitrary and capricious denial of insurance based on the geographic location of the property to be insured, and arbitrary and unfair price discrimination based on the geographic location of the property. **1978 Proc. I 643.**

The report suggested that insurance has become a necessity for everyday life for most citizens, and as such, must be available to anyone who wants it at a fair price. Risk must be taken into account on a fair, equitable and open basis. Classes of risk with similar characteristics should be treated consistently, in an objective fashion. The report suggested that rating territories should be entire states or large sections of states. Cities should not be rating territories, nor should there be special rate factors for cities. **1978 Proc. I 644.**

Another type of rate differential the drafters were asked to define as discriminatory was differing rates based on the age of the property being insured. One comment received suggested that this was a way of discriminating against those in low income groups. **1978 Proc. I 659.**

The committee was interested in the extent of the redlining problem and suggested hearings in the states and the possibility of a study to determine the full extent of the problem. **1978 Proc. II 467-471.**

In attempting to illustrate the meaning of the proposed redlining amendment to the model, the task force also prepared a draft model regulation. Its purpose was to state specific examples of the types of practices that should be deemed unfair. **1978 Proc. II 475-476.**

A study of redlining in New York was included in the *Proceedings*. **1978 Proc. II 478-509.**

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#### Section 4G (cont.)

An advisory committee was asked to prepare a report on steps the insurance industry must take to address the concerns outlined by the redlining task force. The committee was asked to address itself to several issues: (1) what is the duty of the insurance industry to educate policy holders as to the reason for rejection or cancellation; (2) what has the industry done, or should it do, to identify potential problem areas and advise consumers of necessary corrective action to continue insurance coverage. They also reported on alternative forms of coverage. **1978 Proc. II 515-556.**

The model amendment adopted included the substance of the proposed model regulation, so the need for a separate model regulation was obviated. **1979 Proc. II 525.**

A representative from the U.S. Commission on Civil Rights spoke against the model amendments adopted. He felt that inclusion of the phrase prohibiting the practice unless it is “for a business purpose that is not a pretext for unfair discrimination,” amounts to little more than fitting regulations comfortably around current practices rather than curtailing abusive practices. **1979 Proc. II 579.**

The task force spent a considerable amount of time deciding between two alternative amendments to deal with the discrimination issue in general and redlining in particular. The general amendments simply prohibited discrimination in the issuance, renewal, cancellation or limitation of property insurance. A regulation spelled out details with regard to redlining. **1979 Proc. II 547-548.** A more specific amendment detailed types of discrimination prohibited, and this is the alternative adopted. **1979 Proc. II 39-40.**

When modifications were made to the Unfair Trade Practices Act in 1990 to accommodate the separate free-standing act, there remained unfinished business relative to fair treatment of consumers. The changes to ensure an actively competitive marketplace included consideration of several issues: redlining, refusal to offer coverage, rescission of policies and blackballing (using the underwriting decision of other insurers to deny coverage). **1991 Proc. IIA 265.**

In an attempt to deal with the issue of redlining the drafters considered several proposals. The one they ended up adopting changed Paragraph (3) to add the phrase about sound underwriting in place of a provision which had allowed a limitation for a business purpose that was not a pretext for unfair discrimination. **1992 Proc. IA 227-228.**

A change was also suggested to Paragraph (4) to add the word “solely” and again delete language related to a business purpose. It was the regulators’ intent for this to be an affirmative change to not allow any such exception based upon age of the property alone. **1992 Proc. IA 228, 1993 Proc. I.**

A consumer advocate raised the issue regarding the failure of the Unfair Trade Practices Act to specify race, religion and national origin in Section 4G(5). There was a general consensus that Paragraph (5) should be amended. **1992 Proc. IIA 149.**

As a subsequent drafting session, it was decided that there should be provided an exception for fraternal insurance companies since such insurers are inherently allowed to discriminate in these areas by statute. **1992 Proc. IIA 144.**

A new Paragraph (7) was added in 1992 to deal with the issue of “blackballing.” Some insurers apparently considered it efficient to simply reject those consumer that other insurers had previously rejected without any appropriate underwriting. The advisory committee objected that such language would pose a problem for surplus lines business where an insurer actually must inquire as to the rejection of a risk. The drafters changed the original language, which had prohibited an insurer from requesting information about prior cancellation, to respond to this concern. The drafters stated that the purpose of the provision was to make insurers base their decisions upon sound underwriting principles and not merely on rejection by another insurer. One industry attendee suggested that the policy was currently allowed in life and health business, and wondered if this provision was to apply only to property and casualty business. The committee chair responded that the majority of regulators supported the new language without exceptions. **1992 Proc. IA 230.**

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At the next drafting session it was decided to add the second sentence to exempt excess and surplus lines. **1992 Proc. IIA 144.**

Several suggestions were considered for what became the recision reference in Paragraph (8). A concern considered by the drafters was the need to address post claims underwriting to require underwriting on a timely basis. **1992 Proc. IA 232.**

Later the drafters decided that the suggested paragraph was ambiguous, and that a model recision, cancellation and nonrenewal law should be developed as a separate project. The reference was changed so that Paragraph (8) simply referred to the state's law on recision. **1992 Proc. IIA 148.**

H. The drafters of the initial NAIC model surveyed state laws to see what type of unfair trade practice laws were already in place. The only law found to be in effect in all states in 1945 was a prohibition on rebating. **1946 Proc. 148-149.**

The model as originally adopted applied only to rebates of premiums for life insurance, annuities, and accident and health insurance. The drafters considered enlarging this section to apply to all lines. The advisory committee expressed disagreement with that concept, pointing out that rating laws might already contain such a provision, which would lead to duplication and could have the effect of imposing double penalties. For states without a rebate provision in the rating law, the advisory committee recommended adoption of that provision rather than enlarging upon the provisions of the Unfair Trade Practices Act. **1972 Proc. I 503.**

Paragraph (2)(d) and the drafting note following it were added in 2001 to recognize specifically one of the safe harbors of the Gramm-Leach-Bliley Act of 1999 (GLBA). This amendment was just one of a set of amendments made in response to GLBA. **2001 Proc. 1<sup>st</sup> Quarter 752.**

Federal thrift regulators suggested changes to the draft proposal to incorporate reference to the Home Owner's Loan Act. **2001 Proc. 1<sup>st</sup> Quarter 754.**

I. This subsection was added when the model was revised in 1990. **1990 Proc. II 173.**

J. With little discussion, the proposal to require maintenance of marketing and performance records was included in the model revisions. **1992 Proc. IA 232-233.**

K. The subcommittee appointed to consider amendments to the model wanted to include specific language which would define as an unfair trade practice the failure of an insurer to assemble all of the complaints received by the company, or its representatives, in one place to facilitate periodic review by insurance department examiners. They decided the proposal should include a requirement that information be maintained indicating the number of complaints received by classification of coverage; the nature of these complaints; the number rejected; and the length of time it took the insurer to act on the complaints. **1971 Proc. II 342.**

The revised model adopted in 1971 contained the provision now labeled Subsection K. Complaint handling procedures were of increasing interest to regulators. The efficiency with which complaints are handled is a test of public confidence due the insurer. In addition, reporting of complaint handling data would reveal much about the efficiency of the laws, regulations and other regulatory tools used by insurance departments. **1972 Proc. I 492.**

The subcommittee considered making the complaint report a public document. The advisory committee spoke out against the idea, since the *number* of complaints may not be a good measure of how good a job a company is doing. Complaint files must be reviewed by examiners to determine whether a complaint is justified. The advisory committee listed several

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#### Section 4K (cont.)

objections: (1) it would be one more set of reports to prepare; (2) making the report a public document could do great harm to insurers because the document could be used without considering the premium volume of the insurer, the geographic area, or the method of operation of the insurer; and (3) it would be admissible evidence in any hearing. **1972 Proc. I 507.**

L. Misrepresentation in insurance applications was not clearly covered by the original law. For this reason the amended version included this provision to make it clear that such actions were prohibited. **1972 Proc. I 492.**

M. This subsection was added to the model in 1989. The drafting committee first considered development of a model law on financial planners, but decided instead to address the concerns voiced regarding the need for adequate disclosure to consumers. **1989 Proc. II 131-132.**

While the 2001 amendments were under development, a suggestion from a financial planning association was considered. It resulted in the inclusion in Subsection M(1) of language that had been in a drafting note below the paragraph. The financial planner also suggested adding the term “certification,” since technically a designation is permanent, such as an MBA or Ph.D., but a certification is on-going. **2001 Proc. 1<sup>st</sup> Quarter 755.**

N. In 1993 this subsection was added by the Long-Term Care Insurance Task Force. It coordinated with amendments to the Long-Term Care Insurance Model Regulation detailing association responsibilities when an association markets or endorses long-term care insurance. **1993 Proc. 1<sup>st</sup> Quarter 276.**

O. When drafting amendments to the model in 1991 and 1992, the committee first considered a brief proposal requiring claims information for the prior three years be made available to the policyholder. There was considerable concern expressed by the advisory committee with particular objection to providing information on group policies. It was the intent of the drafters to limit this to property/casualty policies so they amended the draft to show that. **1992 Proc. IA 233.**

The next time the subcommittee met to consider the draft, they again discussed the issue of whether this provision should apply only to property and casualty policies. A consumer advocate voiced the opinion that it should be made to apply to life and health insurance as well. A regulator from one state suggested that the provision was incomplete because it did not specify what needed to be included in the claims history and recommended the addition of language similar to that found in his state code. One attendee pointed out that the language being put forth was not found in that state’s Unfair Trade Practices Act. **1992 Proc. IIA 148-149.**

There was extended discussion by the drafters on whether claims history needed to be provided automatically within a certain number of days prior to nonrenewal or only upon request. The concern was raised that if the information was required only 60 days prior to nonrenewal that would not be sufficient time for an insured to utilize it prior to being nonrenewed. The chair of the advisory committee noted that there was no general objection to providing claims history in property and casualty insurance or even in life and health with certain stated limits. However, the advisory committee objected to producing a claims history automatically to every insured when it is in actuality only required in less than one percent of all cases. **1992 Proc. IIA 149.**

At a subsequent meeting the language earlier suggested from one of the state codes was adopted, with some modifications. The primary source of debate was whether there exists sufficient justification to report this information at all. It was articulated by the regulators that in many instances the insured was left in the untenable position of being required by a replacing insurer to provide certain loss information when its existing insurer would not provide it. If the industry wants this type of information in order to underwrite an insured, it must also provide the information. Currently if a replacing insurer asks for data that the insured is not able to provide, the replacing company typically will not quote the business. **1992 Proc. IIA 142-143.**

## UNFAIR TRADE PRACTICES ACT

### Proceeding Citations

Cited to the Proceedings of the NAIC

#### Section 40 (cont.)

There was discussion on whether the time frame for providing the information should be 30 days or 45 days. First the drafters decided to use 45 days, but then agreed that 30 days was clearly sufficient time in the personal lines area. It was also agreed to add a drafting note stating that the provision might not be required in states with a privacy law governing access to the information. **1992 Proc. IIA 143-144.**

At one point in the drafting process it was suggested that the provisions of Subsection O should only apply to *commercial* property and casualty policies. The word was added to the draft at that point, but later removed. **1992 Proc. IIA 149.**

The provisions adopted as a consensus position included removal of a requirement to provide loss reserve information, the addition of a requirement that companies be prohibited from requesting loss reserve information on open claims to underwrite applicants for insurance, and inclusion of an indication that the written notification of the right to request loss information be “prominent.” **1993 Proc. IA 244.**

P. The drafters considered several options for what became the drafting note reference to cancellation laws. They wanted to deal with issues of cancellation and nonrenewal. After discussion there was a consensus that the issue should be considered elsewhere in the insurance code and not in the Unfair Trade Practices Act. It was decided that in place of the drafters’ suggestions, a reference would be made to existing state law. **1992 Proc. IA 231.**

At a later point in the drafting process the drafters again considered including cancellation and nonrenewal in the model. The advisory committee stated the position that it was not appropriate to refer to cancellation and nonrenewal because states have other laws already in their codes. They were concerned with the position courts would take in interpreting the states’ inclusion of cancellation and nonrenewal laws under the Unfair Trade Practices Act as well as the possibility of it leading to bad faith claims judgments. **1992 Proc. IIA 130.**

The position finally agreed upon was to delete any specific reference to cancellation and nonrenewal laws and just to refer in Subsection P to any other sections with a drafting note suggesting states may insert any other laws deemed desirable or necessary, including cancellation and nonrenewal laws. **1993 Proc. IA 243.**

#### Section 5. Favored Agent or Insurer; Coercion of Debtor

Before adoption of the model act, the drafters considered adding another defined unfair trade practice. The committee gave serious consideration to the practice followed by some lenders of insisting upon control of the insurance property before they would agree to loan money. Because this type of provision would have affected people and institutions beyond those normally subject to insurance regulation, it was felt this would be a more appropriate provision for a general statute rather than an insurance regulatory statute. The committee pointed this out in their report lest their action in deleting the section be construed as an abandonment by the committee of its condemnation of the practice. **1946 Proc. 395.**

A group was created in 1971 to review the model Unfair Trade Practices Act. There was considerable interest in four additional practices which the committee wanted to define as unfair trade practices: (a) favored agent or insurer coercion of debtors; (b) use of insurance as an inducement to purchase goods and services; (c) interlocking boards of directors; and (d) claims practices. **1971 Proc. II 341-342.**

The committee looked at provisions prohibiting any requirement that insurance be purchased or renewed through any particular agent, broker, or insurer as a condition to furnishing a loan, service or property. The provisions would not prevent the exercise upon a reasonable basis of any right to approve or disapprove the insurer selected by a person. The advisory committee recommended that this provision be included in the model act as an additional defined unfair practice. **1971 Proc. II 346.**

**UNFAIR TRADE PRACTICES ACT****Proceeding Citations**Cited to the Proceedings of the NAIC**Section 5 (cont.)**

The amended model contained a new section that prohibited discrimination by creditors in favor of certain insurers or agents, and it prohibited coercion of debtors with regard to insurance. The new section was an expansion of the law, but since the abuses related directly in insurance they fit the purpose of the law and were a proper concern. **1972 Proc. I 492.**

In the mid 1970's a task force was created to consider amendments to this section. The objective was to strengthen the model legislation to provide the insurance-buying public freedom of choice as to the placement of insurance and to remove opportunities for unfair competitive advantages held by lender affiliated insurance agencies. **1976 Proc. II 373.**

In December 1976 the format of the section was completely revised. **1977 Proc. I 226-227.**

Amendments to the model under consideration in late 2000 made a number of changes to Section 5. One interested party commented that the proposed amendments extended the model to an affiliate of a depository institution merely because of the affiliation. In the absence of a genuine problem warranting such a compliance burden, the regulatory extension itself would be argued to be discriminatory and susceptible to challenge by either depository institutions or their federal regulator. **2000 Proc. 4<sup>th</sup> Quarter 847.**

Another interested party suggested deleting all reference to depository institutions in Section 5. The commenter agreed that the expansion of the Unfair Trade Practices Act was necessary to ensure that banks were subject to the same treatment as other insurance providers. However, this could be accomplished by expanding the definition of person to include banks and savings associations. This would accomplish the goal of bringing banks within the scope of the model, but would avoid several problems with the various references to depository institutions or affiliates of depository institutions. **2000 Proc. 4<sup>th</sup> Quarter 847-848.**

The interested party noted that although the restrictions in Section 5 were intended to apply to all entities that engaged in leading activities (including insurance agents), distinguishing between banks and other entities by naming them separately only increased the possibility that these restrictions would be seen as applying to them separately, and thus impermissibly. **2000 Proc. 4<sup>th</sup> Quarter 848.**

A. In addition to the references to depository institutions, the 2001 amendments added the last sentence of Subsection A to the model. **2001 Proc. 2<sup>nd</sup> Quarter 848.**

B. This subsection was adopted when the entire section was revised in 1976. **1977 Proc. I 226-227.**

When amendments to the model were considered in 2000-2001, the first draft retained the old language of Paragraph (1), but added additional text about the fact that acceptable insurance was required and that it would be available from the depository institution. **2000 Proc. 4<sup>th</sup> Quarter 863.**

An interested party commented that no safe harbor in the Gramm-Leach-Bliley Act protected the prohibition that had been in the model since 1976 that said a person that lent money could not solicit insurance for the protection of real property after a person indicated interest in securing a first mortgage credit extension, until the person received a commitment in writing from the lender. The commenter opined that this type of restriction would significantly interfere with a depository institution's ability to sell insurance, because the depository institution would be unable to market certain types of insurance products during a time when the customer may need those products the most. **2000 Proc. 4<sup>th</sup> Quarter 848.**

Another interested party responded that a provision would not be prohibited merely because it was not on the list of 13 safe harbors. There must be evidence that the provision significantly interfered with a bank's ability to do business. The commenter opined there was no evidence that Paragraph (1) constituted such an impediment. The reason put forth was that it applied to all lenders, including banks, so did not treat banks any differently. **2000 Proc. 4<sup>th</sup> Quarter 848.**



**UNFAIR TRADE PRACTICES ACT****Proceeding Citations**Cited to the Proceedings of the NAIC**Section 5B (cont.)**

The commenter pointed out that the new proposed language to be added specifically provided that the restriction did not prohibit a lender from informing a customer that insurance was required and noting it was available from that lender. This limitation would enable lenders to inform consumers of their insurance needs and of the availability of the insurance products from the lender. **2000 Proc. 4<sup>th</sup> Quarter 849.**

An early draft of the 2001 model revisions contained a provision requiring a depository institution to obtain a customer's express consent to disclose credit-related insurance information. Some interested parties raised concerns related to privacy and to the Fair Credit Reporting Act. The chair reported in early 2001 that the paragraph had been deleted and replaced by a drafting note that referred to the NAIC's model privacy regulations and the Fair Credit Reporting Act. **2001 Proc. 1<sup>st</sup> Quarter 753.**

An interested party suggested that the new Paragraph (7) on licensing was unnecessary as it was covered in other NAIC models and was not a safe harbor. The chair responded that the drafters had not limited themselves to the safe harbors, but noted that two of the safe harbors were closely related to licensing. Another interested party noted that there might be difficulty prosecuting an unlicensed individual under the current Unfair Trade Practices Act; the language might limit a regulator's options. **2001 Proc. 1<sup>st</sup> Quarter 754-755.**

A representative from an insurance trade association urged deletion of Paragraph (7). She said that language might allow individuals to pursue a private right of action with respect to licensing matters in those states that allow a private right of action under their Unfair Trade Practices Act. Regulators disagreed that there was potential harm from including the provision. **2001 Proc. 2<sup>nd</sup> Quarter 839.**

The trade association representative also urged deletion of Paragraph (8). She said it was unnecessary because it was covered by another NAIC model and was too restrictive. The working group gave the comment serious consideration but declined to change the draft. **2001 Proc. 2<sup>nd</sup> Quarter 839.**

Just before adoption of the model the working group made a change to Paragraph (8). The purpose of the change was to address concerns regarding the application of the "one-time nominal fee" language. **2001 Proc. 2<sup>nd</sup> Quarter 836.**

An interested party suggested an amendment to the new Paragraph (11) to add the words "by depository institutions" to give context to the term "retail deposits." The generally accepted meaning of "retail deposits" would be deposits accepted in the teller area of a depository institution. Without adding the clarifying context, the term could be read to apply to brokerage and other transactions. **2001 Proc. 1<sup>st</sup> Quarter 754.**

C. The Subcommittee on Unfair Competition considered the possibility of further amendments to this section to address the problems presented by the implicit economic leverage that exists when a credit relationship is established with a lending institution, **1984 Proc. II 78.**

The amendments adopted in 1984 added the second paragraph of Subsection C to address coercion of debtor problems identified. **1985 Proc. I 85-86.**

Subsection C was significantly revised when the 2001 amendments were developed. Interested parties suggested the revisions were redundant and duplicative. Credit lenders were already required by the federal Truth in Lending Act to disclose that property insurance may be obtained from a person of the consumer's choice. **2000 Proc 4<sup>th</sup> Quarter 850.**

An interested party suggested adding a limitation regarding personal, family or household purposes, similar to the action the working group took for Subsection D(1). **2001 Proc. 1<sup>st</sup> Quarter 754.**

## UNFAIR TRADE PRACTICES ACT

### Proceeding Citations

Cited to the Proceedings of the NAIC

#### Section 5 (cont.)

D. A new Subsection D was developed as a result of the Gramm-Leach-Bliley Act (GLBA) amendments considered in 2000 and 2001. An interested party commented that the first paragraph of Subsection D required a depository institution or affiliate to make four standard disclosures concerning the limited financial backing of an insurance product. Those disclosures were required to be made prior to the insurance sale and must be in writing. He opined that GLBA generally protected this type of state restriction from federal preemption, but the safe harbor would require the disclosure to be in writing “where practicable.” He said that this was an important qualifier; it recognized that there were certain situations, such as a telephone solicitation, where it was extremely impractical to provide disclosures in writing prior to the sale. He suggested that the model include the “where practicable” language to avoid a restriction that would significantly interfere with a depository institution’s authorized insurance activities. **2000 Proc. 4<sup>th</sup> Quarter 850.**

Another commenter opposed the inclusion of the “where practicable” language. He said several agents associations opposed the inclusion of such open-ended, discretionary language without guidance on what is or is not “practicable.” If the language would be included, the NAIC should specify exactly what circumstances would warrant relaxation of the requirement and to what extent. **2000 Proc. 4<sup>th</sup> Quarter 850.**

As the first draft was written, Subsection D contained only Paragraph (1) and a part of Paragraph (2) requiring written acknowledgment. An interested party suggested that this would confuse consumers with mandatory disclosures not related to property and casualty products. He suggested that the disclosures should only be required for insurance products with investment components. **2000 Proc. 4<sup>th</sup> Quarter 850.**

The next draft was changed by adding language limiting the disclosure requirements to insurance transactions that occur on the premises of the depository institution or on behalf of the depository institution. Paragraph (2) was enhanced by limiting the application of the disclosure requirements to insurance products intended for personal, family or household purposes. **2001 Proc. 1<sup>st</sup> Quarter 753.**

An interested party commented on the provisions of Paragraph (3) in regard to electronic commerce. He expressed concern about the potential conflict between the requirement for written acknowledgment and electronic commerce. He noted that it is highly unlikely this provision would be consistent with a state’s insurance code. **2001 Proc. 1<sup>st</sup> Quarter 755.**

E. The amendments considered in late 2000 included a revision of this subsection, first added in 1976. Most important was a sentence allowing the commissioner to examine the books and records.

An interested party voiced objection to this language because it expanded the commissioner’s power far beyond what had been permissible. He said that under existing laws regulators did not have *carte blanche* to examine the banking or lending records of a financial institution. Lenders have neither the authority nor the right to reveal protected borrow information to regulators. The interested party suggested either eliminating the proposed changes or fine-tuning the language so that lenders were not required to make contractually protected consumer information available to insurance commissioners. **2000 Proc. 4<sup>th</sup> Quarter 850.**

G. As originally drafted in 1976, the section referred to credit life and health insurance. A credit insurance trade association suggested adding credit property and credit involuntary unemployment to that list. **2000 Proc. 4<sup>th</sup> Quarter 850.**

An insurer asked regulators to consider adding mortgage insurance to the exemption in Subsection G. Like credit life insurance and credit health insurance, financial institutions have had the authority to offer mortgage insurance products for decades. The commenter suggested the purpose of the proposed amendments was to address new marketing opportunities available to financial institutions as a result of the passage of the Gramm-Leach-Bliley Act. Accordingly, the scope of the NAIC’s model should not include products that lenders have been authorized to offer for decades. He urged the working group to accept the argument that mortgage insurance was functionally equivalent to credit insurance. Like credit insurance, optional mortgage insurance was intrinsically tied to the loan transaction. **2001 Proc. 1<sup>st</sup> Quarter 753.**

## UNFAIR TRADE PRACTICES ACT

### Proceeding Citations

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#### Section 5 (cont.)

The drafting note at the end of Section 5 was part of the amendments adopted in 2001 in response to the Gramm-Leach-Bliley Act. **2001 Proc. 2<sup>nd</sup> Quarter 851.**

#### Section 6. Power of Commissioner

Section 6 was substantially revised in 2001 by the addition of the last two sentences. To broaden its scope, references to persons were added wherever insurers were noted. **2001 Proc. 2<sup>nd</sup> Quarter 851.**

#### Section 7. Defined and Undefined Practices: Hearings, Witnesses, Appearances, Production of Books, and Service of Process

The sections now numbered Sections 7 and 8 were originally drafted in six sections setting up procedures for enforcement of the model's prohibitions similar to the procedures prescribed by the Federal Trade Commission Act. **1946 Proc. 149.** Before adoption they were consolidated in much the same fashion as the current version. **1946 Proc. 39.**

The procedures for dealing with "undefined" unfair trade practices in the original model were felt by many commissioners to be too cumbersome. This required notice and hearing, and the commissioner to make a determination, but he had no power to order the licensee to desist from such practices. He was required to go to court to get an injunction in order to enforce his findings. **1971 Proc. II 343.**

The NAIC model was drafted to closely parallel the federal law on trade practices and much of the language was lifted bodily from the federal law. Unlike the federal law, the NAIC model enumerated certain defined acts or practices peculiar to the business of insurance. Since any such enumeration could not cover every conceivable situation, the model act contained an omnibus provision virtually identical to the federal laws. In addition, both acts contained similar enforcement provisions. The persons charged with enforcement of the acts were given the authority to examine and investigate, conduct hearings, and issue cease and desist orders, which were subject to judicial review. Even the penalty provision of the two acts were identical. **1971 Proc. II 345.**

One state regulator submitted suggestions for changes. He recommended a rule-making authority to be substituted for the omnibus clause because it was more equitable to those being regulated by the Act, and could be broader in scope than a cease and desist order, to get at the concept of the unfair act or practice at issue. **1971 Proc. II 367.**

A. References to depository institutions were added with the 2001 amendments. The last two sentences were added at the same time. **2001 Proc. 2<sup>nd</sup> Quarter 851.**

B. During the development of amendments in 2001, Subsection B was amended to clarify that persons, depository institutions and affiliates of depository institutions would be afforded the same rights as insurers. **2001 Proc. 1<sup>st</sup> Quarter 753.**

D. Language regarding production of records of depository institutions was added as part of the 2001 amendments. **2001 Proc. 2<sup>nd</sup> Quarter 851.**

#### Section 8. Cease and Desist and Penalty Orders

A. The original model adopted did not contain any specific language for penalties for violation of cease and desist orders. When amendments were being considered in 1971, one suggestion was for specific language amending the penalty section to include a monetary penalty for violations of the act. **1971 Proc. II 342.**

## UNFAIR TRADE PRACTICES ACT

### Proceeding Citations

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#### Section 8A (cont.)

An advisory committee presented a report to the drafting committee suggesting changes to streamline administrative procedures and put more “teeth” in the model. The model as it existed only provided a penalty after a cease and desist order was violated. **1971 Proc. II 343.**

The version adopted in 1971 greatly strengthened the enforcement procedures in the model bill. Every department that had been contacted by the subcommittee expressed dismay and discontent with the originally adopted enforcement powers. The new model made clear that hearings may be held and penalties applied for violations of both defined and undefined trade practices; that the penalties included cease and desist orders, monetary penalties, suspension and revocation of licenses, and other reasonable relief; and that the commissioner could promulgate rules to further clarify the defined unfair trade practices. **1972 Proc. I 492.**

The draft adopted in 1971 set up in Paragraph (1) a two-stage penalty, a lesser amount (\$1,000) for so-called “innocent” or “technical” violations, and a higher amount (\$5,000) for commission of acts which the person “knew or reasonably should have known” were in violation of the Act. The advisory committee suggested that it would be more appropriate not to include monetary penalties for “innocent” violations. **1972 Proc. I 508.**

The penalties were increased when model amendments were adopted in 1990. The aggregate penalty was raised from \$10,000 to \$100,000. The penalty for flagrant violations was raised from \$5,000 to \$25,000 with an aggregate of \$250,000 instead of \$50,000. **1991 Proc. IA 201.**

The grant of authority included in Paragraph (2) the 1971 revision allowed the commissioner to suspend a license if the person “knew or reasonably should have known” he was in violation of the act. The advisory committee suggested the term “willfully” be used instead because it was a somewhat stricter test and was typically required in other state statutes. Consistency with the general statutory scheme would be desirable and appropriate. **1972 Proc. I 508-509.**

The proposed draft of 1971 contained a third alternative penalty. It allowed the commissioner to order such other relief as is reasonable and appropriate. The advisory committee strenuously opposed the provision. They felt it wasn’t needed because the commissioner already had ample authority. They also suggested it conferred on the commissioner the powers of a court of equity without any of the limitations or safeguards prescribed for judicial proceedings. They argued the provision went beyond the authority conferred upon other regulators and was too broad. The laws and legislation committee deleted the provision before final adoption of the model revisions. **1972 Proc. I 509.**

When the model was amended in 2001, Section 8 was rewritten to clarify that persons, depository institutions and affiliates of depository institutions would be afforded the same rights as insurers. **2001 Proc. 1<sup>st</sup> Quarter 753.**

B. Subsection B was added with the 2001 amendments. **2001 Proc. 2<sup>nd</sup> Quarter 852.**

#### Section 9. Judicial Review of Orders

A. While the NAIC was drafting amendments in 2001 in response to the Gramm-Leach-Bliley Act of 1999, reference to depository institutions and insurers was added to Subsection A. **2001 Proc. 2<sup>nd</sup> Quarter 852.**

#### Section 10. Judicial Review of Intervenor

## UNFAIR TRADE PRACTICES ACT

### Proceeding Citations

Cited to the Proceedings of the NAIC

#### **Section 11. Penalty for Violation of Cease and Desist Orders**

Under the original model act the commissioner could recover up to \$5,000 in penalties in a civil action if there was violation of a cease and desist order. The revisions adopted in 1971 permitted the commissioner to call a hearing and assess a penalty up to \$10,000. A provision was also added to allow suspension or revocation of the insurer's license. **1972 Proc. I 500.**

While amendments were being developed in 2001, reference to insurers and depository institutions was added to Section 11. **2001 Proc. 2<sup>nd</sup> Quarter.**

#### **Section 12. Regulations**

The original model did not confer on the commissioner any authority to promulgate regulations. Some commissioners on the drafting committee considering amendments thought the act could be made more effective if some authority was added in this area. One suggestion was to give the commissioner the power by regulation to add new specific unfair trade practices to the list enumerated in Section 4. **1971 Proc. II 343-344.**

The language of the section was broadened in 1990. Instead of specifying acts prohibited by Sections 4 and 5 which would serve as the subject of regulations, the model was changed to give authority to carry out the provisions of the act by promulgating regulations. **1990 Proc. II 176.**

#### **Section 13. Provision of Act Additional to Existing Law**

#### **Section 14. Immunity from Prosecution**

#### **Section 15. Separability Provision**

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#### *Chronological Summary of Actions*

*June 1947: Model law adopted.*

*December 1971: Included hospital and medical service plans under Act; added provisions regarding claims settlement practices. Section 5 on coercion of debtors also added. Penalty and enforcement provisions strengthened; authority to adopt regulations added.*

*December 1976: Revised Section 5 on coercion of debtors.*

*June 1979: Added subsection on unfair discrimination in response to concerns about redlining.*

*December 1984: Amended Section 5.*

*June 1989: Added disclosure provisions for financial planners.*

*December 1989: Changed name of model.*

*June 1990: Developed freestanding model on claims settlement practices and deleted provisions on subject from Unfair Trade Practices Act. Added provision that no private cause of action is created by model. Made technical amendments.*

*December 1990: Further technical amendments to coordinate trade practices and claims settlement practices provisions. Increased penalty for violation of cease and desist orders.*

*December 1992: Changed terminology to refer to "producer" throughout model, revised unfair discrimination subsection, and added requirement to maintain marketing records. Added requirement to provide claims history upon request.*

*June 1993: Added provision requiring insurers to certify information related to association endorsement of long-term care insurance to Section 4.*

*June 2001: Adopted amendments to address issues raised by the federal Gramm-Leach-Bliley Act of 1999.*

*June 2008: Adopted guideline amendments to address lawful travel underwriting issues.*

## Market Conduct Annual Statement Data Element Revision Process

Adopted by the  
Market Conduct Annual Statement Blanks (D) Working Group on  
~~May 10, 2018~~October 10, 2023

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

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

- A minimum of five Working Group jurisdictions should volunteer and participate in subject matter expert (SME) group meetings during the creation of reporting for new MCAS line of business or blank changes to an existing line of business.
- SME group draft documents and a summary of progress should be exposed to Working Group members, interested regulators and interested parties monthly.
- Weekly (SME) meetings should be encouraged from the beginning of SME work.
- A formal meeting should be held after the conclusion of the SME group meetings and prior to the voting deadline to present the draft document to the Working Group members, interested state insurance regulators, and interested parties to increase exposure, facilitate discussion, and proactively identify any concerns.

1. The MCAS Blanks WG may consider relevant changes to the annual statement blank and instructions at any scheduled Working Group conference call or meeting. The MCAS Blanks WG chair will determine which suggested changes are considered.
2. Suggested changes and amendments to the MCAS data elements or definitions may be submitted ([using the MCAS Proposal Submission Form located on the Working Group's web page](#)) to the NAIC support staff for the MCAS Blanks WG at any time during the year.

3. All recommended changes shall include all of the following:
  - A concise statement of the proposed change.
  - The statement type of the suggested change (Life and Annuity, Property and Casualty, Long Term Care, Health, etc.).
  - The reason for the change.
  - Any supporting information relating to the change.
4. Changes that have been adopted by the MCAS Blanks WG prior to June 1 and subsequently adopted by the Market Regulation and Consumer Affairs (D) Committee by August 1 and by the NAIC Plenary by December 31 of the same year will become effective for the following year's experience reporting.

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

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

## Annuity Suitability Revisions to Chapter 23 11-8-23

Revisions made at the 11/8/23 Market Conduct Exam Guidelines (D) Working Group Meeting are shown in gray. Revisions made since the draft dated 6/6/23 are shown in green highlight. The revisions include the IRI edits on pages 13, 17, 27, 45 and 46 and the Annuity SME edits, which occur on pages 24, 26, 28, 33, 38, 46 and 47.

The 6/6/23 revisions made to the draft dated 8/22/22 are shown in blue highlight. The revisions are on pages 24 and 28.

Revisions shown in yellow are the 8/22/22 changes made to the 4/19/22 initial exposure draft.

Revisions not highlighted in any color were in the initial exposure draft of 4/19/22

## Chapter 23—Conducting the Life and Annuity Examination

### IMPORTANT NOTE:

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

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

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

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales (Several specialized Supplemental Checklists are available in Sections H–N of this chapter)
- D. Producer Licensing
- E. Policyholder Service
- F. Underwriting and Rating
- G. Claims (~~Several specialized checklists are available in Sections H–J of this chapter~~)
- H. Supplemental Checklist for Marketing and Sales Standard #1
- I. Supplemental Checklist for Marketing and Sales Standard #4
- J. Supplemental Checklist for Marketing and Sales Standard #8
- K. Supplemental Checklist for Marketing and Sales Standard #10
- ~~K.~~ L. Supplemental Checklist for Marketing and Sales Standard #12
- M. Supplemental Checklist for Marketing and Sales Standard #16
- N. Supplemental Checklist for Marketing and Sales Standard #17



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## C. Marketing and Sales

### 2. Techniques

This area of review should include all advertising and sales material and all producer sales training materials to determine compliance with statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of information provided or to obtain additional information.

As with all of its advertising, regardless of the medium, every insurance company is required to have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of all of its advertisements. All of these advertisements maintained by or for and authorized by the insurer are the responsibility of the insurer.

The exact same regulations and statutes (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. Bearing that in mind, when the examiner is reviewing a company's Internet advertisements, it is important to also review the safeguards implemented by the company.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear so as to avoid deception. The advertisement shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined upon reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

There may be special requirements for applicants age 60 or older. The examiner should refer to statutes, rules and regulations to determine what requirements apply.

In addition to reviewing advertising, examiners should be aware that several NAIC models impose additional duties on regulated entities which go beyond the delivery of accurate information to consumers. If an insurance product is involved and a regulated entity, producer or a registered representative makes a recommendation regarding that insurance product, both insurance suitability laws and insurance replacement laws may apply to the transaction. A person who is advising a consumer about an insurance product, even if it is to replace it with a non-insurance product, must hold an insurance license. An insurance producer who does not hold a license as a registered representative should not give advice or recommendations about securities products.

The *Life Insurance and Annuities Replacement Model Regulation* (#613) was thoroughly updated and expanded in 1998. The new model applies to annuities and life insurance products and requires delivery of certain notices if the proposed purchaser has any existing life insurance or annuity products. Under the new model, insurers are required to have systems in place to monitor compliance with replacement procedures. Under the old model, which is still in place in a number of states, producers generally make a decision at the point of sale as to whether the transaction involves a replacement. Under either model, market regulators should review insurer systems and should also sample transactions that are not reported

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Historically, replacement ratios were quite low. This was due in part to the fact that the definition of a replacement under the "old" *Life Insurance and Annuities Replacement Model Regulation* (#613) only applied to life insurance products and external replacements. Under the prior model, either the producer or the insurer made a decision as to whether the transaction involved a "replacement."

The new model covers internal and external replacement and, if any funds for the new product come from an existing product, the transaction is a replacement and must be reported as such. There are several limited exceptions. Another factor in the increase in replacement activity is the tendency of consumers to move funds between investment and insurance products when the stock market fluctuates. In such transactions, an analysis should be performed to determine whether the insurer has systems in place to supervise its producers. Regulators should review transactions involving the sale or replacement of variable products involving the insurer and its products to verify that a system is in place to confirm that its producers are properly licensed. In the context of the examination, an examiner or analyst is only responsible for reviewing the conduct of insurance producers and conduct which requires an insurance producer license.

~~The *Suitability in Annuity Transactions Model Regulation* (#275) was adopted in 2006. Previously, this model was known as the *Senior Protection in Annuity Transactions Model Regulation*. The 2006 amendments to the previous model removed all references to "senior." The model has been adopted in some states in various forms. Model #275 was revised in 2010 to include new provisions regarding insurer supervision and monitoring of annuity recommendations and continuing education and training requirements for producers. While the previous version of the model imposed a duty on insurers and producers, or the entities they subcontract with, the revised model places the responsibility of supervision and monitoring on the insurer. The language of the revised model provides that an insurer's issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued. The model was also updated to include a revised definition of annuity, a definition of "replacement" and provisions expanding the scope of the model to include replacement of annuity products.~~

~~The *Suitability in Annuity Transactions Model Regulation* (#275) was adopted in 2020. But it was initially adopted in 2006, and revised in 2010, and was a successor to the *Senior Protection in Annuity Transactions Model Regulation*. The 2006 amendments to the previous model removed all references to seniors among other improvements. Variations of the 2020 model have been adopted in some jurisdictions. Section 989J of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 ("Dodd-Frank Act") specifically refers to this model regulation as the "*Suitability in Annuity Transactions Model Regulation*." Section 989J of the Dodd-Frank Act confirmed this exemption of certain annuities from the Securities Act of 1933 and confirmed state regulatory authority. This model also specifically identifies annuities which are exempt. This regulation is a successor regulation that exceeds the requirements of the 2010 model regulation. Examiners should reference their own jurisdiction's versions and adjust review standards accordingly.~~

~~The 2020 version of Model #275 requires producers to act in the best interest of consumers when making a sale or recommendation of an annuity and requires insurers to maintain a system of supervision, and the~~

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Licensees are required to maintain, or be able to make available to the commissioner, records of the information required in Model #275 that are collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures and other information used in making the recommendations that were the basis for insurance transactions for state-specific numbers of years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of a producer. Records required to be maintained by this regulation may be maintained in paper, photographic, micro-process, magnetic, mechanical, or electronic media or by any process that accurately reproduces the actual document.

Market regulators should also be aware that sales of products, such as fixed-index annuities (formerly referred to as equity-indexed annuities) and index life insurance products (such as universal index life insurance) continue to increase. These products typically include features that require an understanding of bonuses, guaranteed elements and an array of interest-crediting methods. In some cases, existing NAIC model laws and regulations may not give specific guidance on all aspects of all products. In such instances, examiners may rely on general principles found in Model #880, the *Life Insurance Disclosure Model Regulation* (#580) and the *Annuity Disclosure Model Regulation* (#245).

Model #582 sets out a variety of requirements to prevent insurers from using misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582. It provides guidance and limitations for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold; and
- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

Evaluation of compliance with annuity suitability may best be accomplished through a process and procedure review coupled with sampling. The process and procedure portion of the review is a good example of a function where states may wish to coordinate their reviews and share responsibilities. A

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Some insurers may outsource the administration of their suitability review, while maintaining ultimate responsibility for the outcomes. It may be instructive for examiners to become familiar with the structure and practices of commonly used services that perform suitability reviews. Examiners may also want to become familiar with vendor-owned services commonly used by insurers to document their suitability reviews.

The NAIC *Stranger-Originated Annuity Transactions Sample Bulletin* was adopted by the NAIC in October 2011. The bulletin was developed to address stranger-originated annuity transactions (STOA). Similar to stranger-originated life insurance transactions (STOLI), STOA transactions provide annuity contracts for the benefit of investors.

In STOAs, insurance producers and/or investors offer an individual, who is usually a “stranger” to the producer and/or investor, a nominal fee for the use of the individual’s identity as the annuitant in an investment-oriented annuity.

Typically, individuals targeted to serve as annuitants are in extremely poor health and are not expected to live beyond the first year of the policy. In order to find individuals who meet the aforementioned criteria, producers and/or investors have been known to take out advertisements in papers as well as solicit individuals residing in nursing homes or hospice facilities.

Once an individual has agreed to the set of conditions posed, the producer will complete the annuity application, ensuring that particular riders, such as a bonus rider or a guaranteed minimum death benefit, are in place to maximize the rate of return for those financing the transaction. Depending on the number of companies the producer represents and the commission policies in effect, the producer may seek to use multiple policies from various companies.

To avoid added scrutiny of the policy or detection of the scheme, producers and/or investors involved in STOAs will often take precautions to ensure that the dollar amount of the annuity falls below specific underwriting guidelines, while other annuities above these dollar amounts are subject to more stringent underwriting. After the annuity is issued, then the investor will significantly increase their investment in the annuity. A trust or an organization may additionally be named as beneficiary of the annuity in order to hide the true identity of those who will benefit from the annuitant’s death.

As the financial implications of STOA transactions could be detrimental to both companies and consumers, the adopted bulletin recommends that insurance companies take certain actions to mitigate their exposure to STOA transactions, which are outlined in the NAIC *Stranger-Originated Annuity Transactions Sample Bulletin*.

It is appropriate for the examiner to remind annuity insurers of this bulletin and to ask if the insurer has considered this bulletin when implementing compliance and/or enterprise risk management procedures.

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**STANDARDS****MARKETING AND SALES****Standard 1**

**All advertising and sales materials are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All life and annuity products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ All company advertising and sales materials, including radio and audiovisual items, such as television commercials, telemarketing scripts and pictorial materials

\_\_\_\_\_ Policy forms, including any required buyers' guides as they coincide with advertising and sales materials

\_\_\_\_\_ Producers' own advertising and sales materials

\_\_\_\_\_ All documents related to the development of crediting rates used in illustrations

**Others Reviewed**

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B*

*Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B*

*Modified Guaranteed Annuity Model Regulation (#255), Section 4B*

*Life Insurance Disclosure Model Regulation (#580), Section 8C*

*Unfair Trade Practices Act (#880)*

*Annuity Disclosure Model Regulation (#245), Section 6 plus appendix*

*Long-Term Care Insurance Model Act (#640)*

*Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest (AG 49)*

~~*Disclosure for Small-Face Amount Life Insurance Policies Model Act (#605)*~~

~~*Suitability in Annuity Transactions Model Regulation (#275)*~~

~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~

~~*Military Sales Practices Model Regulation (#568)*~~

**Review Procedures and Criteria**

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Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either 4 years or until the filing of the next regular report on examination of the company, whichever is the longer period of time.

Review advertising materials in conjunction with the appropriate policy form.

Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead a prospective buyer to believe that he/she is purchasing an investment or savings plan. Problematic terminology may include such terms as: investment, investment plan, founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences;
- Use terms such as "non-medical" or "no medical examination required" if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. Enrollment periods may not be described as terms such as "special" or "limited" when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised, because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol which refers the reader to

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- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate the fact, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in an advertisement;
- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact;
- Contain an assertion, representation or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation;
- Use the existence of the insurance guaranty association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the association;
- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of surplus previously paid on a policy;
- Misrepresent any policy as being shares of stock; and
- Illustrations of benefits payable under any modified guaranteed life insurance<sup>28</sup> shall not include projections of past investment experience. Hypothetical assumed interest credits may only be used if it is made clear that such are hypothetical only.

## Materials should:

- Clearly disclose name and address of insurer;
- If using a trade name, disclose the name of the insurer, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer, or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to a policy advertised and accurately reproduced to avoid misleading or deceiving

<sup>28</sup> “Modified Guaranteed Life Insurance Policy” means an individual policy of life insurance, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. It contains nonforfeiture values that are based upon a market value adjustment formula if held for shorter periods. The formula may, or may not, reflect the value of assets held in the separate account. The assets underlying the policy must be in a separate account during the period or periods when the policyholder can surrender the policy.



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- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact, and any proprietary relationship or payment for the testimonial must be disclosed; and
- The sales material for any modified guaranteed life insurance must clearly illustrate there can be both upward and downward adjustments to nonforfeiture benefits, due to the application of the market value adjustment formula.

Determine if the company approves producer sales materials and advertising. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Determine if the advertising and solicitation materials mislead consumers relative to the producer's capacity as a life insurance agent. Improper terms may include financial planner, investment advisor, financial consultant or financial counseling, if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Determine if the company has procedures in place to monitor the use of senior-specific certifications or professional designations used by producers that solicit for the company.

Determine if the company allows its life and annuity products to be marketed to the military. If so, review the company procedures to ensure that the procedures are in compliance with all applicable laws and regulations regarding sales to military personnel.

Determine if analogies between a life insurance policy's cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments are complete and accurate.

Determine if the advertisement states or implies in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable or in any manner an incorrect or an improper practice.

If nonforfeiture values are shown in any advertisement, ensure the values are shown, either for the entire amount of the basic life policy death benefit, or for each \$1,000 of initial death benefit.

Review the use of the words/phrases "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words/phrases of similar import. Such words/phrases should not be used with respect to any benefit or service being made available with a policy, unless true. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a life insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

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If an advertisement represents a pure endowment benefit as a “profit” or “return” on the premium paid, rather than as a policy benefit for which a specified premium is paid, it is deemed deceptive and misleading and is prohibited.

Determine that company procedures and materials relative to long-term care (LTC) products comply with “right to free look” requirements.

Review the company and producer’s websites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the company/entity?
- Does the website reveal the jurisdictions where the advertised product is (or is not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?

For the review of Internet advertisements:

- Run an inquiry with the company’s name;
- Review the company’s home page;
- Identify all lines of business referenced on the company’s home page;
- Research the ability to request more information about a particular product and verify the information provided is accurate; and
- Review the company’s procedures related to producers’ advertising on the Internet and ensure the company requires prior approval of the producer pages, if the company name is used.

A summary of special requirements is available for the following:

- Products sold using enrollment periods;
- Direct response products;
- Graded or modified benefit policies;
- Policies with premium changes;
- Policies with non-guaranteed elements;
- Products sold to students;
- Individual deferred annuity products or deposit funds; and
- Combination life insurance and annuity products.

Review advertising carefully for use of the term “guarantee.” Verify that the scope and duration of any guarantee is accurately described. Determine that the regulated entity has accurately portrayed non-guaranteed elements. Verify that complete information is provided regarding the scope and duration of guarantees.

Review advertising carefully for use of the term “bonus.” Review the functioning of any such bonus payments and verify that the information provided is accurate in describing the amount and the conditions for payment, retention or recoupment of the bonus.

Review advertising carefully for explanations of surrender periods and charges. Review the functioning of any such surrender charge and, in particular, how the charge is calculated in death claims. Verify that the information provided regarding the amount of the charge and the conditions for assessment are accurate.

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Index products

For advertising for interest-sensitive products, review explanations of the crediting methods and terms. Review the functioning of the crediting methods to determine that the explanations are understandable and accurate. Verify that accurate information is provided regarding the options available to the consumer and the methods by which the consumer is to exercise the options.

In addition to reviewing the advertising of indexed products, the examiner should review the illustration for compliance with Model #582 to ensure that, among other things, unreasonable or deceptive crediting rates are not being used in the illustrations and that the illustrations provide the consumer with the information required by Model #582 and, for indexed universal life (IUL) products, AG 49. Determine whether the explanations and information provided regarding the options available to the consumer are consistent with the requirements and limitations of Model #582 in AG 49.

Review the methods used by the regulated entity, annually or otherwise, to convey ongoing information about policy/contract values and options available to the consumer to change interest-crediting methods or exercise other policy/contract features in future terms.

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**STANDARDS**

**MARKETING AND SALES**

**Standard 2**  
**The insurer’s rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All life and annuity products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Replacement register/Data
- \_\_\_\_\_ Policy/Underwriting files
- \_\_\_\_\_ Loan and surrender files

**Others Reviewed**

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

*Life Insurance and Annuities Replacement Model Regulation (as adopted 1998) (#613)*

*Suitability in Annuity Transactions Model Regulation (#275)*

~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~

*Military Sales Practices Model Regulation (#568)*

**Review Procedures and Criteria**

Review loan and surrender files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm receipt of sales material or required statement. Copies of sales material other than regulated entity-approved sales material, if permitted, must also be in the file.

Review replacement disclosure forms for completeness and signatures, as required.

## Annuity Suitability Revisions to Chapter 23 11-8-23

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If the applicable state's definition of "recommendation" encompasses replacements, review policy/underwriting files to verify that the producer's treatment of and classification of replacements is in compliance with the applicable state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information.

Ensure that producer written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
  - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
  - The consumer would benefit from product enhancements and improvements; and
  - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 180 months.

Review policy/underwriting files to determine that prior to the execution of a replacement of an annuity resulting from a recommendation, an insurance producer has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;

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- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer's procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer's suitability information.

Annuity Suitability Revisions to Chapter 23 11-8-23

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**STANDARDS  
 MARKETING AND SALES**

**Standard 3**  
**The insurer’s rules pertaining to replacements are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All life and annuity products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Replacement register/Data
- \_\_\_\_\_ Policy/Underwriting files
- \_\_\_\_\_ Agency correspondence file/Agency bulletins
- \_\_\_\_\_ Agency procedural manual
- \_\_\_\_\_ Claim files
- \_\_\_\_\_ Agency sales/lapse records
- \_\_\_\_\_ Regulated entity systems manual

**Others Reviewed**

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

- Life Insurance and Annuities Replacement Model Regulation* (as adopted 1998) (#613)
- Suitability in Annuity Transactions Model Regulation* (#275)
- ~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~
- Military Sales Practices Model Regulation* (#568)
- Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin*

**Review Procedures and Criteria**

Determine if the regulated entity has advised its producers of its replacement policy.

## Annuity Suitability Revisions to Chapter 23 11-8-23

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Determine if the regulated entity has provided timely notice to the existing insurer(s) of the replacement.

Examine for effectiveness the regulated entity's system of identifying undisclosed replacements.

Determine if the regulated entity has the capacity to produce data required by replacement regulation to assess producer replacement activity.

Determine if the regulated entity has issued letters in a timely manner to policyholders, advising of the effects of loans and other disbursements on policy values.

Review policy/underwriting files to determine that the regulated entity is retaining required records for required time frames.

Examine the regulated entity's procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the regulated entity provides required credit for suicide and contestability periods on replacements.

If the applicable state's definition of "recommendation" encompasses replacements, review regulated entity procedures to verify that the regulated entity's treatment of and classification of replacements is in compliance with the state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information.

Ensure that regulated entity written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information.



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- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
  - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
  - The consumer would benefit from product enhancements and improvements; and
  - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 3600 months.

Review policy/underwriting files to ensure that prior to the execution of a replacement of an annuity resulting from a recommendation, an insurer, where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer's procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer's suitability information.

Note: All documents necessary to review the appropriateness of a sale may not be in the insurer's possession. It may be necessary to give the insurer additional lead time to obtain the documents from a producer, a third party reviewer or other entity.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin* because sales of stranger-originated annuities may be an indicator of potentially fraudulent transactions.

## Annuity Suitability Revisions to Chapter 23 11-8-23

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**STANDARDS****MARKETING AND SALES****Standard 4**

**An illustration used in the sale of a policy contains all required information and is delivered in accordance with statutes, rules and regulations.**

**Apply to:** All life products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Actuarial records

\_\_\_\_\_ All documents related to the development of crediting rates used in illustrations

\_\_\_\_\_ Underwriting file

**Others Reviewed**

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest (AG 49)*

*Universal Life Insurance Model Regulation (#585)*

*Variable Life Insurance Model Regulation (#270)*

*Life Insurance Disclosure Model Regulation (#580)*

*~~Disclosure for Small Face Amount Life Insurance Policies Model Act (#605)~~*

**Review Procedures and Criteria**

Note: Some policies may be deemed to be sold without an illustration.

If a jurisdiction continues to require surrender cost indices, ensure it is appropriately disclosed in the Statement of Policy Cost and Benefit.

Ensure that the insurer, its producers or authorized representatives do not:

- Represent the policy as anything other than a life insurance policy;
- Use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

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- State or imply that the payment or amount of non-guaranteed elements is guaranteed;
- Use an illustration that does not comply with statutes;
- Use an illustration that at any policy duration depicts policy performance more favorable to the policyowner than that produced by the illustrated scale of the insurer whose policy is being illustrated;
- Provide an applicant with an incomplete illustration;
- Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;
- Use the terms “vanish,” “vanishing premium” or similar terms that imply that the policy becomes paid-up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;
- Except for policies that can never develop nonforfeiture values, use an illustration that is “lapse-supported”; or
- Use an illustration that is not “self-supporting.”

Ensure that the insurer has a documented, reasonable methodology for the manner in which it determines its index-crediting strategy. Verify that the insurer has a system which monitors the interest rates used by its insurance producers in illustrations for compliance with the insurer’s credited interest rates.

Model #582 sets out a variety of requirements to prevent insurers from using unreasonable or misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582 for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold; and
- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

The examiner may be able to test implementation compliance issues by confirming that IUL illustration changes were made on or before the effective dates set out above. For example:

- Did the insurer implement on or before Sept. 15, 2015, a compliant crediting rate methodology for new and in force illustrations on policies sold on or after Sept. 15, 2015?
- Did the insurer implement on or before March 1, 2016, a compliant credit rate methodology for all new illustrations produced on or after March 1, 2016, on in force policies?
- Did the insurer implement the policy loan and additional illustration scales requirement of Section 6 and Section 7 of AG 49 on or before March 1, 2016?

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The following are more complex requirements of AG 49, which may require the assistance of an actuary or other person with expertise in evaluating illustration crediting methodologies and calculations:

- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the credited rate for the Illustrated Scale has been limited according to the requirements of Section 4;
- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the earned interest rate for the Disciplined Current Scale has been limited according to the requirements of Section 5;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that if the illustration includes a loan, the illustrated rate credited as compared to the illustrated loan charge has been limited according to the requirements of Section 6;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a ledger using the Alternate Scale shown alongside a ledger using the illustrated scale with equal prominence according to the requirements of Section 7.A;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates as referenced in Section 7.B; and
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated, as required by Section 7.C.

Ensure that the insurer has established requirements for producers to provide universal life applicants with a “Statement of Policy Information.” The statement should substantially follow the format set forth in the *Universal Life Insurance Model Regulation* (#585). Insurers that use direct response solicitation of universal life insurance products should provide such a statement at the time of policy delivery.

Ensure illustrations are retained in accordance with statutes, rules and regulations. A copy of the basic illustration and a revised basic illustration (if any) signed, as applicable, or a certification that either no illustration was used or that the policy was applied for other than as illustrated, should be retained until 3 years after the policy is no longer in force.

Determine if the illustration is submitted to the regulated entity as required.

- If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of the illustration must be submitted to the insurer at the time of policy application. A copy must also be provided to the applicant.
- If the policy is issued other than as applied for:
  - A revised basic illustration conforming to the policy as issued should be sent with the policy;
  - The revised illustration should be labeled “Revised Illustration”;
  - The illustration should be signed and dated by the applicant or policyowner and producer or other authorized representative of the insurer no later than the time the policy is delivered; and
  - A copy must be provided to the insurer and the policyowner.
- If no illustration is used by an insurance producer or other authorized representative, or if the policy is applied for other than as illustrated:

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- The producer or representative must certify to that effect in writing on a form provided by the insurer;
- The applicant should acknowledge (on the same form) that no illustration conforming to the policy applied for was provided and also acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than the time of policy delivery; and
- The form must be submitted to the insurer at the time of application.
- If the basic or revised illustration is sent by mail from the insurer:
  - It should include instructions for the applicant/policyowner to sign the duplicate copy of the numeric summary page and return the signed copy; and
  - An insurer's obligation will be satisfied if it demonstrates a diligent effort to obtain the signature. Diligent effort includes the mailing of a self-addressed postage-prepaid envelope with instructions for the return of the signed page.

Ensure a signed copy of the basic illustration and revised basic illustration, if any, or a certification that either no illustration was used or that the policy was applied for other than as illustrated is retained until 3 years after the policy is no longer in force. (A copy does not have to be retained if the policy is not issued.)

A summary of illustration requirements is available with special requirements for:

- Basic illustrations;
- Supplemental illustrations;
- Interest-indexed universal life;
- Universal life; and
- Variable life.

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**STANDARDS****MARKETING AND SALES****Standard 5**

**The insurer has suitability standards for its products, when required by applicable statutes, rules and regulations.**

**Apply to:** All life and annuity products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Producer records

\_\_\_\_\_ Training materials

\_\_\_\_\_ Procedure manuals

**Others Reviewed**

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Variable Life Insurance Model Regulation (#270), Section 3C*

*Suitability in Annuity Transactions Model Regulation (#275)*

~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~

*Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin*

**Review Procedures and Criteria**

Determine if multiple sales of the same product have been made to individuals. Identify and review a random sample of policyholders for which multiple policies exist.

Determine if underwriting guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Determine whether marketing materials encourage multiple issues of policies; e.g., use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used.

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Determine if the regulated entity has a system to discourage “over-insurance” of policyholders as defined by the regulated entity’s underwriting requirements.

For annuity products, ensure the regulated entity maintains a written statement specifying the standards of suitability used by the insurer. The standards should specify that an insurer’s issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

Review whether the insurer has established a system of STOA-related oversight (underwriting criteria). If not, discuss the existence of the STOA bulletin with the insurer. The examiner should be mindful that the provisions within the bulletin may not be legally required by their jurisdiction.

Inquire if the company has detected any STOA transactions and if so, the examiner may want to determine if there were any suitability issues surrounding the sale of the STOA. If there were suitability issues, the examiner may want to inquire as to what actions were taken by the company to prevent further suitability issues and if the company took any action against the producer.

Note: Sales made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. Examiners should be mindful of the fact that both variable annuity sales and variable life sales are typically sold using FINRA requirements.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions NAIC Sample Bulletin* because sales of stranger-originated annuities may result in adverse suitability situations.

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**STANDARDS**

**MARKETING AND SALES**

**Standard 9**  
**Insurer rules pertaining to producer requirements with regard to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All annuity products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Policy/Other relevant files

\_\_\_\_\_ New business reports

\_\_\_\_\_ Policy/Underwriting files

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Suitability in Annuity Transactions Model Regulation (#275)*  
~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~

**Review Procedures and Criteria**

As of June ~~October~~ November 2023, the Annuity Suitability (A) Working Group is still discussing the issue of how the Safe Harbor provisions of the *Suitability in Annuity Transactions Model Regulation (#275)*, Section 6E may apply. This examination standard may be revisited after those discussions are complete.

If the insurer has a business rule that calls for completion of a fact-finder or similar disclosure document, review policy files to determine if forms have been completed regarding suitability.

Review policy files. Copies of sales material other than insurer-approved materials, if permitted, must also be in the file or made available to the regulator upon request.



## Annuity Suitability Revisions to Chapter 23 11-8-23

Revisions made at the 11/8/23 Market Conduct Exam Guidelines (D) Working Group Meeting are shown in gray. Revisions made since the draft dated 6/6/23 are shown in green highlight. The revisions include the IRI edits on pages 13, 17, 27, 45 and 46 and the Annuity SME edits, which occur on pages 24, 26, 28, 33, 38, 46 and 47.

The 6/6/23 revisions made to the draft dated 8/22/22 are shown in blue highlight. The revisions are on pages 24 and 28.

Revisions shown in yellow are the 8/22/22 changes made to the 4/19/22 initial exposure draft.

Revisions not highlighted in any color were in the initial exposure draft of 4/19/22. Examine for effectiveness the insurer's system of verifying that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

~~Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.~~

~~Note: Noncompliance with FINRA requirements means that the broker-dealer transaction is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.~~

~~Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:~~

- ~~• Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and~~
- ~~• Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.~~

~~Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with comparable standards as defined in Section 6(E)(5) of Model #275. The regulation identifies four comparable standards:~~

- ~~• The Securities and Exchange Commission (SEC)'s Regulation Best Interest;~~
- ~~• The Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions;~~

## Annuity Suitability Revisions to Chapter 23 11-8-23

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- SEC standards of conduct (including fiduciary duties) imposed upon federally registered investment advisors or investment advisor representatives; and for plan fiduciaries;
- The Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC); and
- The model also allows for an optional fifth comparable standard, covering state registered investment advisors subject to the state's securities laws. Whether this fifth option exists in any state would depend how each jurisdiction adopted the regulation.

Sales made in compliance with comparable standards shall satisfy the requirements under this regulation. This subsection applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue. For instance, a broker dealer could approve a fixed or fixed indexed annuity transaction if it had adopted business rules addressing fixed annuities and applied the same level of scrutiny that the broker dealer would apply to a variable annuity. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.

Note: Noncompliance with comparable standards means that the recommendation or sale is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.

Review the insurer's system of monitoring sales made in compliance with comparable standards and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the relevant conduct of the financial professional seeking to rely on the safe harbor or the entity responsible for supervising the financial professional using information collected in the normal course of an insurer's business; and
- Providing to the entity responsible for supervising the financial professional seeking to rely on the safe harbor information and reports that are reasonably appropriate to assist such entity to maintain its supervision system.

Note: The definition of "financial professional" in Model 275 means a producer that is regulated and acting as

- A broker-dealer registered under federal (or state) securities laws or a registered representative of a broker-dealer;
- An investment adviser registered under federal (or state) securities laws or an investment adviser representative associated with the federal (or state) registered investment adviser; or
- A plan fiduciary under Section 3(21) of the Employee Retirement Income Security Act of 1974 (ERISA) or fiduciary under Section 4975(c)(3) of the Internal Revenue Code (IRC) or any amendments or successor statutes thereto.

The definition of "financial professional" in Model 275 was left as variable on whether a state did or did not want to exempt state-registered investment advisors. That was a policy question that the Annuity Suitability (A) Working Group split on, and thus left it to each state to decide as they adopted the model. If a state includes "federal and state securities laws" in its safe harbor language, then both federal and state-registered investment advisors would be included in the definition of "financial professional." However, if a state only lists "federal securities laws" in its safe harbor language, then state-registered investment advisors would not be included in the definition of "financial professional" and as such, the safe harbor would not apply to a recommendation from a state-registered investment advisor.

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Revisions not highlighted in any color were in the initial exposure draft of 4/19/22. Examine for effectiveness the insurer's system for review or oversight of annuity transactions that either may have violated the insurer's suitability procedures or where no suitability analysis was performed because:

- No recommendation was made;
- A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;
- A customer refused to provide relevant suitability information and the annuity transaction was not recommended; or;
- A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.

Review completed annuity transactions and compare the information obtained by the insurance producer to the type of product purchased to verify that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another transaction or series of transactions, the insurance producer, or the insurer, where no producer is involved, had reasonable grounds for believing that the product was suitable on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
  - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
  - The consumer would benefit from product enhancements and improvements; and
  - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting/other files to verify that an insurance producer has at the time of sale:

- Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;
- Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and

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- Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

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**STANDARDS**

**MARKETING AND SALES**

**Standard 10**  
**Insurer rules pertaining to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All annuity products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Policy/Underwriting files
- \_\_\_\_\_ Agency correspondence file/Agency bulletins
- \_\_\_\_\_ Agency procedural manual
- \_\_\_\_\_ Claim files
- \_\_\_\_\_ Complaint log
- \_\_\_\_\_ Agency sales/lapse records
- \_\_\_\_\_ Regulated entity’s systems manual
- \_\_\_\_\_ Regulated entity’s producer training materials

**Others Reviewed**

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

- Suitability in Annuity Transactions Model Regulation (#275)*
- Suitability of Sales of Life Insurance and Annuities White Paper*

**Review Procedures and Criteria**

As of June ~~October~~ November 2023, the Annuity Suitability (A) Working Group is still discussing the issue of how the Safe Harbor provisions of the *Suitability in Annuity Transactions Model Regulation*

## Annuity Suitability Revisions to Chapter 23 11-8-23

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Revisions not highlighted in any color were in the initial exposure draft of 4/19/22 (#275). Section 6E may apply. This examination standard may be revisited after those discussions are complete.

~~Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and of the insurer's product specific standards, policy and procedures regarding verification of suitability of annuity products.~~

Determine if the insurer has established a system of supervision that includes but is not limited to requirements outlined in Supplemental Checklist K and has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and the insurer's product-specific standards, policy and procedures regarding verification of suitability of annuity products.

It is useful to become acquainted with the definitions in the *Suitability in Annuity Transactions Model Regulation* (#275).

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation* (#275) have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

~~Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability. Examine for effectiveness the insurer's system of monitoring and reviewing that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:~~

- ~~• The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245)).~~
- ~~• The consumer would benefit from certain features of the annuity, such as tax deferred growth, annuitization or death or living benefit;~~
- ~~• The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and~~
- ~~• In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 
  - ~~• The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;~~
  - ~~• The consumer would benefit from product enhancements and improvements; and~~~~

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- ~~The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.~~

~~Monitor and determine that an insurance producer or, where no insurance producer is involved, the responsible insurer representative, has at the time of sale:~~

- ~~Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;~~
- ~~Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and~~
- ~~Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.~~

~~Monitor and determine that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.~~

~~Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:~~

- ~~Age;~~
- ~~Annual income;~~
- ~~Financial situation and needs, including the financial resources used for the funding of the annuity;~~
- ~~Financial experience;~~
- ~~Financial objectives;~~
- ~~Intended use of the annuity;~~
- ~~Financial time horizon;~~
- ~~Existing assets, including investment and life insurance holdings;~~
- ~~Liquidity needs;~~
- ~~Liquid net worth;~~
- ~~Risk tolerance; and~~
- ~~Tax status.~~

~~Examine the insurer's procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer's suitability information.~~

~~Examine for effectiveness the insurer's system of recording or monitoring whether an insurance producer or an insurer, proceeded with an annuity transaction that either may have violated the insurer's suitability procedures or where no suitability analysis was performed because:~~

- ~~No recommendation was made;~~
- ~~A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;~~
- ~~A consumer refused to provide relevant suitability information and the annuity transaction was not recommended;~~

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- ~~• A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.~~

Verify that the insurer has established a supervision system that is reasonably designed to achieve the insurer's and its insurance producers' compliance with applicable state suitability statutes, rules and regulations, including, but not limited to the following criteria:

- Examine the regulated entity's suitability policies and procedures to verify that the insurer maintains reasonable procedures to inform its insurance producers of the requirements of applicable state suitability statutes, rules and regulations. Verify that the requirements of applicable state suitability statutes, rules and regulations are incorporated into relevant insurance producer training manuals;
- ~~• Review the regulated entity's producer training materials to verify that the insurer establishes standards for insurance producer product training and maintains reasonable procedures to require its insurance producers to comply with the requirements of Section 7 of the *Suitability in Annuity Transactions Model Regulation* (#275). For more information on the requirements of Section 7 of Model #275, see Marketing and Sales Standard 11 in this chapter;~~
- ~~• Examine the regulated entity's producer training materials to ensure that the insurer provides adequate product specific training and training materials which fully explain all material features of its annuity products to its insurance producers;~~
- Review the regulated entity's suitability policies and procedures to ensure that the insurer maintains adequate procedures for review of each recommendation, prior to issuance of an annuity, that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. An insurer's review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and the insurer's review process may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria. ~~Additionally, the suitability reviews should consider all internal transactions for a customer even if those transactions occur in multiple states;~~
- ~~Verify suitability review procedures include a review of all internal transactions for the consumer, even if those transactions occur or occurred in multiple states;~~
- Verify that the insurer maintains reasonable procedures to detect recommendations that are not suitable. Insurer procedures may include, but are not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. If there is no provision in applicable state suitability statutes, rules or regulations to the contrary, an insurer may demonstrate compliance in this area by reviewing all transactions flagged for further internal review while either applying sampling procedures; or by confirming suitability information after issuance or delivery of the annuity; and
- Verify that the insurer annually provides a report to senior management (per Supplemental Checklist K), including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

An insurer may contract for performance of one or more functions (including maintenance of procedures) under the criteria set forth in Section 6F(1) of the *Suitability in Annuity Transactions Model Regulation* (#275). An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of Model #275 regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subparagraph (b) of Section 6F(2) of Model #275.



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An insurer's supervision system as described above should include supervision of contractual performance by third parties. This includes, but is not limited to, the following criteria:

- Verify that the insurer is monitoring and, as appropriate, conducting audits to assure that contracted function(s) are properly performed; and
- Review insurer procedures to verify that the insurer is annually obtaining a certification from a senior manager who has responsibility for the contracted function(s) that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

Review agency files and related documentation to verify that insurance producers do not dissuade, or attempt to dissuade, a consumer from:

- Truthfully responding to an insurer's request for confirmation of suitability information;
- Filing a complaint; or
- Cooperating with the investigation of a complaint.

~~Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.~~

~~Note: Noncompliance with FINRA requirements means that the broker-dealer transaction is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.~~

~~Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:~~

- ~~Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and~~
- ~~Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.~~

~~Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with comparable standards as defined in Section 6(E)(5) of Model #275. The regulation identifies four comparable standards:~~

- ~~The Securities and Exchange Commission (SEC)'s Regulation Best Interest;~~
- ~~The Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions;~~
- ~~SEC standards of conduct (including fiduciary duties) imposed upon federally registered investment advisors or investment advisor representatives; and for plan fiduciaries;~~
- ~~The Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC);~~  
~~and~~

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- The model also allows for an optional fifth comparable standard, covering state registered investment advisors subject to the state's securities laws. Whether this fifth option exists in any state would depend how each jurisdiction adopted the regulation.

Sales made in compliance with comparable standards shall satisfy the requirements under this regulation. This subsection applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue. For instance, a broker dealer could approve a fixed or fixed indexed annuity transaction if it had adopted business rules addressing fixed annuities and applied the same level of scrutiny that the broker dealer would apply to a variable annuity. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.

Note: Noncompliance with comparable standards means that the recommendation or sale is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.

Review the insurer's system of monitoring sales made in compliance with comparable standards and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the relevant conduct of the financial professional seeking to rely on the safe harbor or the entity responsible for supervising the financial professional using information collected in the normal course of an insurer's business; and
- Providing to the entity responsible for supervising the financial professional seeking to rely on the safe harbor information and reports that are reasonably appropriate to assist such entity to maintain its supervision system.

Note: The definition of "financial professional" in Model 275 means a producer that is regulated and acting as:

- A broker-dealer registered under federal [or state] securities laws or a registered representative of a broker-dealer;
- An investment adviser registered under federal [or state] securities laws or an investment adviser representative associated with the federal [or state] registered investment adviser; or
- A plan fiduciary under Section 3(21) of the Employee Retirement Income Security Act of 1974 (ERISA) or fiduciary under Section 4975(c)(3) of the Internal Revenue Code (IRC) or any amendments or successor statutes thereto.

The definition of "financial professional" in Model 275 was left as variable on whether a state did or did not want to exempt state-registered investment advisors. That was a policy question that the Annuity Suitability (A) Working Group split on, and thus left it to each state to decide as they adopted the model. If a state includes "federal and state securities laws" in its safe harbor language, then both federal and state-registered investment advisors would be included in the definition of "financial professional." However, if a state only lists "federal securities laws" in its safe harbor language, then state-registered investment advisors would not be included in the definition of "financial professional," and as such, the safe harbor would not apply to a recommendation from a state-registered investment advisor.

Review insurer records of corrective action taken in mitigation of apparent violations of suitability standards for sales directly by the insurer and by any insurance producers who are acting as agents for the entity.

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Determine whether the insurer has elected to maintain records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions, or if the insurer has elected to require its producers to maintain these records. Verify that such a system is in place and is monitored by the insurer.

Note: Review the insurer's denials for suitability reasons. Review underwriting data to determine if an annuity was subsequently issued to the client. If an annuity was subsequently issued, the examiner may want to select a sampling sample of those files to ensure the sale was appropriate.

It should be noted that the model's supervision system does not require the insurer to address the following:

- A producer's recommendations to consumers of products *other than* the annuities offered by the insurer;  
or
- Include consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer.

~~However, these limitations only apply to the insurer's system of supervision and does not exclude these considerations from an analysis of another licensee.~~

Annuity Suitability Revisions to Chapter 23 11-8-23

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**STANDARDS**

**MARKETING AND SALES**

**Standard 12**  
**The insurer has product-specific training standards and materials designed to provide producers with adequate knowledge of the annuity products recommended prior to soliciting the sale of annuity products. The insurer also must have reasonable procedures in place to require its producers to comply with applicable producer training requirements.**

**Apply to:** All annuity products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Agency correspondence file/Agency bulletins
- \_\_\_\_\_ Agency procedural manual
- \_\_\_\_\_ Agency sales/lapse records
- \_\_\_\_\_ Systems manuals
- \_\_\_\_\_ Producer training materials
- \_\_\_\_\_ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

- Suitability in Annuity Transactions Model Regulation (#275)*
- Unfair Trade Practices Act (#880)*
- Producer Licensing Model Act (#218)*
- Suitability of Sales of Life Insurance and Annuities White Paper*

**Review Procedures and Criteria**

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

## Annuity Suitability Revisions to Chapter 23 11-8-23

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It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation* (#275).

Determine if the insurer has required appropriate training, as outlined in Supplemental Checklist L of this chapter, for its producers.

It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation* (#275).

The satisfaction of the training requirements of another state that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements.

An insurer shall verify that a producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

Per Supplemental Checklist L of this chapter Rreview regulated entity's records to confirm that it verifies producers complete a one-time 4 credit hour general annuity training course prior to soliciting the sale of an annuity product.

Determine if the insurer product-specific training materials are appropriate and accurately reflect the specific annuity being recommended. Review regulated entity's records to determine if, when and how product-specific training occurred prior to a producer recommending an annuity.

Note: Testing is not a requirement of the *Suitability in Annuity Transactions Model Regulation* (#275). Assessing compliance with this standard may require the examiner to access compliance with many facets of Model #275. The insurance producer training requirement of the model regulation requires that producers not solicit the sale of an annuity product unless the producer has adequate product knowledge to recommend the annuity. It is the insurer's responsibility to establish standards for product specific training for its producers. Insurers must also establish reasonable procedures to require its producers to have adequate product knowledge prior to the producer recommending an annuity.

If the examiners believe an unsuitable sale may have occurred, the examiner may need to determine the cause of the unsuitable sale.

Examiners will need to assess the product-specific training materials and determine if the materials were appropriate for the specific product. According to *Suitability in Annuity Transactions Model Regulation* (#275), insurance producers may rely on insurer-provided product-specific training materials and standards to comply with Section 7 of Model #275.

Examiners will also need to assess the procedures the insurer established to require its producers have an adequate product knowledge before the producer recommends the annuity. Specifically the examiners will need to determine if the training for the specific product took place before the recommendation of an annuity, how the producer was trained and if the training was reasonably designed to require the producer to have adequate product knowledge prior to the sale.

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Based upon the complexity of the product being offered, there is an expectation that the content of training materials and the way the training occurs may differ.

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**STANDARDS**

**MARKETING AND SALES**

**Standard 13**

**The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving fixed-index annuity products, and all sales are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All fixed-index annuity products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Policy/Underwriting file
- \_\_\_\_\_ Agency correspondence file/Agency bulletins
- \_\_\_\_\_ Agency procedural manual
- \_\_\_\_\_ Claim files
- \_\_\_\_\_ Complaint log
- \_\_\_\_\_ Agency sales/lapse records
- \_\_\_\_\_ Systems manuals
- \_\_\_\_\_ Producer training materials
- \_\_\_\_\_ Contracts with third-party vendors with compliance responsibilities

**Others Reviewed**

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

- Unfair Trade Practices Act (#880)*
- Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B*
- Annuity Disclosure Model Regulation (#245), Section 6 plus appendix*
- Suitability in Annuity Transactions Model Regulation (#275)*
- ~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~

## Annuity Suitability Revisions to Chapter 23 11-8-23

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**Review Procedures and Criteria**

Review policy files to determine that required records are retained for required time frames.  
Examine procedures for verifying producer compliance with established policies and procedures.

Review complaint log for complaints alleging improper or misleading sales practices.

Review claim files for proper crediting and computation of surrender charges at death.

Review commission structure and note any differences between indexed and non-indexed annuity products. If it appears that the difference may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.



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## STANDARDS MARKETING AND SALES

### Standard 16

~~The insurer does not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives based on the consumer's consumer profile information.~~

~~The insurer issues annuities to consumers after determining there is a reasonable basis to believe the annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives based on the consumer's profile.~~

~~The insurer issues annuities to consumers after determining that the four obligations have been met, specifically the obligations of care, disclosure, conflict of interest and documentation.~~

The insurer issues annuities to consumers that are in the best interest of the consumer under the circumstances known to the producer at the time, the recommendation is made, without placing the producer's or the insurer's financial interests ahead of the consumer's interest. The insurer shall establish and maintain reasonable procedures to ensure recommendations comply with the best interest obligations of care, disclosure, conflict of interest and documentation.

**Apply to:** All annuity sales and recommendations for products not otherwise excluded by the *Suitability in Annuity Transactions Regulation*

**Priority:** Essential

### **Documents to be Reviewed**

Applicable statutes, rules and regulations

Policy/Underwriting files including customer profile (if applicable). Note that insurers may (but are not required to) maintain documentation on behalf of their producers. It may be necessary to obtain applicable customer profiles and related materials from the producer(s).

Agency correspondence file/Agency bulletins Business entity producer correspondence file/Business entity producer bulletins

Agency procedural manual Business entity producer procedural manual

Agency sales/lapse records Business entity producer sales/lapse records

Regulated entity's systems manual

Regulated entity's producer training materials

Others Reviewed

## Annuity Suitability Revisions to Chapter 23 11-8-23

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**NAIC Model References**

*Suitability in Annuity Transactions Model Regulation (#275)*

**Review Procedures and Criteria**

Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and the insurer's product-specific standards, policy and procedures regarding verification of the suitability of annuity products.

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation (#275)* have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability. Producer supervision and compliance requirements are set forth in Supplemental Checklist M.

It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation (#275)*.

~~The requirements set forth in Supplemental Checklist M do not create a fiduciary obligation or relationship and only create a regulatory obligation as established in this regulation.~~

~~The requirements apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any. The requirements do not mean the annuity with the lowest one-time or multiple-occurrence compensation structures shall necessarily be recommended.~~

~~The requirements do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be separately owed under the terms of a fiduciary, consulting, investment advising or financial planning agreement between the consumer and the producer.~~

~~Nothing in the *Suitability in Annuity Transactions Model Regulation (#275)* should be construed to require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit or negotiate insurance in this state, including but not limited to any securities license, in order to fulfill the duties and obligations contained in this regulation; provided the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.~~

Transactions not based on a recommendation (Editor's Note, the previous language "Transactions not based..." is a section heading in the *Suitability in Annuity Transactions Model Regulation (#275)* Section 6(B) and is underlined in this exam standard)

- Except as provided under paragraph (2), a producer shall have no obligation to a consumer under subsection A(1) related to any annuity transaction if:
  - No recommendation is made;

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- A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;
- A consumer refuses to provide relevant consumer profile information and the annuity transaction is not recommended; or
- A consumer decides to enter into an annuity transaction that is not based on a recommendation of the producer.
- An insurer's issuance of an annuity subject to paragraph (1) shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

Application of the best interest obligation (Editor's Note, the previous language "Application of the..." is a section heading in the *Suitability in Annuity Transactions Model Regulation* (#275) Section 6(A (5)) and is underlined in this exam standard)

Any requirement applicable to a producer under this subsection shall apply to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

**Notes:**

- The requirements set forth in Supplemental Checklist M apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any. The requirements do not mean the annuity with the lowest one-time or multiple occurrence compensation structures shall necessarily be recommended.
- The requirements set forth in Supplemental Checklist M do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be separately owed under the terms of a fiduciary, consulting, investment advising or financial planning agreement between the consumer and the producer.
- Nothing in the *Suitability in Annuity Transactions Model Regulation* (#275) should be construed to require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit or negotiate insurance in this state, including but not limited to any securities license, in order to fulfill the duties and obligations contained in this regulation; provided the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.

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**STANDARDS**  
**MARKETING AND SALES**

**Standard 17**

**The insurer has taken steps to ensure that prior to the recommendation or sale of an annuity, the producer has prominently disclosed to the consumer on a form similar to that set forth in the *Suitability in Annuity Transactions Model Regulation Appendix A*.**

**Apply to:** All annuity sales and recommendations for products not otherwise excluded by the *Suitability in Annuity Transactions Regulation*

**Priority:** Essential

**Documents to be Reviewed**

Applicable statutes, rules and regulations

Policy/Underwriting files including customer profile (if applicable). Note that insurers may (but are not required to) maintain documentation on behalf of their producers. It may be necessary to obtain applicable customer profiles and related materials from the producer(s).

Agency correspondence file/Agency bulletins

Agency procedural manual

Agency sales/lapse records

Regulated entity’s systems manual

Regulated entity’s producer training materials

**Others Reviewed**

\_\_\_\_\_  
 \_\_\_\_\_

**NAIC Model References**

*Suitability in Annuity Transactions Model Regulation (#275)*

**Review Procedures and Criteria**

Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and of the insurer’s product-specific standards, policy and procedures regarding annuity product disclosure requirements.

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Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation* (#275) have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability. Producer supervision and compliance requirements are set forth in Supplemental Checklist N.

It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation* (#275).

If a state has adopted the *Annuity Disclosure Model Regulation* (#245), the state may have also adopted an additional phrase to explain that the requirements of this section are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation*. The examiner should refer to the applicable state's specific regulation.

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NAIC Staff Note: The below new Marketing and Sales Supplemental Checklists K, L, M and N, which correspond, respectively, to Marketing and Sales Examination Standards 10, 12, 16 and 17, were previously located after each of these examination standards in each of the exposure drafts before the Market Conduct Exam Guidelines (D) Working Group. As part of the Working Group's adoption on Nov. 8, 2023, the new Supplemental Checklists K-N will instead be placed after the Supplemental Checklists A-J at the end of Chapter 23, so that all of the Marketing and Sales Supplemental Checklists will occur in sequential order.

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**K. Supplemental Checklist for Marketing and Sales Standard #10**

<u>Yes</u>	<u>No</u>	<u>Requirement</u>
<b><u>Ensure the insurer's system of annuity suitability supervision includes from Model #275:</u></b>		
		<u>The insurer shall establish and maintain reasonable procedures to inform its producers of the requirements of this regulation and shall incorporate the requirements of this regulation into relevant producer training manuals.</u>
		<u>The insurer shall establish and maintain standards for producer product training and shall establish and maintain reasonable procedures to require its producers to comply with the requirements of Section 7 of this regulation.</u>
		<u>The insurer shall provide product-specific training and training materials that explain all material features of its annuity products to its producers.</u>
		<u>The insurer shall establish and maintain procedures for the review of each recommendation prior to the issuance of an annuity that is designed to ensure there is a reasonable basis to determine that the recommended annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives. Such review procedures may apply a screening system to identify selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. These electronic or other monitoring techniques may be designed to require additional review only of those transactions identified for additional review by the selection criteria.</u>
		<u>The insurer shall establish and maintain reasonable procedures to detect recommendations that are not in compliance with Subsections A, B, D, and E. This may include, but is not limited to, confirmation of the consumer's consumer profile information, systematic customer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures, or by confirming the consumer profile information or other required information under this section after issuance or delivery of the annuity.</u>  <u>Note: In addition to this language from Model #275, examiners should make sure that the company is reviewing all transactions that have been flagged for further internal review.</u>
		<u>The insurer shall establish and maintain reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this section.</u>
		<u>The insurer shall establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information.</u>
		<u>The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a</u>

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		<p><del>limited period of time. The requirements of this subparagraph are not intended to</del> <b>This does not</b> prohibit the receipt of health insurance, office rent, office support, retirement benefits, or other employee benefits by employees as long as those benefits are not based upon the volume of sales of a specific annuity within a limited period of time.</p> <p><u>Note: The intent of this subparagraph (h) is to prohibit sales contests, sales quotas, bonuses, and non-cash compensation based on the sale of a particular product within a limited period of time, but not to prohibit general incentives regarding the sales of a company’s products with no emphasis on any particular product.</u></p>
		<p><u>The insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, which details the results of a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended if any.</u></p>
		<p><u>Nothing in this subsection restricts an insurer from <del>contracting for</del> <b>delegating</b> <del>contracting for</del> performance of a function (including maintenance of procedures) required under this subsection. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of this regulation regardless of whether the insurer contracts for performance of a function and regardless of the insurer’s compliance with subparagraph (b) of this paragraph.</u></p>
		<p><u>An insurer’s supervision system under this subsection shall include supervision of contractual performance under this subsection. This includes, but is not limited to, the following:</u></p> <ul style="list-style-type: none"> <li>• <u>Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and</u></li> <li>• <u>Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.</u></li> </ul>

**L. Supplemental Checklist for Marketing and Sales Standard #12**

<u>Yes</u>	<u>No</u>	<u>Requirement</u>
<b><u>Ensure the insurer’s and applicable producer’s system of annuity suitability supervision and training include from Model #275:</u></b>		
		<u>A producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider <b>to comply with Section 7 of this regulation.</b></u>
		<u>Producers who hold a life insurance line of authority on the effective date of <del>this regulation</del> <b><i>Suitability in Annuity Transactions Model Regulation (#275)</i></b> and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of <del>this the</del></u>



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		<u>regulation. Individuals who obtain a life insurance line of authority on or after the effective date of <del>this</del> the regulation may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.</u>
		<u>The training required under this subsection shall include information on the following topics:</u> <ul style="list-style-type: none"> <li>• <u>The types of annuities and various classifications of annuities;</u></li> <li>• <u>Identification of the parties to an annuity;</u></li> <li>• <u>How product-specific annuity contract features affect consumers;</u></li> <li>• <u>The application of income taxation of qualified and non-qualified annuities;</u></li> <li>• <u>The primary uses of annuities; and</u></li> <li>• <u>Appropriate standard of conduct, sales practices, replacement and disclosure requirements.</u></li> </ul>
		<u>A producer who has completed an annuity training course approved by the department of insurance prior to the effective date of the regulation shall, within six (6) months after the effective date of the regulation, complete either:</u> <ul style="list-style-type: none"> <li>• <u>A new four (4) credit training course approved by the department of insurance after the effective date of the regulation; or</u></li> <li>• <u>An additional one-time one (1) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider on appropriate sales practices, replacement and disclosure requirements under the amended regulation.</u></li> </ul>

**M. Supplemental Checklist for Marketing and Sales Standard #16**

<u>Yes</u>	<u>No</u>	<u>Requirement</u>
		<del>Ensure the insurer's and applicable producer's system of annuity suitability supervision include (per Model #275)–Ensure the insurer's and applicable producer's system of annuity suitability supervision include the following, with appropriate testing as needed (per Model #275):</del>
		<u>Care Obligation. The producer, in making a recommendation shall exercise reasonable diligence, care and skill to:</u> <ul style="list-style-type: none"> <li>• <u>Know the consumer's financial situation, insurance needs and financial objectives;</u></li> <li>• <u>Understand the available recommendation options after making a reasonable inquiry into options available to the producer;</u></li> <li>• <u>Have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and</u></li> <li>• <u>Communicate the basis or <del>basis</del> bases of the recommendation.</u></li> </ul>
		<u>The producer has made reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.</u>

Annuity Suitability Revisions to Chapter 23 11-8-23

Revisions made at the 11/8/23 Market Conduct Exam Guidelines (D) Working Group Meeting are shown in gray. Revisions made since the draft dated 6/6/23 are shown in green highlight. The revisions include the IRI edits on pages 13, 17, 27, 45 and 46 and the Annuity SME edits, which occur on pages 24, 26, 28, 33, 38, 46 and 47.

The 6/6/23 revisions made to the draft dated 8/22/22 are shown in blue highlight. The revisions are on pages 24 and 28.

Revisions shown in yellow are the 8/22/22 changes made to the 4/19/22 initial exposure draft.

Revisions not highlighted in any color were in the initial exposure draft of 4/19/22

		<u>The producer considered the types of products the producer is authorized and licensed to recommend or sell that address the consumer’s financial situation, insurance needs and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation. Producers shall be held to standards applicable to producers with similar authority and licensure.</u>
		<u>The consumer profile information, characteristics of the insurer, and product costs, rates, benefits and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer’s financial situation, insurance needs and financial objectives, but the level of importance of each factor under the care obligation of this paragraph may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.</u>
		<u>The producer has a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit or other insurance-related features.</u>
		<u>In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:</u> <ul style="list-style-type: none"> <li>• <u>The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living or other contractual benefits, or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;</u></li> <li>• <u>The replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and</u></li> <li>• <u>The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.</u></li> </ul>
		<u>Conflict of interest obligation. A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.</u>
		<u>Documentation obligation. A producer shall at the time of recommendation or sale:</u> <ul style="list-style-type: none"> <li>• <u>Make a written record of any recommendation and the basis for the recommendation subject to this regulation;</u></li> <li>• <u>Obtain a consumer signed statement on a form substantially similar to Appendix B documenting:</u> <ul style="list-style-type: none"> <li>• <u>A customer’s refusal to provide the consumer profile information, if any; and</u></li> <li>• <u>A customer’s understanding of the ramifications of not providing his or her consumer profile information or providing insufficient consumer profile information; and</u></li> </ul> </li> <li>• <u>Obtain a consumer signed statement on a form substantially similar to Appendix C acknowledging the annuity transaction is not recommended if a customer decides to enter into an annuity transaction</u></li> </ul>

## Annuity Suitability Revisions to Chapter 23 11-8-23

Revisions made at the 11/8/23 Market Conduct Exam Guidelines (D) Working Group Meeting are shown in gray. Revisions made since the draft dated 6/6/23 are shown in green highlight. The revisions include the IRI edits on pages 13, 17, 27, 45 and 46 and the Annuity SME edits, which occur on pages 24, 26, 28, 33, 38, 46 and 47.

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		<p><u>that is not based on the producer's recommendation.</u></p> <p><u>Note: Examiners should be alert for trends of consumers refusing to provide profile information, on a producer level or insurer level.</u></p>
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## N. Supplemental Checklist for Marketing and Sales Standard #17

<u>Yes</u>	<u>No</u>	<u>Requirement</u>
		<b><u>Ensure the insurer's and applicable producer's system of annuity suitability supervision include from Model #275:</u></b>
		<u>The producer has disclosed to the consumer, on a form substantially similar to Appendix A, a description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction.</u>
		<p><u>The producer has provided an affirmative statement on whether the producer is licensed and authorized to sell the following products:</u></p> <ul style="list-style-type: none"> <li>• <u>Fixed annuities;</u></li> <li>• <u>Fixed indexed annuities;</u></li> <li>• <u>Variable annuities;</u></li> <li>• <u>Life insurance;</u></li> <li>• <u>Mutual funds;</u></li> <li>• <u>Stocks and bonds; and</u></li> <li>• <u>Certificates of deposit.</u></li> </ul>
		<p><u>The producer has provided an affirmative statement describing the insurers the producer is authorized, contracted (or appointed), or otherwise able to sell insurance products for, using the following descriptions:</u></p> <ul style="list-style-type: none"> <li>• <u>One insurer;</u></li> <li>• <u>From two or more insurers; or</u></li> <li>• <u>From two or more insurers although primarily contracted with one insurer.</u></li> </ul>
		<u>The producer has provided a description of the sources and types of cash compensation and non-cash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of the premium or other remuneration received from the insurer, intermediary or other producer or by a fee as a result of a contract for advice or consulting services.</u>
		<u>A notice of the consumer's right to request additional information regarding cash compensation is described in subparagraph (b) of the following checklist provision.</u>
		<p><u>Upon request of the consumer or the consumer's designated representative, the producer shall disclose:</u></p> <ul style="list-style-type: none"> <li>• <u>A reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages; and</u></li> <li>• <u>Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts</u></li> </ul>

Annuity Suitability Revisions to Chapter 23 11-8-23

Revisions made at the 11/8/23 Market Conduct Exam Guidelines (D) Working Group Meeting are shown in gray. Revisions made since the draft dated 6/6/23 are shown in green highlight. The revisions include the IRI edits on pages 13, 17, 27, 45 and 46 and the Annuity SME edits, which occur on pages 24, 26, 28, 33, 38, 46 and 47.

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		<u>or percentages.</u>
		<u>Prior to or at the time of the recommendation or sale of an annuity, the producer shall have a reasonable basis to believe the consumer has been informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, any annual fees, potential charges for and features of riders or other options of the annuity, limitations on interest returns, potential changes in non-guaranteed elements of the annuity, insurance and investment components and market risk.</u>

**POLICY IN FORCE STANDARDIZED DATA REQUEST**  
**Travel Line of Business**

**Content:** This file should be downloaded from company system(s) and contain one record for each policy or contract that the company issued which provided coverage to [applicable state] residents at any time during the examination period.

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

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to the issuance of travel insurance policies or contracts in [applicable state] within the scope of the examination:

- Cross-reference with the claims data file to ensure completeness of exam data submitted; and
- Cross-reference to state(s) licensing information to ensure proper producer licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
CoName	6	64	A		Company name
CoAddr	70	100	A		Company street address
CoCity	170	20	A		Company city
CoSt	190	2	A		Company state
CoZip	192	5	A		Company ZIP code
InsFein	197	10	A		Insured/employer Federal Employer Identification Number
PolForm	207	10	A		Policy form number as filed with the insurance department
PolPre	217	3	A		Policy prefix ( <b>Blank if NONE</b> )
PolNo	220	20	A		Policy number
PolSuf	240	3	A		Policy suffix ( <b>Blank if NONE</b> )
SrfNo	243	15	A		SERFF filing reference (Repeat field as necessary)
SrfSt	258	2	A		State related to SERFF filing reference (Repeat field as necessary)
ProdNo	260	10	A		Product number that distinguishes different products
PlanCode	270	6	A		System plan code <b>Please provide a list of system plan codes and their descriptions</b>

Field Name	Start	Length	Type	Decimals	Description
PolTyp	276	25	A		Type of policy (i.e., life, medical, trip cancellation, evacuation, package, comprehensive, etc.) <b>Please provide a list to explain any codes used</b>
PolDes	301	25	A		Coverage description, repeat as necessary (i.e., Travel Gold, Travel Silver, Travel Bronze)
CovTyp	326	25	A		Type of coverage purchased (i.e., trip cancellation, baggage delay, rental car, etc.) <b>Please provide a list to explain any codes used</b> (Repeat field as necessary)
CovLmt	351	10	N	2	Limit of coverage associated with each coverage type identified above (Repeat field as necessary)
PXWaiv	361	1	A		Is there a pre-existing conditions waiver on the policy? (Y/N)
PolPuDt	362	10	D		Purchase date of policy [MM/DD/YYYY]
PremPdDt	372	10	D		Date premium was actually paid if different from purchase date [MM/DD/YYYY]
StndAln	382	1	A		Stand-alone travel insurance or part of travel protection plan [I=Insurance only, C=Travel Protection Plan]
IndGrp	383	1	A		Individual or group coverage [I=Individual, G=Group]
PremTot	384	10	N	2	Total insurance policy premium collected
AmtChrg	394	10	N	2	Total amount charged to insured per proof of payment (i.e., credit card receipt, check, money order, wire transfer, etc.) The total amount includes but is not limited to insurance premium, fees, concierge/non-insurance services, commission, etc. combined per proof of payment (i.e., credit card, check, money order, etc.)
TxFee	404	10	N	2	Any monies charged in addition to the normal premium computed from the rate filing that the travel administrator charges to administer the travel insurance policy (list as separate fields, repeat field as necessary and include a revised file layout) at each POS (point of sale)
TxFeeDes	414	25	A		Description of monies charged in addition to the normal premium computed from the rate filing. Include any other charges to the insured associated with the purchase of travel insurance (list as separate fields, repeat field as necessary and include a revised file layout)

Field Name	Start	Length	Type	Decimals	Description
DedAmt	439	10	N	2	Amount of deductible (dollar amount or percentage amount) (repeat field for any deductibles per coverage)
PremRpt	449	2	A		State where premium is reported
PremSur	451	10	N	2	Premium surcharge amount
ReasSur	461	25	A		Reason for the surcharge <b>Please provide a list to explain any codes used</b>
PremTax	486	10	N	2	State premium tax paid
TxStPd	496	2	A		State to which the premium tax was paid
OptOut	498	1	A		Was this policy sold under an opt-out approach (Y/N)
OtrSvc	499	1	A		Did this policy include other services, such as assistance services, concierge, or non-insurance services (Y/N)
OtrChg	500	10	N	2	Amount charged for other services (i.e., assistance services, concierge, or non-insurance services)
EndorLst	510	25	A		List endorsements attached to the policy <b>Please provide a list to explain any codes used</b>
EndFrmNo	535	10	A		Endorsement form number
EndSrfNo	545	15	A		Endorsement SERFF filing reference, if applicable
EndTyp	560	25	A		Endorsement type (i.e., life, medical, trip cancellation, evacuation, package, comprehensive, etc.)
EndLmt	585	10	N	2	Policy endorsement limits
PremEnd	595	10	N	2	Endorsement premium amount
InsIDNo	605	10	A		Insured ID number, if different from policy number or certificate number
InsFirst	615	15	A		Insured first name
InsMid	630	15	A		Insured middle name
InsLast	645	20	A		Insured last name
InsAddr	665	100	A		Insured street address
InsCity	765	20	A		Insured city
InsSt	785	2	A		Insured state
InsZip	787	5	A		Insured ZIP code

Field Name	Start	Length	Type	Decimals	Description
DtEff	792	10	D		Date the coverage begins [MM/DD/YYYY]
PolEpDt	802	10	D		Date the coverage ends [MM/DD/YYYY]
CertNo	812	10	A		Certificate number assigned to applicant or insured
CertFirst	822	15	A		Certificate holder first name
CertMid	837	15	A		Certificate holder middle name
CertLast	852	20	A		Certificate holder last name
CertAddr	872	100	A		Certificate holder street address
CertCity	972	20	A		Certificate holder city
CertSt	992	2	A		Certificate holder state
CertZip	994	5	A		Certificate holder ZIP code
CertPuDt	999	10	D		Purchase date of certificate [MM/DD/YYYY]
CertEpDt	1009	10	D		Date certificate will expire [MM/DD/YYYY]
TermStat	1019	2	A		Termination status [ <b>C=Cancellation, NR=Nonrenewed, D=Declined, R=Rescinded, RW=Rewritten, IR=Insured's Request, NP=Premium Nonpayment, O=Other</b> ] Please provide a description if designated as 'Other'. Please provide a description in a separate field, if designated as 'Other'
CanTerRs	1021	64	A		Reason for cancellation/termination of coverage (i.e., lapse, insured request, company cancellation) <b>If codes are used, please provide a list of cancellation codes and their meanings</b>
CanTerDt	1085	10	D		Date policy cancelled/terminated [MM/DD/YYYY]
CanTerNt	1095	10	D		Date the cancellation/termination notice was mailed [MM/DD/YYYY]
PremRef	1105	10	N	2	Amount of travel insurance premium refunded to the insured
RateFact	1115	10	N	5	Pro rate or short rate factor applied to premium refund
AdvTyp	1125	15	A		Type of advertisement (i.e., radio script, TV script, website, leaflet, etc.)
DistMthd	1140	15	A		Distribution method (i.e., wholesale, group, retail) <b>Please provide a list to explain any codes used</b>
AgFlag	1155	1	A		Aggregator involved in sale (Y/N)
AgNPN	1156	6	A		Aggregator NPN



Field Name	Start	Length	Type	Decimals	Description
AgName	1162	64	A		Name of aggregator involved in sale
Repeat producer or limited lines producer fields (from field # to field # below), as necessary					
PrCode	1226	6	A		Company internal producer, CSR or business entity producer identification code <b>Please provide a list to explain any codes used</b>
PrFirst	1232	15	A		Producer first name
PrMid	1247	15	A		Producer middle name
PrLast	1262	20	A		Producer last name
PrStId	1282	6	A		Producer state licensing number
PrLcTyp	1288	1	A		Producer license type [F=Full, L=Limited]
PrNPN	1289	6	A		Producer NPN
PrAddr	1295	100	A		Producer street address
PrSt	1395	2	A		Producer state
PrCity	1397	20	A		Producer city
PrZip	1417	5	A		Producer ZIP code
PrComm	1422	10	N	2	Commission amount paid to the producer
Repeat retailer fields (from field # to field # below) as necessary					
RtTyp	1432	2	A		Retailer type [TR=Travel Retailer, WH=Wholesaler, TS=Travel Supplier, TA=Travel Agency, OT=Other]
RtFirst	1434	15	A		Retailer first name (Includes travel retailer, wholesaler, travel supplier, travel agency, etc.)
RtMid	1449	15	A		Retailer middle name
RtLast	1464	20	A		Retailer last name
RtAddr	1484	100	A		Retailer street address
RtStId	1584	2	A		Retailer state
RtCity	1586	50	A		Retailer city
RtZip	1636	5	A		Retailer ZIP code
RtComm	1641	10	N	2	Commission amount paid to the retailer
GrpName	1651	64	A		Eligible group name (Eligible groups, as defined by applicable state law)
GrpIntNo	1715	6	A		Eligible group internal agency number

Field Name	Start	Length	Type	Decimals	Description
GrpStID	1721	6	A		Eligible group state licensing number
GrpNPN	1727	6	A		Eligible group NPN
GrpID	1733	6	A		Eligible group ID number
GrpCnt	1739	64	A		Name of eligible group contact
GrpAddr	1803	100	A		Eligible group street address
GrpSt	1903	2	A		Eligible group state
GrpCity	1905	20	A		Eligible group city
GrpZip	1925	5	A		Eligible group ZIP code
GrpComm	1930	10	N	2	Commission amount paid to eligible group
Repeat travel administrator fields (from field # to field # below) as necessary (Travel administrator, as defined by applicable state law)					
TAName	1940	64	A		Name of travel administrator
TAIntNo	2004	6	A		Travel administrator internal agency number
TASTID	2010	6	A		Travel administrator state licensing number
TANPN	2016	6	A		Travel administrator NPN
TAFEIN	2022	10	A		Travel administrator FEIN
TAAddr	2032	100	A		Travel administrator street address
TACity	2132	20	A		Travel administrator city
TAST	2152	2	A		Travel administrator state
TAZip	2154	5	A		Travel administrator ZIP code
TAComm	2159	10	N	2	Commission amount paid to travel administrator
LPS	2169	64	A		Last point of sale - should match an entity in the sales chain (i.e., tour operator, MGA/TPA, Internet site, travel agent, group, company, etc.)
AppSrc	2233	25	A		Initial source of application (i.e., company direct, MGA/TPA, tour operator, travel agency, travel agent, travel supplier, other, etc.) <b>Please provide a list to explain any codes used</b>
AppDt	2258	10	D		Date application was signed [MM/DD/YYYY]
ProgTyp	2268	25	A		Program type or affinity/association (i.e., AARP, Rotary Club, etc.)
RateMthd	2293	25	A		Code for rating method <b>Please provide a description of each code/rating method (i.e., age-banded, aggregated, etc.)</b>

Field Name	Start	Length	Type	Decimals	Description
ReCoCode	2318	5	A		Reinsuring company NAIC code
RWCd	2323	5	A		Rewrite code designating coverage rewritten in another affiliate
InsDest	2328	64	A		Insured's destination [ <b>I=International, D=Domestic</b> ]
TrvlTyp	2392	2	A		Travel type description [ <b>I=Inbound, O=Outbound, RT=Round Trip</b> ]
TrvlSeg	2394	1	A		Single segment of travel or multiple [ <b>S=Single, M=Multiple</b> ]
TripCost	2395	10	N	2	Cost of trip if different from coverage amount
DtDepart	2405	10	D		Departure date of trip [MM/DD/YYYY]
DtReturn	2415	10	D		Return date of trip [MM/DD/YYYY]
EndRec	2425	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

## CLAIMS STANDARDIZED DATA REQUEST

### Travel Line of Business

**Content:** This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Do not include expense payments to vendors.

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

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to the handling of travel insurance claims within the scope of the examination:

- Cross-reference with the in-force data file to ensure completeness of exam data submitted; and
- Cross-reference to state(s) licensing information to ensure proper adjuster licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
GrpID	6	5	A		Group ID number
GrpName	11	64	A		Group name
PolPre	75	3	A		Policy prefix ( <b>Blank if NONE</b> )
PolNo	78	20	A		Policy number
PolSuf	98	3	A		Policy suffix ( <b>Blank if NONE</b> )
PolForm	101	10	A		Policy form number
PolTyp	111	25	A		Type of policy (i.e., life, medical, trip cancellation, evacuation, package, comprehensive, etc.) <b>Please provide a list to explain any codes used</b>
CovTyp	136	25	A		Type of coverage purchased (i.e., trip cancellation, baggage delay, rental car, etc.) <b>Please provide a list to explain any codes used</b> (Repeat field as necessary)
CovLmt	161	10	N		Limit of coverage associated with each coverage type identified above (Repeat field as necessary)
PXWaiv	171	1	A		Is there a pre-existing conditions waiver on the policy? (Y/N)

TSupp	172	64	A		Name of travel supplier (wholesaler, tour operator, cruise line, website, etc)
TAgency	236	64	A		Name of travel agency
InsFirst	301	15	A		First name of insured
InsMid	316	15	A		Middle name of insured
InsLast	331	20	A		Last name of insured
InsIDNo	351	10	A		Insured ID number, if different from policy number or certificate number
InsAddr	361	25	A		Insured street address
InsCity	386	20	A		Insured city
InsSt	406	2	A		Insured state
InsZip	408	5	A		Insured ZIP code
CertNo	413	10	A		Certificate number assigned to applicant or insured
CertFirst	423	15	A		Certificate holder first name
CertMid	438	15	A		Certificate holder middle name
CertLast	453	20	A		Certificate holder last name
CertAddr	473	100	A		Certificate holder street address
CertCity	573	20	A		Certificate holder city
CertSt	593	2	A		Certificate holder state
CertZip	595	5	A		Certificate holder ZIP code
CertPuDt	600	10	D		Purchase date of certificate [MM/DD/YYYY]
CertEpDt	610	10	D		Date certificate will expire [MM/DD/YYYY]
ClmNo	620	10	A		Claim number
ClmPre	630	3	A		Claim number prefix ( <b>Blank if NONE</b> )
ClmSuf	633	3	A		Claim number suffix ( <b>Blank if NONE</b> )
AmtSub	636	10	N	2	Amount of claim submitted
ICPdAmt	646	10	N	2	Amount paid under interruption or cancellation of trip or event coverage

BPEPdAmt	656	10	N	2	Amount paid under loss of baggage or personal effects coverage
ARVPdAmt	666	10	N	2	Amount paid under damages to accommodations or rental vehicles coverage
SADPdAmt	676	10	N	2	Amount paid under sickness, accident, disability or death coverages occurring during travel
EvcPdAmt	686	10	N	2	Amount paid under emergency evacuation coverage
RoRPdAmt	696	10	N	2	Amount paid under repatriation of remains coverage
OthPdAmt	706	10	N	2	Amount paid under any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the insurance commissioner of the applicable state
ClmPdDt	716	10	D		Claim paid date [MM/DD/YYYY]
ChkNo	726	10	A		Claim payment check number(s)
ClmPay	736	50	A		Claim payee
CmtFirst	786	15	A		First name of claimant
CmtMid	801	15	A		Middle name of claimant
CmtLast	816	20	A		Last name of claimant
CmtAddr	836	25	A		Claimant street address
CmtCity	861	20	A		Claimant city
CmtSt	881	2	A		Claimant state
CmtZip	883	5	A		Claimant ZIP code
DedAmt	888	10	N	2	Amount of deductible (dollar amount or percentage amount) (repeat field for any deductibles per coverage)
OtrSvc	898	1	A		Did this policy include other services, such as assistance services, concierge, or non-insurance services? (Y/N)
EffDt	899	10	D		Policy effective date [MM/DD/YYYY]
MGU	909	64	A		Name of third-party administrator or managing general underwriter authorized to adjudicate claims
NPN	973	6	A		Adjuster NPN (National (adjuster) number)

LossDt	979	10	D		Date loss occurred [MM/DD/YYYY]
RcvdDt	989	10	D		First notice of loss [MM/DD/YYYY]
ClmAckDt	999	10	D		Date company or its producer acknowledged claim to claimant [MM/DD/YYYY]
DtInvs	1009	10	D		Date claim investigation was completed [MM/DD/YYYY]
NtcInvDt	1019	10	D		Date of written notice to insured/claimant regarding incomplete investigation [MM/DD/YYYY]
DtClsd	1029	10	D		Date claim was closed [MM/DD/YYYY]
RsnClsd	1039	25	A		Reason claim was closed. Please provide a separate list with a description of the codes, i.e. paid, closed-no response, denied, partially denied, withdrawn (by insured), etc.
AmtDen	1064	10	N	2	Amount of claim ineligible or denied
ClmDnyDt	1074	10	D		Date claim was denied (blank if not denied) [MM/DD/YYYY]
ClmDenRsn	1084	25	A		Reason for claim denial <b>Please provide a list to explain any codes used</b>
EndRec	1109	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record This must be in the same character position for every record in this table.

2023 Fall National Meeting

Orlando, Florida

### ANTIFRAUD (D) TASK FORCE

Saturday, December 2, 2023

1:30 – 2:30 p.m.

### Meeting Summary Report

The Antifraud (D) Task Force met Dec. 2, 2023. During this meeting, the Task Force:

1. Adopted its Oct. 20 minutes.
2. Adopted amendments to the *Unfair Trade Practices Act* (#880), including revisions to Section 2—Definitions: (E) “Health Insurance Lead Generator.” The term “entity” will be replaced with “person,” which is defined in Section 2. Additionally, Section 4—Unfair Trade Practices Defined (C) will be included, which states, “Failure to Maintain Marketing and Performance Records. Failure of a health insurance lead generator to maintain its books, records, documents, and other business records in such an order that data regarding complaints and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two (2) preceding years shall be maintained. Failure to do so shall constitute a violation of (INSERT STATE STATUTE).”
3. Received the report of the Improper Marketing of Health Insurance (D) Working Group, which met Dec. 2. During this meeting, the Working Group:
  - A. Adopted its Summer National Meeting minutes.
  - B. Heard a presentation from the federal Centers for Medicare & Medicaid Services (CMS) on the 2025 Medicare Advantage and Part D proposed rule.
  - C. Discussed the new proposed rule and was notified that the comment period for this new proposed rule would end Jan. 5, 2024.
  - D. Heard a presentation from Insurance Care Direct on an agent transfer issue that all jurisdictions are experiencing.
  - E. Discussed continued agent transfers of policy, which is an issue consumers are experiencing, with industry representatives and the CMS. The Working Group discussed the importance of conducting regulator-to-regulator meetings with the CMS concerning this issue, as well as a public forum to discuss with industry representatives, to protect consumers.
4. Received an update on the Antifraud Technology (D) Working Group. The Working Group chair advised that NAIC staff is finalizing the new web service for the redesign of the NAIC’s Online Fraud Reporting System (OFRS). The Working Group will be meeting in 2024 upon completion of the OFRS new web service to review potential enhancements and coordinate with the National Insurance Crime Bureau (NICB) on the fraud referral fields provided to state insurance regulators. The Working Group chair advised the Task Force on the 2023 Global Insurance Summit that took place in October. The chair also advised that the Working Group’s completion of the Antifraud Plan Repository is currently in queue with the NAIC information systems staff.





5. Heard reports from the Coalition Against Insurance Fraud (CAIF) and the NICB on antifraud activity.
6. Recognized Matthew Smith (CAIF) with a resolution honoring his retirement.

*Virtual Meeting**(in lieu of meeting at the 2023 Fall National Meeting)***MARKET ANALYSIS PROCEDURES (D) WORKING GROUP**

Monday, November 20, 2023

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 Analysis Procedures (D) Working Group met Nov. 20, 2023. During this meeting, the Working Group:

1. Adopted its Oct. 16 minutes, which included the following action:
  - A. Adopted its Sept. 18 minutes which included the following actions:
    - i. Adopted its Summer National Meeting Minutes.
    - ii. Discussed plans for a series of Lunch and Learn webinars to instruct new market analysts about market analysis tools and processes.
    - iii. Discussed removing the Market Conduct Annual Statement (MCAS) exemption from filing for fraternal organizations. The Working Group agreed to first consider whether the MCAS premium reporting threshold should be raised.
    - iv. Invited jurisdictions to engage in discussions with the Working Group chair about their use of the Market Analysis Prioritization Tool (MAPT) in their baseline analysis.
    - v. Asked for volunteers to draft standardized ratios for the pet insurance MCAS blank.
  - B. Discussed the Sept. 25 Lunch and Learn, which covered the MAPT, and scheduled the next Lunch and Learn for Oct. 26 to cover the MCAS-MAPT.
  - C. Reported preliminary results of interviews with 12 jurisdictions about their use of MAPT in their baseline analyses.
  - D. Received an update from the pet insurance MCAS ratio drafting group.
  - E. Discussed the current premium reporting threshold for MCAS. The Working Group reviewed data on the number of companies on a national level that would be required to file at different thresholds. The Working Group agreed to provide each jurisdiction with the threshold data on a per jurisdiction basis.
2. Discussed the Oct. 26 Lunch and Learn and agreed to have the next Lunch and Learn in January after the Fall National Meeting and holiday season.
3. Reported on the continuing interviews with jurisdictions regarding the use of MAPT in their baseline analysis.
4. Received an update from the Per Insurance MCAS Ratio Drafting Group.
5. Discussed the MCAS premium reporting threshold. This will be continued during the next meeting after all participating MCAS states review the impact of increasing the threshold.

*E-Vote**(in lieu of meeting at the 2023 Fall National Meeting)***PRODUCER LICENSING (D) TASK FORCE**

Thursday, Nov. 30, 2023

**Meeting Summary Report**

The Producer Licensing (D) Task Force conducted an e-vote that concluded Nov. 30, 2023. During this e-vote, the Task Force:

1. Adopted its Oct. 20 minutes, which included the following action:
  - A. Adopted its 2024 proposed charges.
2. Adopted its Summer National Meeting minutes, which included the following action:
  - A. Adopted its Dec. 8, 2022 minutes.
  - B. Adopted a new public adjuster licensing charge to: Review and amend, as needed, Model #228 to enhance consumer protections in the property/casualty (P/C) claims process.
  - C. Adopted the NAIC Continuing Education Recommended Guidelines for Instructor Approval.
  - D. Adopted reports for the Adjuster Licensing (D) Working Group and the Uniform Education (D) Working Group.
  - E. Received a report from the NIPR Board of Directors.

*Virtual Meeting**(in lieu of meeting at the 2023 Fall National Meeting)***MARKET ANALYSIS PROCEDURES (D) WORKING GROUP**

Monday, November 20, 2023

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 Analysis Procedures (D) Working Group met Nov. 20, 2023. During this meeting, the Working Group:

1. Adopted its Oct. 16 minutes, which included the following action:
  - A. Adopted its Sept. 18 minutes which included the following actions:
    - i. Adopted its Summer National Meeting Minutes.
    - ii. Discussed plans for a series of Lunch and Learn webinars to instruct new market analysts about market analysis tools and processes.
    - iii. Discussed removing the Market Conduct Annual Statement (MCAS) exemption from filing for fraternal organizations. The Working Group agreed to first consider whether the MCAS premium reporting threshold should be raised.
    - iv. Invited jurisdictions to engage in discussions with the Working Group chair about their use of the Market Analysis Prioritization Tool (MAPT) in their baseline analysis.
    - v. Asked for volunteers to draft standardized ratios for the pet insurance MCAS blank.
  - B. Discussed the Sept. 25 Lunch and Learn, which covered the MAPT, and scheduled the next Lunch and Learn for Oct. 26 to cover the MCAS-MAPT.
  - C. Reported preliminary results of interviews with 12 jurisdictions about their use of MAPT in their baseline analyses.
  - D. Received an update from the pet insurance MCAS ratio drafting group.
  - E. Discussed the current premium reporting threshold for MCAS. The Working Group reviewed data on the number of companies on a national level that would be required to file at different thresholds. The Working Group agreed to provide each jurisdiction with the threshold data on a per jurisdiction basis.
2. Discussed the Oct. 26 Lunch and Learn and agreed to have the next Lunch and Learn in January after the Fall National Meeting and holiday season.
3. Reported on the continuing interviews with jurisdictions regarding the use of MAPT in their baseline analysis.
4. Received an update from the Per Insurance MCAS Ratio Drafting Group.
5. Discussed the MCAS premium reporting threshold. This will be continued during the next meeting after all participating MCAS states review the impact of increasing the threshold.

*Virtual Meeting***MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP**

Sunday, December 3, 2023

**Summary Report**

The Market Conduct Annual Statement Blanks (D) Working Group met Oct. 10, 2023. During this meeting the Working Group:

1. Adopted its Aug. 24 minutes, which included the following action:
  - A. Adopted its July 19 minutes, which included the following action:
    - i. Discussed the Market Conduct Annual Statement (MCAS) directions for determining when a claim is closed on the private passenger auto (PPA) and homeowners line of business.
    - ii. Discussed changes to the MCAS data element revision process timeline.
    - iii. Discussed filing deadlines for other health and short-term, limited duration (STLD) lines of business.
  - B. Reviewed reporting of closed claims for PPA and homeowners lines of business
  - C. Reviewed the MCAS data element revision process timeline.
  - D. Reviewed filing deadlines for other health and STLD lines of business.
2. Adopted its minutes from the Sept. 18 Electronic Votes, which included the following action:
  - A. Adopted a motion to remove duplicate data elements from the MCAS other health blank:
    - i. Data elements #54 and #61 both ask for covered lives impacted by cancellations initiated by the policyholder/certificate holder during the period. The Working Group voted to remove data element #54 and retain data element #61.
    - ii. Data elements #58 and #62 both ask for covered lives impacted by cancellations resulting from nonpayment. The Working Group voted to remove data element #58 and retain data element #62.
3. Approved a proposal to rename the claims closed data elements in the property/casualty (P/C) MCAS blanks to read as follows: “number of claims closed in your system with the date of final payment within ‘x’ days” or “number of claims closed in your system without payment within ‘x’ days.”
4. Approved a May 31 annual MCAS reporting deadline for the other health and STLD MCAS lines of business to align with the reporting deadline for the health MCAS.
5. Approved edits to the data element revision process document to provide guidelines that encourage drafting groups to finish their work products at least 60 days prior to the June 1 deadline for adoption of revisions.

*Virtual Meeting***MARKET CONDUCT EXAMINATION GUIDELINES (D) WORKING GROUP**

November 8, 2023

**Summary Report**

The Market Conduct Examination Guidelines (D) Working Group met Nov. 8, 2023. During this meeting, the Working Group:

1. Adopted revisions to Chapter 23—Conducting the Life and Annuity Examination of the *Market Regulation Handbook* (Handbook). The revisions include: revised introductory paragraphs on page 1; revisions to Subsection 2. Techniques of Section C. Marketing and Sales; extensive revisions to the marketing and sales examination standards section; and the addition of new marketing and sales examination standards 16 and 17 and new supplemental checklists for marketing and sales examination standards 9, 10, 16, and 17. The adopted changes in Chapter 23 relate to the revisions to the *Suitability in Annuity Transactions Model Regulation* (#275), which the NAIC adopted in February 2020.
2. Adopted a new travel insurance in-force standardized data request (SDR) and a new travel insurance claims SDR for incorporation into the reference documents of the Handbook.

[MCEG\\_WG\\_Interim\\_Summary.docx](#)

*Virtual Meeting**(in lieu of meeting at the 2023 Fall National Meeting)***SPEED TO MARKET (D) WORKING GROUP**

Friday, November 17, 2023

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 – 9:00 a.m. PT

**Meeting Summary Report**

The Speed to Market (D) Working Group Force met Nov. 17, 2023. During this meeting, the Working Group:

1. Heard a presentation on the status of the System for Electronic Rates & Forms Filing (SERFF) modernization.
2. Heard an update from the Interstate Insurance Product Regulation Commission (Compact). The Compact welcomed North Dakota to its membership and now has 47 member jurisdictions.
3. Discussed revisions to the NAIC *Product Filing Review Handbook*. The revisions will be considered for adoption by the Working Group in February. A process will also be implemented for the Working Group to annually review and update the handbook.



**Public Access to Market Conduct Annual Statement Data /  
Improving Data Collection and Related Tools for Market Analysis**

**NAIC Market Regulation and Consumer Affairs (D) Committee**

**December 1, 2023**

Birny Birnbaum  
Center for Economic Justice  
[birny@cej-online.org](mailto:birny@cej-online.org)



## The Center for Economic Justice

CEJ is a non-profit consumer advocacy organization dedicated to representing the interests of low-income and minority consumers as a class on economic justice issues. Most of our work is before administrative agencies on insurance, financial services and utility issues.

On the Web: [www.cej-online.org](http://www.cej-online.org)

## About Birny Birnbaum

Birny Birnbaum is the Director of the Center for Economic Justice, a non-profit organization whose mission is to advocate on behalf of low-income consumers on issues of availability, affordability, accessibility of basic goods and services, such as utilities, credit and insurance.

Birny, an economist and former insurance regulator, has studied insurance markets and competition for over 30 years. He performed the first insurance redlining studies in Texas in 1991 and since then has conducted numerous studies and analyses of competition in various insurance markets for consumer and public organizations. He has consulted with financial service regulators and public agencies in several states and internationally. He has served for many years as a designated Consumer Representative at the National Association of Insurance Commissioners and is a member of the U.S. Department of Treasury's Federal Advisory Committee on Insurance, where he chairs the subcommittee on insurance availability.

Birny served as Associate Commissioner for Policy and Research and the Chief Economist at the Texas Department of Insurance. At the Department, Birny developed and implemented a robust data collection program for market monitoring and surveillance.

Birny was educated at Bowdoin College and the Massachusetts Institute of Technology. He holds Master's Degrees from MIT in Management and in Urban Planning with concentrations in finance and applied economics.

## Why CEJ Works on Insurance Issues

### ***Insurance Products Are Financial Security Tools Essential for Individual and Community Economic Development:***

CEJ works to ensure ***fair access*** and ***fair treatment*** for insurance consumers, particularly for low- and moderate-income consumers.

### ***Insurance is the Primary Institution to Promote Loss Prevention and Mitigation, Resiliency and Sustainability:***

CEJ works to ensure insurance institutions maximize their role in efforts to reduce loss of life and property from catastrophic events and to ***promote resiliency and sustainability*** of individuals, businesses and communities.

## MoneySmart Australia

“We believe taking control of your money can change your life for the better.

“One in three Australians find dealing with money stressful and overwhelming. Everyday we all make dozens of decisions about money.

“Making informed decisions leads to greater financial wellbeing. That’s where we come in.”

<https://moneysmart.gov.au/how-life-insurance-works/life-insurance-claims-comparison-tool>

## MoneySmart Life Insurance Claims Comparison Tool

“Compare a life insurer

“Use this tool to see:

- the percentage of claims a life insurance company pays out
  - how long an insurance company takes to pay a claim
  - the number of disputes consumers have lodged about claims with an insurer”
- 
- Select a Type of Insurance
- 
- Choose a Sales Channel

## MoneySmart Life Insurance Claims Comparison Tool

	Claims Accepted Rate	Average Claim time (months)	Disputes per 100,000 lives insured	Policy Cancellation Rate
<b>Industry Average</b>	<b>91.1%</b>	<b>2.5</b>	<b>28.0</b>	<b>11.60%</b>
ClearView	94.4%	5.0	44.4	15.00%
Hannover Re	88.9%	2.4	36.9	12.60%
NobleOak	93.2%	0.9	16.7	9.10%
St Andrews	94.2%	1.9	0.0	10.90%
Swiss Re	84.3%	1.8	25.1	8.30%
TAL	89.9%	3.0	27.2	12.50%
TLIS	98.1%	1.0	14.6	10.40%
Zurich	96.1%	2.2	30.0	14.30%

## APRA Insurer Level Data on Claims and Disputes

“The Australian Prudential Regulation Authority (APRA) publishes life insurance claims and disputes statistics on a biannual basis. These statistics contains industry and insurer-level data on life insurance claims and disputes, and a selection of the published data is also made available in a consumer-friendly format on the Australian Securities and Investment Commission’s MoneySmart website.”

<https://www.apra.gov.au/life-insurance-claims-and-disputes-statistics>

[Life insurance claims and disputes statistics database June 2018 to June 2023XLSX7.01 MB](#)

Published 17 October 2023

## APRA Insurer Level Data on Claims and Disputes

“The Life Insurance Claims and Disputes Statistics contains industry and insurer-level data on life insurance claims and disputes.”

By Insurer:

**Policy Statistics** by type of insurance and sales channel: Lives Insured, Annual Premium, Sum Insured, Lapse Rate, New Business Rate

**Claims** by type of insurance and sales channel and type of claimant: Total Claims Received, Finalised Claims Admitted, Finalised Claims Denied, Withdrawn Claims, Undetermined Claims,

**Disputes** by type of insurance and sales channel: Disputes Lodged, Disputes Resolved, Disputes Undetermined, Disputes Withdrawn, Original Decisions Maintained, Original Decisions Reversed, Average Amount Paid (by Decision)

**Claim Declined Reasons** by type of insurance and sales channel



## Individual Insurer MCAS Data is Confidential? Why?

The simple answer: the data are collected pursuant to market conduct examination authority which declares all information collected as confidential.

But why is MCAS data collected under this exam authority instead of general data collection authority or statistical agent authority?

- **Data are clearly not a trade secret**
- **Regulators and insurers are not the only entities capable of analyzing and using these data**
- **Public access to data showing how insurers actually perform would promote more competitive markets and better empower consumers to shop on bases other than price.**

## **Data Might Be Misused?**

State public records law are based on the principle that the public needs access to information to monitor the actions of their governments and hold those governments accountable. It is not the role of government agencies – at least in the United States – to determine what government records should or should not be available to the public. The legislatures make those decisions through public information laws. A regulator’s decision to withhold data based on the opinion that data might be misused is simply not a valid exercise of regulatory authority.

Further, MCAS data can be misused by a regulator – as was the case with a report by the Florida Commissioner of Insurance – with little or no recourse because the data are available to the regulator only.

## **It Gets Worse – Even When Some Form of Public Access is Permitted, Regulators Have Chosen Confidentiality**

**Request to NAIC:** “Please provide countrywide aggregate amounts for each of the data elements in the 2021 and 2022 Annuity and Life Insurance MCAS lines of business. For annuities, this would be the countrywide total amounts for data elements 13 to 40 by product type. For life insurance, this would be countrywide total amounts for data elements 11 to 47 broken out by product type.

**Response:** [The NAIC] can't provide the data. The data itself belongs to each state. The NAIC enters into an "MCAS Terms of Use Agreement" with each state which does not allow us to disclose the data and requires us to keep it confidential.

## **It Gets Worse (con't)**

The NAIC publishes some state-aggregate MCAS Data – Report Cards. For each line of insurance, the regulators have created metrics of statewide insurer market outcomes. The public Report Cards show the number of insurers within selected ranges of market outcomes for many of the ratios.

Yet, market regulators have decided to withhold from public view some of the state-aggregate ratios:

### **No public ratio data are published for Health Insurance**

Why? In some states there are only one or two health insurers, so publishing statewide MCAS ratios would reveal or enable one of the insurers to calculate the other insurers' outcomes.

**But why is this limitation extended to all states – even states with three or more insurers?**

## **It Gets Worse (con't)**

The Travel Insurance MCAS ratios includes the loss ratio. Regulators have decided to keep this ratio confidential, even though there is no other data source available to the public to learn the actual loss ratios of travel insurers?

Why is this ratio withheld? “Travel insurance loss ratios are low and, consequently, the data might be misused.”

**While public access to individual insurer MCAS data requires a change in the source of regulatory authority for the data collection, the issues of missing aggregate data and ratios can be addressed by regulators now without regulatory or statutory changes.**

## **The Broader Issue of Data Needed for Effective Market Regulation**

The inability of current MCAS data to provide sufficient raw material for effective market analysis and market monitoring has been explained by CEJ for many years:

- Highly summarized data elements not sufficiently granular for market analysis or market monitoring
- Annual reporting late into the year following the experience period means stale information.

## **The Broader Issue of Data Needed for Effective Market Regulation**

Market and financial regulators have consistently rejected proposals for more granular data reporting – transaction data – on a more timely – quarterly – basis of consumer market outcomes.

Market regulators are still using mid-20<sup>th</sup> century technology for monitoring 21<sup>st</sup> century markets.

The fact that the NAIC and nearly all state regulators are unable to answer basic questions about current availability and affordability issues across various lines of insurance in the states speaks volumes about the inadequate state of market regulation data collection.

## **The NAIC is Criticizing FIO's Climate Risk Data Collection?**

This inadequacy state insurance regulator market outcome data collection is highlighted by the NAIC now developing (another) special data call to monitor the impacts of climate risk on availability and affordability of insurance – because the Federal Insurance Office has no other option but to collect these data themselves. Yet, despite having no data to offer the federal government – either FIO or the Financial Stability Oversight Council – about the threats to financial stability of failing property insurance markets, the NAIC and some states have criticized FIO!



## **The Path Forward is Relatively Simple – Modernize the Statistical Agent Reporting Infrastructure to Capture the Needed Data and Provide Regulators with Improved Analytic Tools**

See the attached presentation showing how regulators can leverage the statistical agent reporting infrastructure to address the current problems with inadequate data for market analysis and market monitoring. More granular and timely data are a prerequisite for regulators ability to employ advanced analytics and AI in market analysis.

Data visualization is not a substitute for data analytics

Why can't insurance regulators, for example, get an alert, when quarterly data reported by life insurers indicate an unusually high number of annuity replacements for a particular producer for a particular product?

Why can't insurance regulators get an alert when quarterly data reported by auto insurers show a particular insurer with an unusually higher number of claim denials for a particular type of claim in a particular part of the state?

**Thank you for the opportunity  
to share our concerns and proposals!**



**Presentation to NAIC Statistical Data Working Group**  
**Modernizing Personal Lines PC Statistical Reporting**

**May 18, 2022**

Birny Birnbaum  
Center for Economic Justice

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# What Type of Information Is Needed For Effective Market Regulation and Development of Public Policy?

## *Let's look at information available as the pandemic unfolded*

Workers' Compensation: As the pandemic unfolded, the advisory organization / statistical agent for WC in most states was able to track Covid-related WC claims – including the number and projected cost of such claims by state and by industry sector, as well as by severity of type and severity of Covid-related claims.

Mortgage and Other Lending: Federal agencies and private organizations provided monthly and quarterly data on use of CARES Act loan accommodations and delinquencies by geographic area and type of loan.

## **What about Personal Auto and Homeowners Insurance?**

We knew PPA claim frequency and claim costs had to decline because of business closures and stay and home orders emptying the roads, but what information was available to help insurers and regulators?

**On March 10, 2022**, the NAIC published a report showing a 2.2% increase in average homeowners premium **from 2018 to 2019**.

**On January 31, 2022**, the NAIC published a report showing a 2.2% decrease in collision frequency **from 2016 to 2018** and average premium **for 2019**.

There was a **special data call** for business interruption claims.



## **The NAIC Statistical Handbook says,**

(Insurance regulatory) Responsibilities most relevant to statistical collection include:

- to ensure that rates meet statutory standards, i.e., that they are not inadequate, excessive or unfairly discriminatory and
- to monitor market structure and performance and act if necessary to restore competition or remedy the problems caused by market failure

Clearly, the current statistical data system fails to provide the timely and relevant data for most p/c lines to assist regulators in carrying out these responsibilities as well as other critical responsibilities such as informing public policy and examining consumer outcomes for racial bias or bias against other protected classes.

Why are timely and granular data on insurer and consumer market outcomes available for WC and lending, but not for the largest property/casualty lines of insurance and life insurance?

## **Statistical Reporting is Principal Source of Market Regulation Data**

It may be news to many that the principal source of market regulation data comes from a statistical agency system that hasn't been updated – in the vast majority of states – in over 40 years. It is this anachronistic statistical agent system that results in the NAIC producing auto and home data three years after the beginning of the experience year and two years after the end of the experience year.

But WC is insurance – what's the difference that requires timely reporting of granular experience data and timely publication of insurer and consumer market outcomes?

## WC versus PPA and HO Data Collection

There are three main differences – who collects the data for regulators, what type of data are collected and how frequently data are reported.

1. WC data collection is performed by a **single statistical agent** in each state. Most states designate NCCI to be that statistical agent. In contrast, most states permit insurers writing property casualty lines of insurance to pick among at least four different statistical agents.

2. WC data collection is **transaction data** – insurers report each premium and claim transaction – on a monthly basis. This means that adding new data reporting – like a COVID flag – requires only adding a data field to the statistical reports. In contrast, the majority of personal lines p/c experience is reported at a summary level on an annual basis. With such summary reporting, adding any new data element or new break-out of experience requires re-writing the entire statistical plan.

Transaction data is a report of individual transactions with all the characteristics of the consumer, vehicle, property and other pricing characteristics used. With transaction data, the regulator, statistical agent and reporting company don't have to pre-determine the types of analyses and data compilations that may be performed.

Summary data, by definition, limits the types of analyses to summary reporting categories. While this approach may have worked in the past, it is no longer suited to current regulatory issues.

3. Advisory organizations and states that **collect transaction data on a monthly or quarterly basis**. More frequent reporting not only permits more frequent assessment of premiums and exposures (e.g. written and earned premium, written and earned exposures) but also permits evaluation of claims far differently than permitted under the current NAIC statistical handbook time frame. The handbook specifies how long claims must develop in order to be reported and that claim development drives the entire reporting time frame.

With monthly or quarterly transaction reporting, the statistical agent can assess claims at any period of claim development requested by regulator. Or identify specific types of claims that occurred during a specific time frame.

## **Current Personal Lines PC Statistical Reporting is Anachronistic**

The current personal lines statistical reporting system is **long outdated**. The data reported and the timelines for reporting were designed for an era in which regulators either set or approved industry-wide rates for auto and home insurers. So the systems are designed to produce industry aggregate data for industry aggregate rate analysis – essentially a slow method of accumulating the ratemaking data for industry aggregate rate analysis.

## **Outdated Statistical Reporting Yield Little Benefit**

The result of this historical anomaly is the production of statistical reports with almost no value to regulators or the public today and an impediment to effective market regulation.

The reports do not provide timely or relevant information for nearly all issues of concern for market regulation – like the impacts of COVID on personal auto rates in 2020 and 2021 or the ability to examine racially-biased outcomes or other algorithmic bias in insurer pricing, claims settlement and anti-fraud.

Perhaps most bizarre, the statistical agents – agents designated and appointed by the Commissioner to collect data on behalf of the Commissioner – refuse to provide individual insurer data to the regulator, citing contractual provisions with reporting insurers.

## **Straightforward Solution to Modernizing P/C Data Collection**

The solution to multiple problems – lack of timely or useful data, an outdated data collection system, unresponsive statistical agents – is straightforward with ample precedence.

Use existing regulatory authority to update statistical plans, ***designate a single statistical agent through a competitive bidding process and establish requirements that the primary duty of the statistical agent is to serve the regulator.***

In terms of updating statistical plans, the ***statistical plans should require transaction detail reporting on at least a quarterly basis.***



In terms of a ***single statistical agent, such an approach logically produces efficiency, uniformity and accountability.*** It also stops insures from picking a statistical agent based on the lowest requirements for data reporting and data quality.

In terms of a ***primary responsibility to serve the regulator,*** the statistical agent should be required to provide the regulator with any data collected by statistical agent in its role as the regulator's statistical agent – including individual company data whether summarized or transaction.

## Historical Precedence

I mentioned historical precedence and we've already discussed the use of this approach for WC insurance. There is another example. In 1995, the Texas Department of Insurance was examining racial bias in auto insurance and the then-statistical agents told the Department they wouldn't provide company-specific data to the Department – just as the statistical agents refused to provide company-specific data as part of the NAIC's recent efforts to study auto insurance issues.

TDI issued a Request for Interest and Qualifications (“RFIQ”) from organizations seeking to become the Department's statistical agent for private passenger auto. Similar RFIQs were issued for residential property insurance and commercial lines. Attached to these slides are the opening pages of the PPA RFIQ. Here is the first expectation of the designated statistical agent. While unremarkable, it was not the norm in Texas in 1995 and is still not the norm in other states today:

***The designated statistical agent is the agent of the Department. Data reported to the statistical agent are, in fact, data reported to the Department. The designated statistical agent's primary responsibility in carrying out the activities of the Texas statistical agent will be to the Department.***

Moving towards a more efficient and effective system of market regulation data collection is even more straightforward today than it was in 1995 with far greater opportunities to utilize new technologies, such as the OpenIDL blockchain being developed by AAIS and a number of insurers and regulators.

## **Stat Agents Currently Collecting Transaction Data Are Ready**

In the Statistical Data WG's recent surveys of statistical agents to speed up production of the auto and home reports, the stat agents currently collecting transaction detail on a quarterly basis were able to provide experience reports within about two months or faster after the end of the experience quarter.

Further, the transaction reporting stat agents have the ability to provide regulators with online access to data to enable regulators to access company-specific or industry aggregate data as needed in real time.

Ask yourselves why you are even getting these printed reports instead of having online access to a database in which you can pull the data you need when you need it?

As yourselves, when was the last time you used the annual statistical agent reports for any purpose? And even if you have done so, how useful were the reports?

## More Efficient and Effective for All Stakeholders

By moving to more timely, granular, uniform and statistical data collection through a modernized statistical agent framework, regulators can

- create ***massive efficiencies*** for yourselves and insurers ranging from ***elimination of special data calls*** and the current MCAS;
- develop ***more effective market analysis that minimizes burden on companies performing well for consumers***; and
- develop ***new abilities to apply predictive models and AI to all phases of the insurance life cycle to much more quickly identify and stop practices harming consumers and promote more competitive insurance markets.***

**Texas Department of Insurance**

**Request for Interest and Qualifications**

**of Organizations Interested in Designation as  
the Texas Residential Property Statistical Agent**

**Issued December 5, 1995**

**1. Purpose of Request for Interest and Qualification (RFIQ)**

The Commissioner of Insurance intends to designate a statistical agent for residential property insurance statistical data collection in Texas. The purposes of this RFIQ are to:

- describe the Department's expectations regarding the services and performance of a designated statistical agent;
- provide detailed instructions for interested organizations to submit statements of interest and qualifications for serving as the Department's statistical agent; and
- provide information necessary for interested organizations to understand the requirements of a designated statistical agent and adequately respond to the RFIQ.

**2. Definition of Residential Property Insurance**

Residential property insurance, for the purpose of statistical data collection, includes the following coverages: homeowners, tenant homeowners, condominium, farm and ranchowners, dwelling fire, dwelling extended coverage, farm fire and farm extended coverage.

**3. Statutory Authority and Requirements for Statistical Data Collection**

Article 21.69, *Texas Insurance Code*, was modified by the 74th Legislature.

**21.69 STATISTICAL DATA COLLECTION**

- (a) The commissioner may, for a line or subline of insurance, designate or contract with a qualified organization to serve as the statistical agent for the commissioner to gather data relevant for regulatory purposes or as otherwise provided in this code.

- (b) To qualify as a statistical agent, an organization must demonstrate at least five years of experience in data collection, data maintenance, data quality control, accounting and related matters.
- (c) The commissioner's designation or contracting with a statistical agent under this article authorizes the statistical agent to collect from the reporting insurers any fees necessary for the statistical agent to recover the necessary and reasonable costs of data collection services provided by the statistical agent. A reporting insurer shall pay the fee to the statistical agent for the data collection services provided by the statistical agent.
- (d) A statistical agent designated or contracted with by the commissioner under this article shall collect data from reporting insurers under a statistical plan promulgated by the commissioner.
- (e) An insurer shall provide all premium and loss cost data to the commissioner or the commissioner's agent designated or contracted with under this article as the commissioner or the agent requires.
- (f) The statistical agent may provide aggregate historical premium and loss data to its subscribers.
- (g) The commissioner may adopt rules necessary to accomplish the purposes of this article.

#### **4. TDI Expectations of a Designated Statistical Agent**

The Department expects the following from its designated statistical agent:

- 4.1 The designated statistical agent is the agent of the Department. Data reported to the statistical agent are, in fact, data reported to the Department. The designated statistical agent's primary responsibility in carrying out the activities of the Texas statistical agent will be to the Department.
- 4.2 The statistical agent will collect data from reporting companies pursuant to the Department's promulgated statistical plan. If requested by a reporting company, the statistical agent may collect data from reporting companies in a different format than specified in the statistical plan. However, the statistical agent must collect data in detail at least as great as specified in the statistical plan and be able to reproduce the company submission in the detail and format specified by the statistical plan.
- 4.3 The statistical agent will accommodate and implement changes in data collection and reporting activities resulting from promulgated changes to the statistical plan.

- 4.4 The statistical agent will work with the Department to update and revise the residential property statistical plan for implementation with reporting of 1997 experience.
- 4.5 The statistical agent will employ a variety of activities to ensure the reliability, validity, accuracy and completeness of data reported to the Department, including, but not necessarily limited to, edit procedures and reasonability checks employed by the statistical agent, provision of edit packages for use by reporting companies prior to submission of data, and financial and other incentives for accurate and timely reporting.
- 4.6 The statistical agent will not alter reporting companies' submissions unless such activity is authorized by the Department.
- 4.7 The statistical agent will process reporting company submissions, develop and maintain required databases, and produce accurate reports, on both regular and ad hoc bases, for the Department.
- 4.8 The statistical agent will create a capability for the Department to have access to databases through on-line direct connection to the statistical agent's computer, provision of data on CD-ROMs, or other appropriate mechanism
- 4.9 The statistical agent will bill reporting companies for the costs of designated statistical agent activities. Such billing procedures will optimize the goals of encouraging the timely submission of reliable data and spreading the costs of statistical agent activities equitably among policyholders.
- 4.10 The statistical agent will implement data security procedures to ensure no unauthorized access to data reported by insurers to the Department.
- 4.11 The statistical agent will submit to financial and performance audits on a regular basis. The cost of such audits will be billed back to reporting companies in a manner equitable to policyholders. The statistical agent will maintain and make available to TDI staff or other individuals designated by TDI, books, records, work papers, electronic files and other materials related to services as the Texas residential property designated statistical agent.
- 4.12 The statistical agent will strive to meet the Department's performance standards.



- 4.13 The statistical agent will provide statistical agent services in a cost-effective manner and will provide the Department with feedback on the costs of complying with Departmental requests, such as reports or data access.
- 4.14 The statistical agent will not use data collected through its role as a statistical agent for any purposes other than authorized by the Department in designating a statistical agent, unless the Department specifically authorizes those additional purposes or the data are otherwise available pursuant to the Texas Open Records Act. Advisory organizations are invited to seek designation as a statistical agent, but the roles of advisory organization and statistical agent shall be separate and distinct. Designation as a statistical agent shall not confer any special privileges to an advisory organization in its role as an advisory organization.
- 4.15 The statistical agent shall maintain data, databases and related programs in a manner which allows for ease of transfer to another organization in the event the Department withdraws statistical agent designation. Data, databases, statistical plans, edit and reasonability test specification, and certain programs for editing data at the company level and for generating certain reports are the property of the Department and will be provided by the statistical agent to the Department upon request.

**5. Procedures for the Commissioner's Designation of a Residential property Statistical Agent**

- 5.1 By issuing this RFIQ, the Department makes no guarantee that one of the respondents to the RFIQ will be designated as the residential property statistical agent.
- 5.2 All questions regarding this RFIQ and the designation of a residential property statistical agent and all responses to this RFIQ shall be addressed to:

Birny Birnbaum  
Associate Commissioner for Policy and Research  
Texas Department of Insurance MC 113-1C  
333 Guadalupe Street  
P.O. Box 149104  
Austin, TX 78714-9104  
Phone: (512) 305-7194  
Fax: (512) 475-2005

- 5.3 The activities and timeline leading to designation of a residential property statistical agent are:

<u>Date</u>	<u>Activity</u>
12/4/95	Notice of Commissioner's Intent to Designate a Texas Statistical Agent for Residential Property Insurance Data Collection
12/5/95	Request for Interest and Qualifications (RFIQ) from Organizations Interested in Being Designated as the Texas Residential Property Statistical Agent Available.
1/3/95	Deadline for Submission of Questions Regarding RFIQ
1/16/96	Questions and Answers Distributed to Interested Parties
1/30/96	Responses to RFIQ Due
2/20/95	Publication of Proposal to Designate Texas Residential Property Statistical Agent
3/5/96	Public Hearing to Consider Proposed Designation of Texas Residential Property Statistical Agent

- 5.3 Questions regarding the RFIQ must be submitted in writing. A copy of questions received and the Department's answers will be provided to all interested parties. Questions received by January 3, 1995 will be answered by the Department. The Department will provide the questions and answers to interested parties no later than January 16, 1995
- 5.4 The due date for responses to the RFIQ is 3:00 p.m., January 30, 1995. Facsimile submissions are not permitted and will not be accepted.
- 5.5 TDI reserves the right to reproduce all or portions of any information submitted in response to this RFIQ for the purpose of evaluation. All submitted materials become the property of TDI and are subject to release under the Texas Open Records Act, unless the materials are exempt from disclosure under the Act. Trade secret material is exempt from disclosure under the Act. Respondents should clearly identify any trade secret material included in the response to the RFIQ to ensure that the material may be considered exempt from the Act.

- 5.6 The designation of the statistical agent is at the sole discretion of the Commissioner of Insurance, subject to the statutory requirements of Article 21.69.

## **6. Information to Assist in Response to RFIQ**

The following information is attached to assist interested parties in responding to the RFIQ:

- 6.1 Appendix A contains the Department's current residential property statistical plan.
- 6.2 Appendix B contains a description of the status of residential property data collection, including products available from the Department's current statistical agent, statistics on reporting companies and data volume and the anticipated status of data processing at the time of designation of a new statistical agent.
- 6.3 Appendix C contains the Department's desired statistical agent performance standards.
- 6.4 Appendix D contains a description of the Department's desired validity edits and reasonability tests.
- 6.5 Appendix E provides a description of the Department's desired reports.

## **7. Instructions for Responding to the RFIQ**

- 7.1 Responses to this RFIQ must be received by 3:00 p.m., January 30 by the following:

Birny Birnbaum  
Associate Commissioner for Policy and Research  
Texas Department of Insurance MC 113-1C  
333 Guadalupe Street  
P.O. Box 149104  
Austin, TX 78714-9104  
Phone: (512) 305-7194  
Fax: (512) 475-2005

- 7.2 Submit one original and five (5) copies of the response to the RFIQ. Submissions by facsimile machine are not permitted and will not be considered.
- 7.3 Please print the words "Response to Residential Property RFIQ" and the name of the responding organization on as many pages of the response as practically feasible. Do not put this information on all pages created expressly for the response to this RFIQ. Do not put this information on annual reports or previously-printed supporting materials.
- 7.4 Proposals should be organized into the following sections. Please note that detailed instructions for each section follow this overview.
1. Letter of Transmittal
  2. Respondent's Statement of Intent
  3. Background Information on Respondent
  4. Technical Qualifications
  5. Data Collection and Maintenance
  6. Data Quality and Reliability Procedures
  7. Data Security Procedures
  8. Provision of Reports and Data to TDI
  9. Proposal and Timeline for Transition to New Agent
  10. Estimated Annual Cost and Allocations to Reporting Companies
  11. Billing Procedures and Financial Reports
  12. Performance Standards

7.5 Detailed Instructions

The following sections provide more details on the required services.

*Section I: Letter of Transmittal*

The letter of transmittal must contain the following information:

- A. Date of response
- B. Name of RFIQ for which response is to be considered
- C. Name of respondent's organization
- D. Signature of person authorized to make decisions on behalf of respondent
- E. Contact person's name, mailing address, telephone and facsimile numbers

*Section 2: Respondent' Statement of Intent*

The purpose of this section is for the respondent to briefly respond to the Department's expectations of a statistical agent as described in section 4 of this RFIQ. The respondent shall respond to each item in section 4 and state agreement, partial agreement (with explanation) or disagreement (with explanation). The respondent's statement of intent may reference other sections of the response to the RFIQ.

*Section 3: Background Information on Respondent*

Please provide the following information in this section:

- A. Company profile providing introductory and background information on the entity, any affiliated companies, and any subcontractors
- B. Organizational structure of the respondent, including affiliates and parent companies
- C. Activities of the respondent, its affiliates and parents
- D. Profiles of key individuals who will be responsible for providing the required services
- E. A summary of financial performance for the past three years, with a copy of the most recent audited financial statements included as an attachment to the response
- F. Three references including name, address, contact person and telephone number

*Section 4: Technical Qualifications*

Please provide the following information in this section:

- A. Experience as a statistical agent, in general, including data collection operations, data base management, data quality activities, billing and invoicing, financial accounting, software and report development and other relevant activities
- B. Experience as a statistical agent for residential property insurance
- C. Overview of computer resources and capabilities, including:
  - Computer equipment and software
  - Ability to provide remote data access to TDI
  - Capability to collect and disseminate data in a variety of common formats and media
- D. Physical location of personnel, offices, computer resources and data
- E. Key personnel who will be providing services to TDI with description of their expertise and experience.

- F. Any additional information the respondent feels relevant for TDI to assess respondent's qualifications as a residential property statistical agent

*Section 5: Data Collection and Maintenance*

Please provide the following information in this section:

- A. Respondent's proposed process and procedures for data collection and maintenance, including
- Tracking submissions and identifying insurers who have not made required submissions
  - Procedures and timetable for processing submissions, applying edit checks and reasonability tests and building databases
  - Procedures and timetable for handling error correction and resubmission of company data
  - Procedures for maintaining database or databases, including back-up and/or off-site copies of data or databases

*Section 6: Data Quality and Reliability Procedures*

Please provide the following information in this section:

- A. Procedures to implement the Department's validity and relational edit checking specifications described in Appendix D or the respondent's proposal, with justification, for different specifications
- B. Procedures to implement the Department's reasonability testing specifications described in Appendix D or the respondent's proposal, with justification, for different specifications
- C. Procedures to minimize late and/or inaccurate data reporting, including, but not limited to, incentives for timely and accurate reporting, provision of company edit package and other support services to reporting companies
- D. Any additional activities to promote data quality and reliability

*Section 7: Data Security Procedures*

Please provide the following information in this section:

- A. Data security procedures, including, but not limited to, restrictions on access to data and databases and prevention of alteration to data and databases.

*Section 8: Provision of Reports and Data to TDI*

Appendix E describes the reports and data to be provided to the Department. Please describe your proposed schedule and methods for providing the regular reports, including rate development reports. Please describe your approach to responding to ad hoc report requests from the Department.

*Section 9: Proposal and Timeline for Transition to New Statistical Agent*

It is TDI's desire to effect a smooth transition from the current statistical agent. TDI has developed certain technical reporting procedures, data edit programs, data base layouts, report programs and other materials. The respondent may, at its options, make use of the products and materials. Appendix B contains a description of the status of residential property data collection, including products available from the Department, statistics on reporting companies and data volume and the anticipated status of data processing at the time of designation of a new statistical agent. For the purposes of this section, assume official designation as the residential property statistical agent on March 5, 1996. In this section, please provide the activities and timeline for the following:

- A. Transfer of historical data and reporting records from current statistical agent
- B. Initial reporting of experience by insurers to new designated statistical agent
- C. Movement to regular schedule of data collection, processing and reporting
- D. Initial billing for services to reporting companies
- E. Update/Rewrite of residential property statistical plan of implementation with reporting of 1997 experience
- F. Other activities necessary to transfer statistical agent activities and initiate activities as the new residential property statistical agent

*Section 10: Estimated Annual Cost and Allocations to Reporting Companies*

Please provide the following information in this section:

- A. Estimate of the annual fees required by the respondent to perform the activities of the Texas residential property statistical agent for each of the first three years as the statistical agent. To better provide the Department with cost implications for various services, please categorize annual compensation into the following categories:
  - Start-up/Development Costs
  - Data Collection and Maintenance
  - Data Quality and Reliability Procedures
  - Production of Reports and Data to TDI
  - Billing/Invoicing and Accounting
  - Other Activities (please describe)
- B. Estimated cost savings, if any, from moving from monthly reporting by insurers to quarterly reporting
- C. Cost saving suggestions and opportunities

*Section 11: Billing Procedures and Financial Reports*

Please provide the following information in this section:

- A. Respondent's procedures for invoicing reporting companies for services
- B. Proposed schedule of fees for services, i.e., method of allocating the cost for services among reporting companies
- C. Procedures for occurrences of non-payment by reporting companies

*Section 12: TDI Performance Standards*

Please review the Performance Standards contained in Appendix C of this RFIQ and describe your willingness and ability to meet or exceed these standards. Please respond to each standard with "Will Not Meet", "Meet", or "Exceed". Provide brief explanations or references to other sections for "Will Not Meet" or "Exceed" responses.



**Review of NAIC Market Conduct Analysis Statement Data in  
April 2, 2021 Letter from FLOIR to Chairman Ingoglia**

**Prepared by Birny Birnbaum, Consulting Economist**

**April 16, 2021**

I am an economist and former insurance regulator with 30 years of experience with insurance data collection and analysis for purposes of assisting insurance regulation and public policy analysis. I have been involved with the Market Conduct Annual Statement (“MCAS”) from the germ of the idea through its initial and subsequent development and implementation. I have participated in the development of MCAS data elements, definitions and ratios. I hold the Advanced Market Conduct Management certification from the Insurance Regulatory Examiners Society.

I served as Chief Economist and Associate Commissioner for Policy and Research at the Texas Department of Insurance where I developed a data collection regime for market surveillance. I was also responsible for review and approval of personal auto and residential property rate filings. Since leaving the Department, I have consulted with public agencies and consumer organizations. I have testified before numerous state departments of the insurance, including the Florida Office of Insurance Regulation, on insurance rates. In 2002 and 2003 the then-Florida Department of Insurance appointed me to a panel of mediators to review rate filings. I also serve as Director of the Center for Economic Justice, a non-profit consumer advocacy organization dedicated to fair access and fair treatment of insurance consumers.

I’ve been asked to review the analysis and conclusions regarding MCAS data provided by Commissioner David Altmaier in his April 2, 2021 letter to the Chair of the Florida House Commerce Committee.

**Summary of Findings**

The presentation of the MCAS data by the FLOIR purportedly showing that Florida accounts for  $\frac{3}{4}$  of all homeowner insurance claims litigation is a misuse of data intended for purposes other than supporting restrictions on consumers’ access to the civil justice system. Further, the presentation of the data by the FLOIR is without context, excludes other MCAS data that would provide that context and promotes misinterpretation. While there may be other data relevant for the issue before the Legislature, a review of the public MCAS data suggest that any homeowners insurance litigation problem can be tied to a small number of insurers and is not an industry-wide problem demanding wholesale changes to the civil justice system.

## Purpose of MCAS

The MCAS data is collected by state insurance regulators as part of a market conduct oversight function. The MCAS data, combined with other data collected by market regulators, assist regulators in identifying outlier companies whose consumer market outcomes vary from industry averages or have changed significantly over time.

The Market Conduct Annual Statement (MCAS) was developed in the 2002 to provide regulators with a uniform system of collecting market-related information to help states monitor the market conduct of companies.<sup>1</sup>

The collection of MCAS data began in 2002 with the goal of collecting uniform market conduct related data. MCAS ratios were developed to provide more meaningful comparisons between companies than the raw data allowed.<sup>2</sup>

As a prioritization tool, MCAS ranks companies according to the level of concern to a market analyst. Ratios have been developed for each MCAS line of business utilizing the data elements obtained from the MCAS filing. There are seven private passenger auto and homeowners insurance ratios and eight life insurance and annuity ratios. The assumption behind each of the ratios is that the higher the ratio, the more attention is required from the market analyst. The rankings for each ratio, therefore, reflect how high the company ratio is when compared to the other companies in the state that filed an MCAS. The company's ranks for each ratio can be added together to arrive at an overall rank. A high overall rank means that a company has higher ratios than a company with a lower rank.<sup>3</sup>

## No Public Access

The MCAS data are collected by state insurance regulators pursuant to their market conduct examination authority. Under that authority, all information collected from insurers is confidential. This means that the calculations made by the FLOIR are not subject to independent review or corroboration.

It should be noted that there is no rationale for keeping individual insurer MCAS data confidential. The use of market conduct examination authority to prompt insurer reporting of MCAS is a holdover from the pilot testing of the program in mid 2000's. It is evident from the d MCAS reporting template,<sup>4</sup> the data describe basic consumer market outcomes – like how long it

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<sup>1</sup> [https://content.naic.org/cipr\\_topics/topic\\_market\\_conduct\\_annual\\_statement\\_mcas.htm](https://content.naic.org/cipr_topics/topic_market_conduct_annual_statement_mcas.htm)

<sup>2</sup> [https://content.naic.org/cipr\\_topics/topic\\_market\\_conduct\\_annual\\_statement\\_mcas.htm](https://content.naic.org/cipr_topics/topic_market_conduct_annual_statement_mcas.htm)

<sup>3</sup> NAIC Center for Insurance Policy and Research, *The Market Conduct Analysis Framework*, October 2012, page 22 at [https://www.naic.org/cipr\\_newsletter\\_archive/vol5\\_market\\_conduct\\_framework.pdf](https://www.naic.org/cipr_newsletter_archive/vol5_market_conduct_framework.pdf)

<sup>4</sup> [https://content.naic.org/sites/default/files/inline-files/industry\\_mcas\\_data\\_collection\\_2020\\_homeowners.pdf](https://content.naic.org/sites/default/files/inline-files/industry_mcas_data_collection_2020_homeowners.pdf)

takes to get a claim settled, how often the insurer non-renews a consumer, how often claims are taken to lawsuits. Consumers are often chastised for only paying attention to price when it comes to buying insurance, but insurance is the only consumer product for which there is no public data on how well the product performs.

By making MCAS data available to the public, consumers would have better information about insurer performance and have a stronger market position to promote competition. While some poorly performing insurers might be embarrassed, there are no trade secrets involved, unless one considers how slowly an insurer pays claims to be a trade secret. Further, were the MCAS data publicly available, other stakeholders – and not just the FLOIR – could review and analyze the data.

### **Flawed Analysis: No Context and Absence of Relevant Data**

#### The MCAS Ratios

As noted above, in addition to the raw data submitted by insurers, regulators review of MCAS involves assessment of ratios intended to bring meaning to the raw data. For homeowners MCAS, the ratios are:

- 1 Claims Closed without Payment to Total Claims Closed
- 2 Claims Unprocessed at End of Period
- 3 Claims Paid Beyond 60 Days
- 4 Non-Renewals to Policies in Force
- 5 Cancellations over 60 Days to Policies in Force
- 6 Cancellations over 60 Days to Policies to New Policies Issued
- 7 Suits Opened During the Period to Claims Closed Without Payment

Of these ratios, several are particularly important for assessing individual company market performance. Claims paid beyond 60 days is an indicator of whether the insurer's claim settlement practices are timely or slow. A higher percentage of slow claims settlements is a logical cause of more litigation.

Non-renewals refer to actions by the company to decline to renew a policy. Again, a high percentage of non-renewals is a logical cause of more litigation.

Cancellations refer to consumer initiated actions to cancel the policy. A high percentage of cancellations suggests a high number of consumers dissatisfied with the company.

MCAS data is available to measure all claims closed during the period and the two components of that total – claims closed with payment and claims closed without payment. Ratio 7 captures all lawsuits, but measures that number only against claims closed without payment. Lawsuits may also be generated by claims closed with inadequate payment.

### Florida Data Anomalies

Although individual company MCAS data submissions are not public, the NAIC compiles the company submissions into statewide aggregate ratios, so we can look at these ratios state by state.

When we look at Florida for the years 2016 to 2019, we see the following:

	2019	2018	2017	2016
<b>Florida</b>				
Claims Closed without Payment to Total Claims Closed	27.89%	25.76%	37.63%	34.59%
Claims Unprocessed at End of Period	19.56%	15.66%	13.79%	14.46%
Claims Paid Beyond 60 Days	50.57%	36.84%	27.38%	33.08%
Non-Renewals to Policies in Force	2.53%	1.98%	1.46%	1.45%
Cancellations over 60 Days to Policies in Force	1.00%	0.97%	1.17%	1.46%
Cancellations over 60 Days to Policies to New Policies Issued	6.92%	7.46%	5.51%	5.11%
Suits Opened During the Period to Claims Closed Without Payment	27.57%	19.91%	5.96%	13.46%

The first thing that jumps out is that ratio of suits opened to claims closed without payment jumps all over the place from a low of 5.96% to a high of 27.57%. This alone suggests not taking the data on face value, but examining the reliability of the data. For example, do individual insurers have similar experience to the statewide average or are the numbers skewed by one or a few insurers with bad practices? We discuss this issue below by reviewing additional MCAS data.

The FLOIR letter does not even identify this wide variation in ratio 7, let alone offer an explanation. Rather, the FLOIR simply concludes:

Next, because Florida's domestic homeowners' insurance market is heavily reliant on Florida-only or regional insurers, we analyzed the litigation to claims ratio<sup>6</sup> of insurers operating in Florida and other states to see if we detected a pattern of these insurers experiencing litigation higher than their peers in other states; a potential indicator of, *inter alia*, claims handling issues. We did not detect any such systemic pattern that could explain this disparity.

While we continue to explore these and other possibilities to explain the disparity, OIR does not have a readily available explanation for Florida's outlier status other than to simply state that Florida is experiencing far more claims-related litigation than the 47 other reporting states.<sup>5</sup>

As shown below, there is clear evidence that Florida homeowners insurers perform differently than insurers in other states. It is unclear how FLOIR could have performed a thorough review of the MCAS data and failed to note these outcomes.

### Florida versus other States

Let's now look at another state, California.

	<b>California</b>			
	2019	2018	2017	2016
Claims Closed without Payment to Total Claims Closed	32.82%	29.59%	31.79%	32.16%
Claims Unprocessed at End of Period	13.16%	15.88%	11.32%	11.23%
Claims Paid Beyond 60 Days	28.29%	26.41%	23.95%	25.20%
Non-Renewals to Policies in Force	1.53%	0.82%	0.60%	2.27%
Cancellations over 60 Days to Policies in Force	0.30%	0.35%	0.42%	0.43%
Cancellations over 60 Days to Policies to New Policies Issued	3.11%	2.81%	2.73%	2.46%
Suits Opened During the Period to Claims Closed Without Payment	1.61%	2.08%	1.47%	1.70%

We see that the ratio for suits opened to claims closed with payment is much higher in Florida than in California. But we also see the following:

- Ratio 7 is far more consistent in California than in Florida, again suggesting a data reporting problem from Florida insurers.
- Florida has a much higher percentage of claims paid beyond 60 days and in 2019, the Florida ratio was nearly twice as great as California's – 50.6% to 28.3%. This translates into tens of thousands of slowly settled claims in Florida.
- Insurers' non-renewals of policies were far higher in Florida than in California, even in 2019 when wildfires in California prompted fear among insurers in California.

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<sup>5</sup> Letter at page 3.

My review of the MCAS ratios for other states show that Florida is an outlier among the states regarding insurer performance. While it is impossible to identify the cause of the poor consumer treatment by Florida insurers based on MCAS ratios, one possible explanation of higher amounts of litigation in Florida may be weak market conduct enforcement by the FLOIR, forcing consumers to fend for themselves in Florida for issues the insurance regulator addresses in other states.

MCAS Data Show Litigation Issues Limited to a Few Insurers, Not an Industry-Wide Problem

We know that Florida has a number of Florida-only insurers. One analysis that might help put the data in context would be to compare all the ratios for the same insurer across states, in combination with an analysis, suggested above, of looking at variation among individual insurers within Florida. While the publicly-available data does not permit a review of individual insurer’s performance across states, the data do show variation among insurers within Florida.

For ratio 7 for 2019, the MCAS data shows a breakout of the number of insurers in percentage groupings.<sup>6</sup> The data show for suits opened during the period to claims closed without payment:

Percentage of Suits to Claims Closed w/o Pay	# of Insurers FL	# of Insurers CA	# of Insurers IL
0	22	27	76
>0 to 10%	22	75	77
>10% to 20%	14	4	4
>20% to 30%	17	0	0
>30% to 40%	9	0	0
>40% to 50%	3	0	0
>50% to 60%	5	0	0
>60% to 70%	2	0	0
>70% to 80%	0	0	0
>80% to 90%	2	0	0
>90% to 100%	1	0	1
>100%	3	1	0

<sup>6</sup> [https://content.naic.org/mcas\\_data\\_dashboard.htm](https://content.naic.org/mcas_data_dashboard.htm)

The data show outliers – the term used by market conduct analysts to identify companies whose market performance varies from the norm. In California and Illinois, almost every insurer operating in those states shows a low percentage of suits to claims closed without payment. In Florida, while the vast majority of insurers are also in the four lowest percentage groups, there are many insurers in high percentage groups, including 3 with more suits than claims closed without payment.

Given that the majority of insurers do not seem to be suffering from out-of-control litigation, these data suggest that the problem is with a number of insurers and not the system. Stated differently, if there was an industry wide problem with litigation, as opposed to litigation reflecting the performance of some insurers, we would expect to see most or all insurers in the high percentage categories and not the minority of insurers shown in the chart.

## **Conclusion**

An analysis of the publicly-available MCAS ratios indicates that the MCAS data presented in the April 2, 2021 letter are incomplete, without context and misleading. A review of the available data suggests that homeowners litigation issues in Florida are associated with a small percentage of the homeowners insurers operating in Florida and is not an industry-wide problem. The data suggest that regulatory investigation of these companies' claim settlement practices is the logical approach, as opposed to major changes in the civil justice system.

The history of property insurance in Florida following Hurricane Andrew in 1992 suggests that the biggest problem facing the Florida market is the recognition of catastrophic risk faced by insurers offering property insurance. It is only by addressing this catastrophic exposure – through risk prevention and mitigation and devising ways to cap unlimited risk exposure for insurers – that more insurers will be willing to risk their capital in Florida. Curtailing consumers' access to the civil justice system does nothing to reduce catastrophe risk exposure for Florida insurers.