



**Birny Birnbaum, AMCM**

## Standing at the Crossroads: Insurance Market Regulation in the Era of Big Data in Insurance

There's been a revolution in insurance pricing, marketing and claims settlement resulting from insurers' use of Big Data – massive databases of new insurance and non-insurance, personal consumer information with associated data mining and predictive analytics and scoring models or algorithms. Algorithms are lines of computer code that rapidly execute decisions based on rules set by programmers or, in the case of artificial intelligence (AI) or machine learning, the models change automatically. Coupled with the increased volume and granularity of data is the digital technology to generate, access, process, analyze and deploy Big Data and associated algorithms in real time.

**How do Big Data algorithms work in insurance?** One example – a consumer shops online for insurance and goes an insurer website. By providing her name and address, the insurer now has access to a variety of insurance and non-insurance personal information about the consumer. By quickly tapping into these databases, the insurer can pre-fill an application for insurance to speed up and simplify the insurance purchase. The insurer might also tap into databases containing the consumer's employment history, financial information and social media use to score the consumer's propensity for fraud to help the insurer decide whether to write the policy or not. Or the insurer might use databases containing the consumer's web browsing and shopping data in an algorithm that simultaneously evaluates the consumer's price sensitivity with likely competitive options available to the consumer to determine the price the insurer will offer the consumers.

As the sources and uses of ever-growing amounts of personal consumer information – insurance and non-insurance – by insurers grows quickly, it becomes apparent why insurers' use of Big Data creates more than opportunities and challenges for insurers and consumers, but shakes the regulatory foundation of insurance market regulation and consumer protection to its core.

1. Insurers' use of Big Data has huge potential to benefit consumers and insurers by transforming the insurer-consumer relationship and by discovering new insights into and creating new tools for loss mitigation, resiliency and sustainability.
2. Insurers' use of Big Data has huge implications for fairness, access and affordability of

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## MARK YOUR CALENDAR

**September 30-October 3**  
The SILA National Education  
Conference (Indianapolis, IN)

**October 14-17**  
Insurance Consumer Affairs  
Exchange - Fall 2018 Conference  
(Fort Myers, FL)

**November**  
MCM Course (Kentucky)  
DETAILS COMING SOON

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and more upcoming events.



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insurance and for regulators' ability to keep up with the changes and protect consumers from unfair practices.

**3. The current insurance regulatory framework generally does not provide regulators with the tools to effectively respond to insurers' use of Big Data.** Big Data has massively increased the market power of insurers versus consumers and versus regulators.

**4. Market forces alone – "free-market competition" – cannot and will not protect consumers from unfair insurer practices.** So-called "innovation" without some consumer protection and public policy guardrails will lead to unfair outcomes.

## Why Insurance Is Different from Other Consumer Products

Before discussing the regulatory challenges from insurers' Big Data use, it is important to keep in mind why insurance is different from other consumer products, why normal "competition" does not protect consumers and why the consumer protection requirements of insurance market regulation exist.

- 1. The insurance is required** – by law and by lenders requiring protection of home or vehicle collateralizing the loan.
- 2. Contract is a promise for future benefits** if an undesirable event occurs. If the product "fails" – the consumer learns the insurance policy won't cover the loss – she is stuck and can't purchase another policy that would protect her against a known loss.
- 3. Consumers have little or no information about the insurers' performance.** Unlike other consumer products, there is virtually no information about how well the product performs.
- 4. Cost-based pricing is required by actuarial standards of practice and financial solvency.** The requirement for cost-based pricing is to protect insurer financial condition and prevent intentional or unintentional unfair discrimination
- 5. There is profound public interest in broad coverage** – failure or inability of consumers and businesses to access insurance has implications not just for individual families and businesses, but for taxpayers, communities and the nation.

## Current Regulatory Framework Challenged in Era of Big Data

The current regulatory framework for insurance market regulation was created many decades ago and has remained largely unchanged. The market regulation regulatory framework is based largely on the following:

- **Regulatory oversight over data, data-sharing, policy forms, rating factors and claim settlement** – generally, oversight over the inputs.
- **Cost-based pricing** – rates must reflect the cost of claims and expenses

- **No unfair discrimination** – defined as departures from cost-based pricing or consumers of the same risk and hazard treated differently.

- **No unfair discrimination against protected classes** – no consideration of prohibited factors regardless of actuarial or statistical evidence.

The regulatory framework established decades ago for insurance is that regulators had authority over and oversight of the information that goes into pricing and claims. Regulators enforce the requirements that rates not be unfairly discriminatory and that claims be settled fairly by stopping the use of information that would lead to violations for these requirements. For example, most states prohibit the use of race, religion, national origin. By reviewing rate manuals and underwriting guidelines, a regulator historically could have seen if any prohibited factor was used. If a company used a new risk classification in its rating plan, a regulator could ask for proof that the risk classification was related to risk of loss.

*Regulators no longer have oversight of or even access to most of the new data used by insurers for all aspects of the insurers' business.*

Regulators no longer have oversight of or even access to most of the new data used by insurers for all aspects of the insurers' business. And in most cases, insurers don't disclose the new data used to regulators, let alone to consumers. Market forces cannot discipline insurers and protect consumers without transparency.

For example, in the past 15 years, many states adopted insurance credit scoring legislation which brought insurance credit scoring under the oversight of insurance regulators – in addition to oversight of credit bureaus by federal agencies under the Fair Credit Reporting Act – and provided consumers with, among other things, disclosures and protection against certain unfair practices. Today, many types of non-insurance personal consumer information are used by insurers with no disclosure and no accountability. In addition to obtaining consumer information from sources other than the consumer, insurers are collecting massively more information about consumers from consumers, their vehicles, their homes, drones and other means – with little, if any oversight or accountability.

Insurers' use of Big Data challenges the insurance market regulation framework in many ways, including, but not limited to,

- **Insurers now using data not subject to regulatory oversight or the consumer protections of the FCRA.** Regulators have no ability to ensure the accuracy or completeness of these new data sets.

- The concept of unfair discrimination – consumers of similar class and hazard treated differently – becomes meaningless when insurers submit rating plans with millions of rate classes and no two consumers in a class of the same risk and hazard.
- New risk classifications and anti-fraud/claim settlement algorithms can be proxies for protected classes, but with no recognition of disparate impact, risk classifications and algorithms that have the effect of discriminating against protected classes are permitted. Big Data amplifies this problem.

Let's examine some unfair discrimination issues in more detail.

## Disparate Treatment, Disparate Impact and Ethical Algorithms

Many states prohibit insurance discrimination on the basis of race, religion or national origin – for underwriting, pricing or claims settlement regardless of actuarial justification. For other rating factors, at a minimum, actuarial justification is required.

What is actuarial justification? A showing of a statistical relationship (correlation) between a particular characteristic of the consumer, vehicle, property or environment and the designated outcome – e.g., claim frequency, claim severity, pure premium, loss ratio, fraudulent claim, of a claim, likelihood of a fraudulent claim, loss ratio, retention, cross-sales, demand models.

Why are race, religion and national origin considered suspect classifications by the Supreme Court?<sup>1</sup>

1. there is a history of discrimination against the group in question;
2. the characteristics that distinguish the group bear no relationship to the group members' ability to contribute to society;
3. the distinguishing characteristics are immutable; and
4. the subject class lacks political power.

Disparate treatment is the legal term used for intentional discrimination. In the case of insurance, disparate treatment would be, for example, explicit discrimination on the basis of race with an underwriting guideline, rating factor or claim settlement guideline that distinguished intended outcomes on the basis of race. Insurers argue that states' insurance unfair discrimination laws prohibit intentional discrimination based on race – the explicit use of in pricing or claims settlement.

Disparate impact is the legal term used for practices that, whether intentional or not, have the effect of discriminating on the basis of race. Disparate impact has long been recognized as unfair discrimination in employment and housing. Many courts, including the U.S. Supreme Court in a recent decision, recognize disparate impact as a violation of the federal Fair Housing Act – a law which applies to residential property insurance. Insurers argue that dis-

parate impact is not recognized as unfair discrimination in state insurance laws.

Insurers' argue that since they do not consider race, religion or national origin, so there can be no unfair discrimination on the basis of these factors. They further argue that state insurance regulators have no authority to consider disparate impact:

*Absent discriminatory treatment or failing to match price to the risk, the issue is whether they are even appropriate inquiries to apply to insurance rating. This is especially the case since some states prohibit even asking about the applicant's or policyholder's race or some other protected class status. As a result, the rating for a particular risk is truly color blind.<sup>2</sup>*

Industry claim that their algorithms are "color blind" are, of course, nonsense to anyone familiar with algorithms because algorithms can reflect and perpetuate the historical biases of the data and the developers.

### As Barocas and Selbst have written in *Big Data's Disparate Impact*

*Advocates of algorithmic techniques like data mining argue that they eliminate human biases from the decision-making process. But an algorithm is only as good as the data it works with. Data mining can inherit the prejudices of prior decision-makers or reflect the widespread biases that persist in society at large. Often, the "patterns" it discovers are simply preexisting societal patterns of inequality and exclusion. Unthinking reliance on data mining can deny members of vulnerable groups full participation in society.*

### Virginia Eubanks, in *Automating Inequality: How High-Tech Tools Profile, Police, and Punish the Poor*, writes:

*America's poor and working-class people have long been subject to invasive surveillance, midnight raids, and punitive public policy that increase the stigma and hardship of poverty. During the nineteenth century, they were quarantined in county poorhouses. During the twentieth century, they were investigated by caseworkers, treated like criminals on trial. Today, we have forged what I call a digital poorhouse from databases, algorithms, and risk models. It promises to eclipse the reach and repercussions of everything that came before.*

Further – if intentional discrimination against protected classes is prohibited, why would we ignore or permit unintentional discrimination that has the same effect? Given that states (for auto insurance) and lenders (for auto and property insurance) require the purchase of insurance, and that states (fines, loss of civil rights, imprisonment) and lenders (force-placed insurance) penalize consumers who fail to maintain required insurance, it is reasonable and necessary for insurance regulators to effectively monitor availability, affordability and actual market outcome on, among other reasons, the basis of protected classes. How does disparate impact analysis figure into this?

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<sup>1</sup> AVRAHAM, RONEN; LOGUE, KYLE D.; AND SCHWARZ, DANIEL BENJAMIN, "UNDERSTANDING INSURANCE ANTI-DISCRIMINATION LAWS" (2013). LAW & ECONOMICS WORKING PAPERS. [HTTP://REPOSITORY.LAW.UMICH.EDU/LAW\\_ECON\\_CURRENT/52](http://repository.law.umich.edu/law_econ_current/52)

<sup>2</sup> AIA AND NAMIC COMMENTS TO NAIC BIG DATA WORKING GROUP, JANUARY 26, 2018

Consider the TransUnion Criminal History Score – an algorithm based on criminal complaints filed – not ultimately resolve, but filed. Trans Union describes their algorithm:

*“TransUnion recently evaluated the predictive power of court record violation data (including criminal and traffic violations)”*

*“Also, as court records are created when the initial citation is issued, they provide insight into violations beyond those that ultimately end up on the MVR—such as violation dismissals, violation downgrades, and pre-adjudicated or open tickets.”*

What is the likelihood that Criminal History Scores have a disparate impact against African-Americans? Let's consider policing records in Ferguson, Missouri as described in an investigation by the U.S. Department of Justice.

*Ferguson's approach to law enforcement both reflects and reinforces racial bias, including stereotyping. The harms of Ferguson's police and court practices are borne disproportionately by African Americans, and there is evidence that this is due in part to intentional discrimination on the basis of race.*

*Ferguson's law enforcement practices overwhelmingly impact African Americans. Data collected by the Ferguson Police Department from 2012 to 2014 shows that African Americans account for 85% of vehicle stops, 90% of citations, and 93% of arrests made by FPD officers, despite comprising only 67% of Ferguson's population.*

*FPD appears to bring certain offenses almost exclusively against African Americans. For example, from 2011 to 2013, African Americans accounted for 95% of Manner of Walking in Roadway charges, and 94% of all Failure to Comply charges.*

*Our investigation indicates that this disproportionate burden on African Americans cannot be explained by any difference in the rate at which people of different races violate the law. Rather, our investigation has revealed that these disparities occur, at least in part, because of unlawful bias against and stereotypes about African Americans*

While insurers will argue that the TU Criminal History Score or other algorithms based on criminal violations are not unfairly discriminatory as long as race is not explicitly considered in the model, the fact is that criminal history scores or any algorithm based on data reflecting historic discrimination will continue to reflect and perpetuate that discrimination through disparate impact.

Algorithms reflect bias in data and bias in modelers. Consider data used in anti-fraud models. These models tap a variety of data sources to identify characteristics of the consumer and/or the claim correlated with a fraudulent or suspicious claim. But what is the source of the claims identified as fraudulent used in the development of the models? Do the set of claims identified as fraudulent reflect historical bias in anti-fraud and claim settlement practices? Do the modelers have unintentional biases based on cultural backgrounds?

## Ethical Algorithms – Minimizing Disparate Impact in Insurance Models

In an era of Big Data in insurance, disparate impact should be recognized as unfair discrimination in insurance. Regardless of such recognition, insurers and regulators should work to minimize disparate impact against protected classes by employing ethical algorithms. By ethical algorithms, we mean employing best practices in data selection, data analysis, model development and model testing to minimize disparate impact – consistent with the foundational requirement for cost-based practices – of pricing or claim settlement algorithms against protected classes. One tool for minimizing disparate impact while improving cost-based practices is counter-intuitive – explicitly consider race, religion and national origin in the development of the model.

Data scientist Cynthia Dwork explains in a 2015 New York Times interview about algorithms and bias:

**Q:** Some people have argued that algorithms eliminate discrimination because they make decisions based on data, free of human bias. Others say algorithms reflect and perpetuate human biases. What do you think?

**A:** Algorithms do not automatically eliminate bias. . . . Historical biases in the . . . data will be learned by the algorithm, and past discrimination will lead to future discrimination.

*Fairness means that similar people are treated similarly. A true understanding of who should be considered similar for a particular classification task requires knowledge of sensitive attributes, and removing those attributes from consideration can introduce unfairness and harm utility.*

Algorithms are statistical, actuarial or economic models that seek to use one type of information – the independent or predictive variables or factors – to predict an outcome, which, for insurance, might be loss ratio, likelihood of cross selling, expected tenure, likelihood of a fraudulent claim, among many outcomes sought by insurers. As the model is developed, the insurer examines which independent variables are significant – that is, which variable have a statistically significant contribution to explaining the outcome.

But all models – particularly models developed through data mining – suffer from the potential for a spurious correlation in which one variable seems highly correlated with the outcome, but that relationship is fictitious because of data anomalies or because the spurious factor is correlated with another factor. For example, the divorce rate in Maine has a 99% correlation with per capita consumption of margarine.<sup>3</sup> Despite this powerful statistical relationship, we don't believe that lowering the per capita consumption of margarine will reduce the divorce rate in Maine or that an increase in the divorce rate in Maine will lead to great margarine consumption per capita.

So, one tool for minimizing disparate impact in insurance algorithms is to minimize the correlation of predictive factors with race so that the contributions of these predictive factors to explaining

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3 [HTTP://WWW.TYLERVIGEN.COM/SPURIOUS-CORRELATIONS](http://www.tylervigen.com/spurious-correlations)



the outcome are these factors' independent contribution and not the contribution of race by virtue of the factors' correlation with race. And the way to minimize correlation of other factors with race in an algorithm is to introduce race into the model as a control variable. With race used as a control variable, the statistical contribution of the other factors that remains is a more accurate picture of these factors contribution to explaining the target outcome.

## Illustration of One Technique to Minimize Disparate Impact

Let's create a simple model to predict the likelihood of an auto claim:

$$b_0 + b_1X_1 + b_2X_2 + b_3X_3 + e = y$$

Say that  $X_1$ ,  $X_2$  +  $X_3$  are miles driven, driving record and credit score and we are trying to predict  $y$  – the frequency of an auto claim.

Let's assume that all three  $X$ s are statistically significant predictors of the likelihood of a claim and the  $b$  values are how much each  $X$  contributes to the explanation of claim.

$b_0$  is the "intercept" – a base amount and  $e$  is the error term – the portion of the explanation of the claim not provided by the independent variables.

**What happens when we explicitly consider a variable for race?**

$$b_0 + b_1X_1 + b_2X_2 + b_3X_3 + b_4R_1 + e = y$$

$R_1$  is a control variable – by including race in the model development, the correlation of the  $X$ s to race is statistically removed and the new  $b$  values are now the contribution of the  $X$ s, independent of their correlation to race, to explaining the likelihood of a claim

When the model is deployed, the variable for race is removed – the  $X$ s remain, but the  $b$  values now minimize disparate impact.

## Ethical Algorithm Techniques are Consistent With and Improve Cost-Based Practices

Actuarial justification is a statistical test – that a particular characteristic of the consumer, vehicle, property or environment is correlated with a particular outcome, like pure premium (average claim cost). The same statistical test can be used to evaluate and minimize disparate impact. Stated differently – if a particular correlation and statistical significance is used to justify, say, insurance credit scoring, those same standards of correlation and statistical significance are reasonable evidence of disparate impact and unfair discrimination on the basis of prohibited factors. Ethical algorithm techniques are reasonable and necessary because they

1. Minimize Disparate Impact – Stop the Cycle of Perpetuating Historical Discrimination.
2. Promote Availability and Affordability for Under Served Groups
3. Improve Cost-Based Insurance Pricing Models
4. Improve Price Signals to Insureds for Loss Mitigation Investments
5. Help Identify Biases in Data and Modelers / Improve Data Insights
6. Improve Consumer Confidence of Fair Treatment by Insurers

## Conclusion

State insurance regulators need a number of new tools and skills as insurers embrace Big Data and artificial intelligence. One group of these tools should be a requirement for and the ability to monitor disparate impact as unfair discrimination. ■

### About the Author:

**Birny Birnbaum**, AMCM, 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, has served for many years as a designated Consumer Representative at the National Association of Insurance Commissioner. He is a member of the Federal Advisory Committee on Insurance, chairing the Subcommittee on Affordability and Availability of Insurance. Birny served as Associate Commissioner for Policy and Research and the Chief Economist at the Texas Department of Insurance. Birny was educated at Bowdoin College and the Massachusetts Institute of Technology.

## Letter from the President



**Ken Allen**

### Baseball, hot dogs, apple pie, and CDS!

That's how the classic advertising jingle went, right? Well, I might be a little bit off on that point, but the subjects mentioned in that jingle are sure-fire indicators that summer is here. There is plenty of baseball to take in, lots of hot dogs to go around (although 74 fewer of them thanks to a record-breaking performance on the 4th of July), and apple pie to finish off the meal. But the arrival of summer also means that the annual IRES CDS is right around the corner.

I hope that you are able to attend this year's CDS on August 12th – 15th in San Antonio, Texas. In glancing at the CDS agenda, such varied topics as cybersecurity, GLMs, disaster response, travel insurance, blockchain, InsureTech, tax reform, data analytics, and a whole host of compliance issues and other hot topics are on tap for discussion. Truly, there is something for everyone at CDS.

And while I'm thinking of it, don't forget to submit your electronic ballot for this year's IRES Board of Directors election. In a recent e-mail, IRES members were provided with a link to review the candidate bios and a link to vote. Nine candidates are vying for six coveted spots, so make sure you read each candidate's bio, vote early, and vote often. Okay, "vote often" is probably not the best terminology to use here. Rather, you can vote for up to six candidates on your ballot, so make sure you submit only one ballot but that your ballot includes votes for up to six candidates.

But the nearing CDS also means that this President's reign is fleeting. I can honestly say that I have enjoyed my time as IRES President this past year and am grateful for the opportunity this experience has provided to me in my own professional growth and development as a leader. I would like to thank each Board member for their dedicated service to IRES this past year and

ask that the 2018-19 IRES Board continue their on-going commitments in making IRES such a great organization.

I would like to personally thank the IRES Executive Committee that has served this past year, as they have provided me with sage advice, words of wisdom, and leadership par excellence. So to Tom McIntyre, Martha Long (Hey Martha, you're up next!), Tracy Biehn, Randy Helder, LeAnn Crow, Pieter Williams, Kallie Somme, and Lisa Brandt, "THANK YOU" for all of your hard work and detailed efforts in chairing your respective committees. I have been very fortunate in being able to work with such a great group of individuals, and IRES is better off because of your contributions.

One last nod of gratitude goes to Megan Van Petten and the Van Petten Group (VPG) team. It's been a long road from the start of the association management RFP process a little over a year ago to today, but we've made some great strides in this new working partnership between IRES and VPG with many membership upgrades and improvements now available to IRES members on the enhanced IRES website. Hopefully this partnership continues to flourish and be beneficial for both organizations in the years to come.

Now for a little bit of fun for those of you still hanging on and paying attention. You will have to be in attendance at the CDS to have a shot at this, but a San Antonio souvenir will be up for grabs, available to the first IRES member (sorry, IRES Board members are not eligible!) who can provide me with the correct answer to the following question: How many steps does the tallest structure in San Antonio have? The correct answer, as determined by me, must be given in person to me at the San Antonio CDS. Good Luck!

In closing, for those of you attending the CDS in San Antonio, I hope you have an enjoyable time and are able to take away some knowledge and information that is new to you and that is of value to your colleagues and co-workers. For those who are not able to attend the CDS in San Antonio, I hope to see you at the 2019 CDS in Spokane, Washington. Until then, enjoy!

## State Chair Update

Summer means multiple things. Vacations, sunshine, ball games, picnics and times with family and friends and hot temperatures! Summer also means that the IRES CDS is on the horizon, which means that very soon we will get the opportunity to network with our IRES friends from across the country. A highlight of the IRES CDS for me is the face-to-face IRES State Chairs meeting. During this meeting the State Chairs have incredibly thoughtful discussions about enhancements that can be made to IRES for the betterment of the organization and the advantage of our members. Not only do the state chairs bring amazing insight into advancement of IRES they also help perpetuate these changes.

As the IRES CDS quickly approaches, I encourage you to reach out to your state chair with suggestions on how to continue to make IRES the premier organization for Insurance Regulators and the Insurance Industry. For a list of the current State Chairs in each state, please click here: <https://go-ires.org/about-ires/state-chapters>.

In our previous newsletter we mentioned the exciting upcoming enhancements that will be available to our members and our state chairs. These enhancements are all based on discussions and insight brought forward by the state chairs.

Some of these enhancements include:

- A Blog for IRES members allowing them to discuss questions, comments or issues, as well as current events and state undertakings. This will allow our members a forum to get expert feedback on current issues affecting the insurance marketplace.
- Library: IRES members are a wealth of information. We have published articles, assisted with NAIC initiatives, presented on various topics, and are closely monitoring everything that is happening in the insurance market. Wouldn't it be great to have a repository for this information? IRES state chairs will create an online reference library where our members can easily access information regarding their insurance topics of interest.

The State Chairs will continue to keep our members updated on the enhancement initiatives. This information will be presented in the Regulator, but will also be available on the IRES website at <https://www.go-ires.org/state-chapters#events>. Be sure to check the website regularly, as updates will frequently be added for your information.

If you would like to be involved with the state chairs, or have suggestions or ideas to assist the state chairs spread the word about IRES, please reach out to [hblanchard@riaconsulting.net](mailto:hblanchard@riaconsulting.net).

We look forward to seeing you all in San Antonio for another great IRES CDS!! ■



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## Market Regulation and Consumer Affairs



**Tim Mullen**

It is hard to believe we are already half-way through 2018 with both the NAIC Summer National Meeting and the IRES Career Development Seminar fast approaching in August. So, where did the first half of 2018 go, what has been accomplished, and what lies ahead for the rest of 2018?

### Market Conduct Annual Statement and Market Analysis

The NAIC recently updated the public Market Conduct Annual Statement (MCAS) scorecards with enhanced visualization and communication of ratio information. In addition to the state contact and ratio information that has been displayed, companies can now

view a national map illustrating each jurisdiction's ratio result for a specific ratio chosen. In addition, companies can find an illustration of all the values and distributions of all the ratios of a selected jurisdiction. I would encourage everyone to visit the following NAIC Weblink to view the new format for the scorecards: [https://www.naic.org/mcas\\_data\\_dashboard.htm](https://www.naic.org/mcas_data_dashboard.htm). In addition to the new scorecards, the MCAS filing system is being updated to collect 2017 health information in 2018. The reporting deadline for the filing of health data is Sept. 30, 2018.

In addition to enhancements to the current MCAS filing system, the Market Regulation and Consumer Affairs (D) Committee adopted a new MCAS blank for Disability Income Insurance during a July 10th conference call. This annual statement covers both individual and group short-term and long-term disability insurance and includes the collection of the following data: (1) claims information; (2) claims decisions processed; (3) information on claims closed without payment; (4) reasons for claim denials; (5) information on claims closes after initial payment; (6) underwriting activity; (7) information on covered lives; and (8) information on complaints and lawsuits. The NAIC's Executive Committee and Plenary will consider the adoption of the new MCAS blank at the NAIC Summer National Meeting in August. The Market Regulation and Consumer Affairs (D) Committee is also receiving comments on the Market Analysis Procedures (D) Working Group's decision to not develop an MCAS blank for Travel Insurance and will make a decision at the NAIC Summer National Meeting on whether to affirm the Working Group's direction or request the Working Group to reconsider the issue.

Regarding NAIC Working Group activity related to market analysis, the Market Conduct Annual Statement (D) Working Group is developing a draft MCAS blank for Private Flood Insurance. Modeled after the MCAS blank for homeowners insurance, the proposed flood blank includes the collection of data for claims, underwriting, lawsuits, and complaints. The Market Analysis Procedures (D) Working Group recently adopted recommended scorecard ratios for the new MCAS blank for Lender-Place Auto and Homeowners Insurance. The Market Analysis Procedures

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## Educational Corner

It is that time of the year again and National IRES Continuing Education (NICE) Program deadlines are quickly approaching.

The deadline to:

- Complete your continuing education is **August 31, 2018**
- Submit your continuing education credits is **September 30, 2018**

### How many credits do I need?

The NICE Program requires 15 hours of qualifying continuing education (CE) credit to be earned and reported each year. Courses submitted for credit must be completed during the current compliance period September 1, 2017 to August 31, 2018.

### How can I check to see how many CE credits I already have this compliance period?

You can check your CE credits any time online. Just visit the IRES website, log-in to your account and navigate to the Professional Development section of your profile. Information on Navigating the Professional Development Area of the IRES Website can be from the Professional Development section of your profile.

### How do I submit CE credits?

Submitting CE credits is easy and is done online. After logging into your IRES account, navigate to the Professional Development section of your profile and Add a New Entry. More detailed instructions for reporting your credits appeared in the Spring 2018 issue of The Regulator®. You can also access instructions on reporting CE credits on the Professional Development section of your profile.

### What if I am a few CE credits short?

The NICE program allows members to 'reachback' and use up to three excess hours from the prior year that were not previously used to satisfy your CE requirement. You may 'reachback' only one year and you must report the 'reachback' CE credits for this reporting period. IRES does not automatically apply excess hours from the prior year to the current reporting period.

### How do I report 'reachback' credits?

The process for reporting 'reachback' credit is almost identical to reporting regular credits. The only difference is that you select the Reachback as the credit type, rather than the credit type that describes the type of credit earned. The rest of the information reported is the same as it would be if the credits being reported were not 'reachback' credits.

### What if I am not able to complete my CE by August 31, 2018, even using the 'reachback' option?

One-year extensions to complete and report your CE are available to members when circumstances prevent you from completing the required CE. Extensions are not automatic and must be requested prior to September 1, 2018. To request an extension, visit the IRES website, log-in to your accounts and complete the Extension Request Form.

**For more information on the NICE program and its requirements, see the NICE Program Manual.**

<https://go-ires.org/designation-programs/continuing-education-program-nice> ■



**Jo A. LeDuc**



(D) Working Group is also exploring the merger of the Level 1 and Level 2 analysis reviews and potential enhancements to the NAIC's Market Analysis Review System, which state regulators use to share market analysis.

## Updates to the NAIC Market Regulation Handbook

The Market Conduct Examination Standards (D) Working Group continues to enhance the standardized data calls contained in the NAIC Market Regulation Handbook. The Market Regulation and Consumer Affairs (D) Committee recently adopted six standardized data requests for annuities. The revised data requests address in force contracts, replaced contracts, new business declarations, plan codes, and claims. While not required for examinations, states are encouraged to use the standardized data requests to enhance the uniformity of examinations.

The Market Conduct Examination Standards (D) Working Group is in the early stages of developing examination standards for the following: (1) mental health parity, (2) the NAIC's Insurance Data Security Model Law, and 3) pharmacy benefit managers. The Working Group is also drafting a document outlining the procedures for updating the NAIC's Market Regulation Handbook to provide all interested parties additional detail on how the Handbook may be revised.

Finally, the 2018 version of the NAIC's Market Regulation Handbook is being restructured to make it more use-friendly. The Handbook will now be published in four volumes. The first volume of the Handbook will focus on broader market conduct terminology and processes, the second volume will focus on market analysis, and the third and fourth volumes will focus on examination standards.

## Public Adjusters

The Market Regulation and Consumer Affairs (D) Committee adopted three documents addressing public adjuster activities. The first work product is an advisory bulletin to property and casualty insurance companies asking companies to assess and implement methods to improve policyholder education about the role of adjuster. The bulletin recognizes that adjusters bring important assistance and lend value to claimants but that claimants often lack a solid grasp of the types of adjusters, their authorizations, their roles, fees, and potential conflicts that can arise. The second work product is a consumer outreach notice explaining the responsibilities of public adjusters and their fees. The third work product is a notice to home improvement contractors. This notice provides guidance to contractors on what they can do in the claim settlement process and what they cannot do unless they are licensed as a public adjuster. With the adoption of these documents at the NAIC Spring National Meeting, the Market Regulation and Consumer Affairs (D) Committee disbanded the Public Adjuster (C/D) Working Group.

## Pre-Dispute Mandatory Arbitration Clauses

The Pre-Dispute Mandatory Arbitration Clauses (D) Working Group is finalizing a bulletin to provide guidance to insurers regarding provisions within personal lines policies that impose pre-dispute mandatory arbitration clauses, choice of law provisions, and choice of venue provisions. In summary, the draft bulletin states these types of clauses and provisions unfairly limit or impose unreasonable preconditions on a consumers' ability to adjudicate their disputes in state courts and should be prohibited in personal lines policies. The most recent discussions

of the Working Group have focused on clarifying that state laws requiring disputed valuations of auto property damage claims or disputes over UM/UIM damages to be resolved through arbitration would not be considered an inappropriate use of a pre-dispute mandatory arbitration clause. The Working Group intends to finalize the bulletin at the NAIC Summer National Meeting.

## Voluntary Market Regulation Certification Program

The pilot program for the Voluntary Market Regulation Certification Program is in its final year and has expanded from 14 jurisdictions to 18 jurisdictions. The following jurisdictions participated in the pilot in 2017: Alaska, Arkansas, Indiana, Kansas, Montana, Nebraska, New Jersey, Oklahoma, Oregon, Texas, Vermont, Washington, Wisconsin, and Wyoming. For 2018, the following jurisdictions have joined the pilot: Iowa, Missouri, New Hampshire, and West Virginia.

The pilot jurisdictions are conducting self-assessments on how completely they comply with the 12 certification requirements that address such areas as statutory authorities, appropriate levels of qualified market conduct staff, collaboration with other jurisdictions, participation in market regulation working groups, and reporting data to NAIC market information databases. Feedback from the pilot jurisdictions has suggested the requirements surrounding staffing requirements and qualifications may need better clarification. The Market Regulation Certification (D) Working Group will hear an update from the pilot jurisdictions at the NAIC Summer National Meeting. The volunteer jurisdictions will provide their final reports at the NAIC Fall National Meeting and the Working Group will consider changes to the Market Regulation Certification based on recommendations from the pilot program.

## Availability and Affordability of Auto Insurance

The Auto Study (C/D) Working Group has received the requested data from the statistical agent to assist in assessing auto insurance markets. The data files contain 20 million records and NAIC staff continue to provide analysis of the aggregate data. A primary focus of the analysis is whether the average premium for auto insurance varies significantly between ZIP codes while taking into account differences in coverage, loss frequency, and loss severity between ZIP codes. The Working Group continues to discuss its plans to release the raw data once the initial analysis has been completed.

## Big Data Discussions

While the Big Data Working Group now reports to the NAIC's Executive Committee, many of the issues being discussed touch on market conduct. The Working Group made significant progress earlier this year with the adoption of several recommendations for the NAIC's Executive Committee and the Property and Casualty (C) Committee.

The Working Group first recommended the NAIC's Executive (EX) Committee direct NAIC management to research the appropriate skills and the potential number of resources required for the organization to address the needs of the NAIC membership in conducting their reviews of predictive models. Secondly, the Working Group requested the NAIC's Executive Committee to request the NAIC Legal Division to issue a memorandum analyzing methods and procedures to be followed in sharing predictive modeling

information so as to maintain applicable statutory confidentiality protections.

Additionally, the Working Group requested the Property and Casualty Insurance (C) Committee consider the following additional charges for the Casualty Actuarial and Statistical (C) Task Force: (1) draft and propose changes to the Product Filing Review Handbook to include best practices for the review of predictive models and analytics filed by insurers to justify rates; (2) draft and propose state guidance for rate filings that are based on complex predictive models; and (3) facilitate training and the sharing of expertise through predictive analytics webinars.

With these requests now adopted by the respective Committees and much of the prior discussions focusing on personal lines property and casualty insurance, the Working Group plans to turn its focus to the use of data for accelerated underwriting in life insurance.

### Progress on State Ahead

Finally, I want to remind everyone of the tremendous work underway to fulfill the strategic direction the NAIC Membership set forth in State Ahead. In summary, State Ahead is a three-year strategic plan that provides a blueprint for the NAIC and state regulators to meet the demands in a rapidly changing environment driven by consumer expectations and technology. State Ahead is organized into three core themes: 1) Safe, Solvent and Stable Markets; 2) Consumer Protection and Education; and 3) Superior Member Services and Resources.

In the specific area of consumer protection, State Ahead recognizes the NAIC members are leveraging technology to collect and store more market data. Because of this, it will be important for the NAIC to optimize the collection and use of market data, including analytical tools for the benefit of state insurance departments. This goal will be achieved through rebuilding the NAIC's MCAS application as a cloud-based solution, implementing business intelligence tools for data analysis and visualization, and creating an analytics data warehouse to allow state insurance regulators to more easily identify data across all NAIC functions. Additional information about these and other activities of the Market Regulation and Consumer Affairs (D) Committee, its Task Forces, and Working Groups, may be found under the Market Regulation and Consumer Affairs (D) Committee heading at [https://www.naic.org/cmte\\_d.htm](https://www.naic.org/cmte_d.htm). The complete State Ahead plan is available at [https://www.naic.org/documents/state\\_ahead\\_strategic\\_plan.pdf](https://www.naic.org/documents/state_ahead_strategic_plan.pdf). ■

### About the Author:

**Tim Mullen**, JD, MBA, CPCU, CIE, is the Director of Market Regulation at the National Association of Insurance Commissioners. He oversees a wide range of activities supporting NAIC committees, task forces and working groups addressing antifraud, consumer services, market analysis, market conduct examinations, and producer licensing. He joined the NAIC in 1997 and was with the Missouri Department of Insurance prior to joining the NAIC. In addition to his work in state government, he worked for Aetna Insurance and was a practicing attorney before joining Aetna. He is a member of the Missouri Bar and the Kansas Bar, the 2009 recipient of the Paul L. DeAngelo Memorial Teaching Award from the IRES Foundation, and serves as President-Elect of the Kansas City CPCU Chapter.

## Membership and Benefits Committee 2017-2018 Wrap-up



**Tracy Biehn**

Over the last year, I have had the pleasure of working with a great group of Committee Volunteers. The enthusiasm and willingness to jump in has been amazing. We have had some hurdles with the transition to the New Management Company. The Committee members stepped up to the plate and offered their assistance with the Membership Renewal campaigns.

We have developed a great list of ideas we would have liked to implement, but were unable to do so this year. For

example: this includes the ability to purchase IRES pens, magnets, sticky pads, or other small items to be used by the States for distribution to students (Important: we approached the Executive Board and received permission to pursue, however, we need to evaluate funding and distribution opportunities of those items to all of the States interested in receiving IRES paraphernalia), the pursuit of a "survey" to issue to Lapsed Members to find out the reasons for their lapsed membership, and find ways to pursue more State specific Student Initiative opportunities which includes communicating with College Student Resource/Career Offices, Law School programs and supplying the updated IRES Membership brochures with Student membership information to the campus student career offices.

As the functionality of YourMembership (YM) is explored further, the Membership and Benefits Committee look forward to the ability to capture Membership data in a more real-time environment. Additionally, we look forwards to exploring YM's ability for multiple year membership renewals, if a member so desires.

The State Chair Committee has been very active. They were able to create a designated area on the website where the State Chairs can have their blog, resource library, and State specific folders. To help acclimate the State Chairs to the access on the website, a webinar was being pursued to show all the functionality and receive input from the State Chairs.

The M&B Committee updated the IRES Membership Brochure to include a Student Membership Section.

The Awards and Recognition Committee is excited to roll back the application due date of the Al Gross/Jim Long Rookie of the Year and Thomas L. Reents Memorial Scholarships to December 31st of each year which will allow recipients' the flexibility to use the scholarship funds for all possible events and to allow for a 12 month scholarship usage period. The Awards letters indicate that

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the scholarship funds must be used within 12 months from the date of the award letter.

Finally, under the Student Initiative Section, the Kansas Department of Insurance (DOI) shared information about their Kansas Insurance Certificate Program. The Kansas Insurance Department and the Kansas Insurance Education Foundation have established an insurance certificate for college students at Kansas universities. The representatives from Kansas DOI provided presentations to the Membership and Benefits and the State Chairs Committees to help explain the process and provide guidance on how to start pursuing a similar opportunity in their State. The Kansas Insurance Certificate Program is quite elaborate. The hope is for States to be able to utilize some portion of the program within their State. The Kansas DOI plans to provide a presentation to the “new” Board Members at the IRES CDS in San Antonio, TX in August 2018.

Additionally, the following was pursued and approved by the Board:

- The Student Membership fee will be reduced to \$20.00 a year. The website will be updated soon.
- Funds are available for the purchase of promotional items for use by the States when they are hosting Student or attending Student events. ■

## IRES Zoning Update



**Kathy Donovan**

### Northeast =

#### New York

Circular Letter 2018-8, issued June 22, 2018, provides guidance regarding underwriting in life insurance, disability income insurance, and long-term care insurance for the use of PrEP to reduce the risk of contracting HIV infection, where “PrEP is described as an HIV prevention strategy where individuals who are not infected with HIV but may be at risk of exposure to the virus take medication to reduce their risk of becoming infected.” This Circular Letter further states that “under Insurance Law § 4224, issuers may not unfairly

discriminate in their underwriting or rate setting based on an applicant’s use of HIV prevention strategies, such as PrEP.”

#### Pennsylvania

SB 878, effective July 3, 2018, revises the rebating laws by including the following provision: “An insurance company, association or exchange, by itself, its officers, members or attorney-in-fact or any other party may offer or give to an insured or a prospective insured, on an annual aggregate basis, any favor, advantage, object, valuable consideration or anything other than money that has a cost or redeemable value of less than or equal to one hundred dollars (\$100.) Notwithstanding any other provision of this section to the contrary, an insurance company, association or exchange, by itself, its officers, members or attorney-in-fact or any other party may not make receipt of anything of value contingent on the purchase of insurance.”

#### Vermont

While HB 593 became effective on May 28, 2018, the new limitations on the use of credit information in personal insurance policies are applicable to policies that either are written to be effective or are renewed on or after nine months after the date of bill passage. Some key provisions under the new 8 V.S.A. § 4727 mandate that an insurer which uses credit information to underwrite or rate is not allowed to:

- Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor.
- Deny, cancel, or nonrenew a policy of personal insurance solely on the basis of credit information without consideration of any other applicable underwriting factor independent of credit information.
- Base an insured’s renewal rates for personal insurance solely upon credit information without consideration of any other applicable factor independent of credit information.
- Take an adverse action against a consumer solely because he or she does not have a credit card account without consideration of any other applicable factor independent of credit information.
- Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance unless the insurer takes one of the specified actions detailed in 8 V.S.A. § 4727.
- Take an adverse action against a consumer based on credit information unless an insurer obtains and uses a credit report issued or an insurance score calculated within 90 days from the date the policy is first written or renewal is issued.

CONTINUED ON PAGE 12

- Use credit information unless not later than every 36 months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report.

Provisions for taking into consideration “extraordinary life circumstances” are also established.

## Midwest Zone

### Iowa

SF 2418 prohibits a health benefit plan, issued or renewed on or after July 1, 2018, that provides coverage for pharmacy benefits from requiring a covered individual to pay a copayment for pharmacy benefits that exceeds the submitted charges. It further provides that any amount paid by a covered individual for a covered prescription drug pursuant to this section will be applied toward any deductible. Additionally, a pharmacy or pharmacist has the right to provide a covered individual information regarding the amount of the covered individual’s cost share for a prescription drug and a pharmacy benefits manager is not allowed to prohibit a pharmacy or pharmacist from discussing any such information or from selling a more affordable alternative to the covered individual, if one is available.

### Oklahoma

Effective Nov. 1, 2018, SB 1101 provides “a basis and procedures for the transfer and statutory novation of policies from a transferring insurer to an assuming insurer by way of an Insurance Business Transfer (IBT) without the affirmative consent of policyholders or reinsureds.” Various requirements for notice and disclosure, as well as standards and procedures for the approval of the transfer and novation by the Oklahoma Insurance Commissioner and the District Court of Oklahoma County pursuant to an IBT Plan, are established.

## Southeast Zone

### Georgia

Effective July 1, 2018, HB 760 amends various insurance code sections to include new requirements for insurers to provide a written notice of reduction in coverage to the named insured for certain lines of business. The notice must be printed in all capital letters in a separate document entitled “NOTICE OF REDUCTION IN COVERAGE.” Sections 33-24-45 and 33-24-46 state that the insurer must provide the written notice of reduction in coverage to the named insured no less than 30 days prior to the effective date of the proposed reduction in coverage, while Section 33-24-47 states that the insurer must provide the written notice no less than 45 days prior to the effective date. HB 760 also defines a reduction in coverage to mean “a change made by the insurer which results in a removal of coverage, diminution in scope or less coverage, or the addition of an exclusion” and does not include any change, reduction, or elimination of coverage made at the request of the insured.

## Louisiana

SB 283, effective Jan. 1, 2020 establishes new requirements applicable to pharmacy benefit managers (PBMs). Some of these requirements are:

- The Louisiana Department of Insurance (LDI) is to provide a dedicated location on its website for PBM information and links.
- For each PBM’s contractual or other relationships with a health benefit plan or health insurance issuer, the PBM is to provide the LDI with the health benefit plan’s formulary and provide timely notification of formulary changes and product exclusions.
- A PBM will be required to issue an annual transparency report that discloses certain aggregate data on rebates received from drug manufacturers, administrative fees, and aggregate rebates received that did not pass through to the health benefit plan or insurer.
- LDI is required to publish the transparency report within 60 days of receipt from the PBM.

Additionally, effective Aug. 1, 2018, another legislative initiative, SB 241, mandates that no PBM or other entity that administers prescription drug benefits “shall prohibit, by contract, a pharmacy or pharmacist from informing a patient of all relevant options when acquiring their prescription medication, including but not limited to the cost and clinical efficacy of a more affordable alternative if one is available and the ability to pay cash if a cash payment for the same drug is less than an insurance copayment or deductible payment amount.”

## Western Zone

### California

On July 2, 2018, given the recent reduction in the federal corporate tax rate from 35 percent to 21 percent, Insurance Commissioner Dave Jones issued an order requiring every insurer licensed to write workers’ compensation insurance to report their federal income tax savings annually through a rate filing. Under this order, each insurer is to submit a rate filing to report the dollar amount of their tax savings by Dec. 31, 2018, and on a yearly basis through Dec. 31, 2020. Additional supplemental information will also need to be submitted.

### Hawaii

HB 1778, effective July 6, 2018, provides for comprehensive medical benefits for firefighters under the workers’ compensation law upon diagnosis of cancer which is presumed to “arise out of and in the course of employment.” Specifically, if a claim filed by an employee with five or more years of service as a firefighter is accepted or determined to be compensable, section 386-21 of the workers’ compensation law shall remain applicable, “provided that the employer shall be liable for medical care, services, and supplies for a minimum of one hundred ten per cent, and not to exceed one hundred fifty per cent of fees prescribed in the Medicare Resource Based Relative Value Scale applicable to Hawaii as



prepared by the United States Department of Health and Human Services.” Regarding a controverted claim the injured employee’s private health care plan is required to pay for or provide medical care, services, and supplies in accordance with the private health care contract. However, when the claim is accepted or determined to be compensable, the employer is required to reimburse the private health care plan and the injured employee in accordance with the amounts determined by law.

## Nevada

R590-276, effective Apr. 23, 2018, establishes record retention requirements for foreign, alien, commercially domiciled, foreign title and foreign fraternal. The specific records and reports retention period for foreign, alien, commercially domiciled, and foreign fraternal insurers is three years, plus the current year, for review by the Division of Insurance (Division) as needed. All title insurers are required to keep records for 15 years under 31A-20-110. The Division indicates that it will begin enforcing this new rule 45 days from the effective date.

## Washington

The Office of the Insurance Commissioner’s (OIC) Advisory T-2018-01, issued Apr. 18, 2018, addresses “Implementation credits as illegal inducement or rebate.” The Commissioner stated that “As

the use of implementation credits by an insurer violates Washington law, offering, promising, allowing, giving or paying any such credits is prohibited in any insurance transaction. Further, such credits should not be requested by any customer, regardless of size or governmental status.” Additionally, the Advisory indicates that any filings which include implementation credits will not be approved by the OIC. ■

## CONGRATULATIONS TO THE NEWEST IRES DESIGNEES

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# Affiliate Transfers: A Practical Guide for Migrating Insurance Policies Between Legal Entities



**James Talbert**

## Introduction

From time to time, insurers find it useful to transfer policies between legal entities within their holding company systems. This process is frequently referred to as an "affiliate transfer."

Although affiliate transfers are not uncommon, they have received scant attention in the insurance literature. This article is an initial step toward filling that gap. It provides a basic overview of the affiliate transfer concept, and it offers several threshold recommendations for performing these inter-company transfers.

## Holding Companies and Underwriting Companies

Insurers are typically structured as holding companies with several or even dozens of subsidiaries. The subsidiary entities serve various purposes, such as business support, investment management, and realty management. Also included in the holding company systems are the entities that engage in the core business of insurance: issuing, and servicing insurance policies. These entities are known as "underwriting companies."

Most insurers maintain several underwriting companies. Large insurers may have dozens of them. Typically, each underwriting company specializes in a particular level of risk or a certain class of policyholder. Some underwriting companies, for example, only issue non-standard (high-risk) automobile policies; others might specialize in residential properties that were built using asbestos.

Maintaining a number of underwriting companies can be useful. Among other things, it facilitates pricing flexibility, and can help to silo the negative consequences (e.g. regulatory supervision) of a state- or line-specific trend or catastrophe.

## Unnecessary Underwriting Companies & Affiliate Transfers

Occasionally, however, insurers encounter situations where they have created or inherited too many underwriting companies. This situation commonly arises following an inter-insurer merger or acquisition. For example, imagine that two insurers each maintain underwriting companies designated to issue preferred (low-risk) personal auto policies. If these two companies merge, the surviving company will be left with two legal entities that serve the same essential purpose – issuing and servicing low-risk automobile policies. Under most circumstances, this constitutes a redundancy.

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Maintaining unnecessary underwriting companies can be expensive and also risky. First, it entails various costs, including licensing fees, filing fees, record maintenance costs, reporting costs, and costs associated with keeping each entity appropriately capitalized. Second, the added complexity of the enterprise can make it harder to ensure that each entity remains compliant with various laws, regulations, vendor agreements, and agent contracts. The obvious solution is to eliminate the unnecessary underwriting companies. Unfortunately, this process can itself be difficult and risky. First, the insurer will have to determine which entities it wants to keep on a go-forward basis. The following considerations commonly influence the decision:

- The number of in-force insurance policies and annual premium attributable to each of the existing underwriting companies;
- The number of in-force agent contracts associated with each underwriting company, and the difficulty of assigning or rescinding and reforming these contracts;
- The relative functionality of the software platforms used by the various underwriting companies, and the difficulty of transferring such platforms to new entities;
- The companies' A.M. Best ratings; and
- The companies' names (an entity's name may not be appropriate to use on a go-forward basis if, for example, the name is associated with a previously-acquired company, and the buyer no longer wishes to write business under that name).

Second, after an insurer decides to eliminate a particular underwriting company, it must reckon with how to dispose of that entity's in-force insurance policies. Generally speaking, it will have two options: it can terminate the policies, or it can transfer those policies to another company within the insurer's holding company system.

Assuming the policies are profitable, insurers will generally prefer the second option – preserving the relationship with the policyholders by transferring the policies to an affiliated underwriting company. But affiliate transfers are subject to a host of regulatory, litigation, and business risks. They are regulated differently in

different states. This necessitates state-specific research, which, if it is not performed carefully, can set the stage for non-compliance and regulatory actions. Additionally, affiliate transfers can be confusing processes for policyholders. The insurer and/or the agent may have to do some handholding to make the transition as smooth as possible for the policyholder. Otherwise, the policyholder may get exasperated and decide to shop for insurance elsewhere.

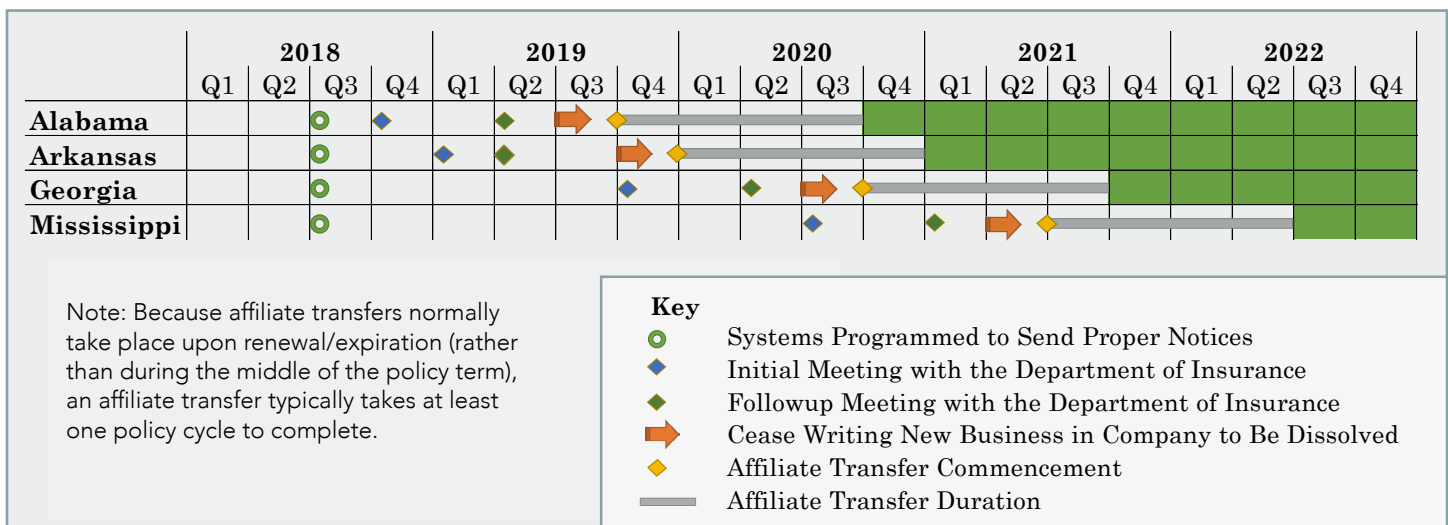
## Guidance for Insurers Seeking to Perform Affiliate Transfers

This section offers a number of suggestions to reduce the risk that an affiliate transfer will result in regulatory action or litigation. The suggestions also contain logistical guidance focused on making affiliate transfers run more smoothly from the standpoint of the insurer as well as the policyholder.

### a. Develop Timelines for Performing the Affiliate Transfers in Each State

When preparing for an affiliate transfer, a good first step is to create "transfer timelines" for each state where affected policies (i.e. policies that are slated to transfer between underwriting companies) have been issued. The timelines should include important dates, such as the date that renewal policies will begin rolling over into the new entity, and the date that the transfer will be complete (the date that all of the policies will have migrated to the new entity).

When an affiliate transfer involves policies in multiple states, the insurer should consider performing the transfer in phases – starting with one state and proceeding consecutively with the others. Phasing-in an affiliate transfer helps prevent any serious workload bottlenecks, and enables personnel to learn from any mistakes made during the early phases of the transfer. For example, with respect to an affiliate transfer involving policies in Alabama, Arkansas, Georgia, and Mississippi, the timelines might end up looking something like the following:



## b. Set up Meetings with the Relevant State Departments of Insurance

An insurer should consider discussing its plans to initiate an affiliate transfer with the department of insurance (“DOI”) in each state where affected policies have been issued. As the reader knows, insurance regulators like to be kept in the loop. Regulators may also offer valuable insights, including information regarding unwritten “desk drawer” rules that impact a proposed affiliate transfer.

In these DOI meetings, the insurer should generally inform the regulator of its plan to transfer business, review the mechanics of the proposed conversion, welcome any feedback, and notify the department that it may set up a follow-up meeting to pose additional questions. The insurer might also consider preparing a nutshell explanation of the transfer for each DOI – something that department staff can reference if policyholders call in asking about the changes.

Typically, the DOI will send two or three representatives to meet with the insurer. They may have various questions or comments about the transfer plan. The insurer’s representatives should take notes during these meetings. The notes will serve to memorialize the insurer’s conversations with the DOI, and should be circulated to the process stakeholders, including any attorneys assigned to do the state-specific research in preparation for the transfers.

## c. Determine How Best to Characterize the Affiliate Transfers in Each State

A crucial first step to executing an affiliate transfer is knowing what to call it. Depending on the state and the line of business, an affiliate transfer may constitute a “renewal,” or it may constitute a “non-renewal and re-write” of the policy. States generally break down into four categories with respect to how they characterize affiliate transfers:

- (1) States that expressly permit one or more lines of business to be renewed within an affiliated underwriting company;
- (2) States that expressly permit one or more lines of business to be renewed within an affiliated underwriting company, but only if certain requirements are met (e.g. the underwriting company to which the policy is transferred must have an A. M. Best rating which is at least as favorable as that of the transferring company<sup>1</sup>);
- (3) States that expressly declare affiliate transfers to constitute non-renewals and re-writes; and
- (4) States that simply do not address affiliate transfers.

Consider the following examples:

• **Idaho:** Idaho is a good example of category number one – states that explicitly permit affiliate transfers to be accomplished via “renewal.” Section 41-1842, which applies to most commercial property and casualty policies, defines “renewal” as “the issuance, or the offer so to issue, by an insurer of a policy succeeding a policy previously issued and delivered by the same insurer or an insurer within the same group of insurers.”<sup>2</sup>

• **Florida:** With respect to residential property policies, Florida exemplifies the second category of states (states that explicitly

permit affiliate transfers to be accomplished via “renewal,” but only if certain conditions are satisfied). Florida law states that a residential property policy may be “renewed” within an affiliated underwriting company, but only if the following requirements are met:

- (a) The authorized insurer to which the policy is being transferred must be admitted in Florida and other states, and writing residential property insurance in multiple states.
- (b) The transfer must not cause the transferred policy to be converted to a surplus lines policy.
- (c) The underwriting company to which the policy is being transferred must have been determined by the Florida Office of Insurance Regulation to have the same or better financial strength than the transferring insurer.
- (d) The transfer must result in substantially similar coverage.
- (e) The policyholders subject to the transfer must have been selected on a nondiscriminatory basis.
- (f) The Florida Office of Insurance Regulation must approve the transfer.<sup>3</sup>

If a residential property policy transfers underwriting companies upon the expiration of its policy term, but the requirements of (a)-(d) are not met, then the transfer would likely be considered a non-renewal and re-write.

• **Kentucky:** In connection with private passenger automobile policies, Kentucky exemplifies the third category of states (states which expressly provide that affiliate transfers are considered non-renewals). Section 304.20-040 provides: “The transfer of a [private passenger automobile policy] between companies within the same insurance group shall be considered a non-renewal.”<sup>4</sup>

• **Colorado:** Colorado serves as a good example of the fourth category of states (states that simply do not address affiliate transfers). As is the case with many states, Colorado law is silent with respect to affiliate transfers. Because these states do not permit an affiliate transfer to be characterized as a renewal, the safest course of action is to assume that the transfer must be performed via non-renewal and re-write.

Insurers should keep in mind that the proper characterization for an affiliate transfer may differ depending on the state and the line of business. For example, just because commercial property policies may be “renewed” with an affiliated underwriting company in a particular state, this does not mean that the same rule applies to, for instance, personal property policies or medical malpractice policies. If there is any ambiguity about how an affiliate transfer should be characterized, the insurer should consult with the applicable state insurance department.

However, as a general matter, it is worth noting that an insurer should avoid placing too much reliance on the DOI’s position that

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1 IOWA CODE § 515.128.3.B.

2 IDAHO CODE § 41-1842(2)(E) (EMPHASIS ADDED).

3 FLA. STAT. § 627.4133(8).

4 KY. REV. STAT. § 304.20-040(6).



a particular action is permissible – especially when statutory language seems to indicate otherwise. Department assurances might mitigate regulatory risk (i.e. the risk that the DOI will investigate or penalize the insurer), but they do not eliminate litigation risk. Courts and arbitrators, after all, are not bound by unpublished interpretations of the law by the DOI.

#### **d. Identify the Correct Policyholder/Lienholder Notice Requirements and Prepare to Comply with Them**

After the insurer determines how to characterize the affiliate transfer, the next step is to identify the proper notices to send in connection with the transfer. Consider the following examples:

• **Minnesota:** With respect to Minnesota workers' compensation policies, affiliate transfers will likely constitute non-renewals and re-writes.<sup>5</sup> Accordingly, at least 60 days prior to performing the affiliate transfer, the insurer must mail or deliver notice of non-renewal to the policyholder.<sup>6</sup> The insurer must also give this notice to the agent of record, if any.<sup>7</sup> Finally, within 10 days after the issuance of the new workers' compensation policy, the insurer must file notice of coverage with the Commissioner of Labor and Industry.<sup>8</sup>

• **Mississippi:** With regard to Mississippi property and casualty policies, if the affiliate transfer results in "the same or substantially similar coverage," then the transfer may be characterized as a "renewal," and the following notice requirements will apply:

(1) The insurer must mail or deliver to the policyholder at least 30 days' prior notice of any terms or conditions that are less favorable to the policyholder.<sup>9</sup>

(2) The transferring insurer shall notify the policyholders of the affiliate transfer. This notice shall include the financial rating of the affiliated company to which the policies are being transferred, and must be provided to the policyholders along with the notice of renewal premium at least 30 days prior to the effective date of the transfer.<sup>10</sup>

(3) The insurer shall also give the DOI at least 45 days' advance notice that the policies will be transferred to another licensed insurer within the same group or holding company. This notice shall include the name of the transferring insurer and the name and financial rating of the receiving insurer.<sup>11</sup>

If, with respect to Mississippi property and casualty policies, the affiliate transfer does not result in the same or substantially similar coverage, the insurer must mail or deliver to the policyholder and any loss payee, at least 30 days' prior notice of non-renewal and re-write.<sup>12</sup>

• **New Mexico:** With respect to New Mexico property and casualty policies, affiliate transfers constitute "renewals," and the insurer must provide the policyholder at least 30 days' prior notice of any change of limitation, restriction in coverage, or change in deduct-

ible.<sup>13</sup> Additionally, at least 30 days prior to the expiration date of the policy, the insurer must provide written notice of affiliate transfer to the agent of the policyholder.<sup>14</sup>

• **Iowa:** In Iowa, when an insurer migrates a commercial property or casualty policy between two affiliated underwriting companies, the transfer may be characterized as a "renewal" if the following requirements are satisfied:

(a) The transfer does not result in an interruption in coverage.

(b) The rating of the affiliate from the A. M. Best company or a substitute rating service acceptable to the commissioner, is the same or better than the rating of the transferring insurer.

(c) The transfer results in the same or broader coverage.

(d) Notice of the transfer is delivered to the policyholder or sent by first class mail to the policyholder's last known address not less than 45 days prior to the transfer. This notice is not, however, required in the event that the policyholder requests or consents to the transfer.

(e) The notice of transfer provides the name and telephone number of the policyholder's insurance producer, agent, or agency, if any.<sup>15</sup>

If an affiliate transfer does not meet the aforementioned requirements, it must be treated as a non-renewal and re-write. In this case, the insurer will have to mail or deliver notice of non-renewal to the policyholder and any loss payee at least 45 days prior to the existing policy's expiration date.<sup>16</sup>

If an Iowa affiliate transfer does meet the aforementioned requirements ((a)-(e) above), then the insurer must send notice of the affiliate transfer to the policyholder. This notice must be sent by first class mail at least 45 days prior to the transfer.<sup>17</sup> Additionally, at least 45 days prior to the transfer, the insurer must notify the policyholder of any of the following changes:

- An increase in the deductible of 25% or more;
- An increase in the premium rates of 25% or more; or
- A material reduction in the limits or coverage of the policy.<sup>18</sup>

Some states do not explicitly require insurers to provide any sort of notice in connection with an affiliate transfer. In these states, insurers should nevertheless notify policyholders of the affiliate transfer and of any material policy changes that occur during the course of the transfer. Courts across the country have held that insurers have the right to expect that a policy will be replaced on the same terms and conditions unless they are given notice of any changes.<sup>19</sup> As stated by Couch on Insurance: "If there is a change in the condition or terms of the renewal policy, it is the duty of the

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5 BECAUSE MINNESOTA LAW DOES NOT CONTEMPLATE THAT AFFILIATE TRANSFERS MAY BE CHARACTERIZED AS "RENEWALS," THE CONSERVATIVE ASSUMPTION IS THAT THESE TRANSACTIONS MUST EFFECTED THROUGH NON-RENEWAL AND RE-WRITE OF THE POLICIES.

6 MINN. STAT. § 176.185, SUBD. 1.

7 MINN. STAT. §§ 60A.38, SUBD. 3; 60A.352.

8 MINN. STAT. § 176.185, SUBD. 1A.

9 MISS. CODE § 83-5-28(1); S.B. 2311, 2018 REG. SESS. (MISS.).

10 MISS. CODE § 83-5-28(5); S.B. 2311, 2018 REG. SESS. (MISS.).

11 MISS. CODE § 83-5-28(4); S.B. 2311, 2018 REG. SESS. (MISS.).

12 MISS. CODE § 83-5-28(1).

13 N.M. CODE R. 13.8.4.11.

14 N.M. CODE R. 13.8.4.12.

15 IOWA CODE § 515.128.3.

16 IOWA CODE § 515.128.2; SEE ALSO IOWA CODE § 515.129.6.

17 IOWA CODE § 515.128.3.D.

18 IOWA CODE § 515.128A.1.

19 AMERICAN CASUALTY CO. V. HAMBLETON, 233 ARK. 942, 947-48 (1961); FIELDS V. BLUE SHIELD OF CALIFORNIA, 163 CAL. APP. 3D 570, 579 (CAL. APP. 4TH 1985); INDUSTRO MOTIE CORP. V. MORRIS AGENCY, INC., 76 MICH. APP. 390, 396 (1ST DIST. CT. APP. 1977); BAUMAN V. ROYAL INDEMN. CO., 36 N.J. 12, 25-25 (1961); MCD ACQUISITION CO. V. N. RIVER INS. CO., 898 F. SUPP. 2D 942, 952 (N.D. OHIO 2012); MEDLEY V. GERMAN ALLIANCE INS. CO., 55 VA. 342, 360-61 (1904).

insurer to call attention to the change, and if the latter fails to do so, the renewal contract is subject to reformation by the courts of equity to make it conform to the original contract.”<sup>20</sup>

#### **e. Legal Teams Should be Prepared for Pushback from Business Units**

Affiliate transfers can be burdensome undertakings, sometimes requiring insurers to re-execute policy documents and send multiple forms and notices (some of which must be manually generated) to each policyholder. For the sake of time and money, business units may balk at these requirements. For example, they might take umbrage at the idea that, in some states, affiliate transfers should be characterized as non-renewals and re-writes. Understandably, the business units—and probably also the policyholders—often think of the transferred policies as mere continuations of the expiring policies, and they would prefer to avoid the hassle of generating and mailing non-renewal notices.

In response to this sort of pushback, the company’s legal team should generally inform the business of the risks associated with relying on bold or tenuous interpretations of the law. Additionally, while it may be reasonable in certain circumstances to adopt risky interpretations of the law, the legal department should take a harder line where the business advocates anything resembling willful non-compliance with clear legal requirements.

#### **f. Be Aware that Affiliate Transfers May Trigger State Withdrawal/Block Non-Renewal Requirements**

Many states set forth certain notice or filing requirements that are triggered when an underwriting company ceases to write a certain line of business, non-renews a block or class of business, withdraws from the state, or surrenders its certificate of authority in that state.<sup>21</sup> Arkansas, for example, provides: “Any insurer desiring to surrender its certificate of authority, withdraw from [Arkansas], or discontinue the writing of certain classes of insurance in [Arkansas] shall give ninety 90 days’ notice in writing to the State Insurance Department and shall state in writing its reasons for such action.”<sup>22</sup>

Affiliate transfers sometimes implicate these sorts of withdrawal and block non-renewal requirements. If, for example, an affiliate transfer causes a company to cease writing a certain line of business, this would trigger Arkansas’s block non-renewal requirement (discussed in the paragraph above). In some states, such as New Jersey, block non-renewals and withdrawals can be cumbersome and lengthy processes, and this must be factored into the overall timeline for the affiliate transfer processes.<sup>23</sup> Accordingly, insurers should research these provisions in each state affected by the proposed affiliate transfer.

#### **g. Be Aware that Affiliate Transfers May Trigger Reporting and Filing Requirements Found in State Motor Vehicle and Labor Codes**

State insurance codes and regulations are not the only sources

of law that govern affiliate transfers. State motor vehicle codes (also referred to as “transportation codes”) and state labor codes (also referred to as “workers’ compensation codes”) also set forth requirements that are applicable to affiliate transfers.

For example, section 72-311 of Idaho’s Workers’ Compensation code provides:

*No [workers’ compensation policy], where the policy . . . is intended to provide coverage of greater than one hundred eighty (180) days, shall be canceled or not renewed until at least sixty (60) days after notice of cancellation has been filed with the [Idaho Industrial Commission], and also served on the other contracting party either personally or by certified mail to the last known address of the other contracting party.*<sup>24</sup>

Because Idaho does not permit workers’ compensation policies to be “renewed” in affiliated underwriting companies, the insurer would likely have to characterize the transfers as non-renewals and re-writes. Accordingly, affiliate transfers would implicate section 72-311’s 60-day filing requirement.

Affiliate transfers can also implicate motor vehicle financial responsibility laws. For example, Pennsylvania regulations provide:

*An insurer who has issued a contract of motor vehicle liability insurance and knows or has reason to believe that the contract is for the purpose of providing financial responsibility, shall immediately notify the Department [of Transportation] if the insurance has been cancelled or terminated by the insured or by the insurer. The insurer shall notify the Department [of Transportation] not later than 10 days following the effective date of the cancellation or termination.*<sup>25</sup>

In Pennsylvania, affiliate transfers may be characterized as “renewals” only if the new policy provides “types and limits of coverage at least equal to those contained in the policy being superseded.”<sup>26</sup> Thus, if the affiliate transfer is accompanied by a diminution of the “types and limits of coverage,” the affiliate transfer will constitute a non-renewal and re-write, and the insurer will be required to provide notice of non-renewal to the Department of Transportation.

#### **h. Consider the Effects of the Affiliate Transfer on Previously Executed Policy Documents and Endorsements**

Insurance policies are frequently modified or accompanied by supplementary or amendatory forms, agreements, and disclosures (electronic funds transfer authorizations, e-delivery agreements, uninsured motorist coverage rejection/selection forms, etc.). For simplicity, these documents will hereinafter be referred to as “ancillary documents.”

Affiliate transfers may have the unintended consequence of rendering these ancillary documents ineffective. Take the following

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<sup>20</sup> LEE RUSS ET AL., *COUCH ON INSURANCE* 27:79 (3D ED. 2011).

<sup>21</sup> SEE E.G. N.D. CENT. CODE § 26.1-25-04.4; OKLA. ADMIN. CODE § 365:15-1-18; ARK. CODE § 23-63-211(E); S.D. CODIFIED LAW § 58-11-62.

<sup>22</sup> ARK. CODE § 23-63-211(E).

<sup>23</sup> SEE N.J. REV. STAT. § 17:33B-3 (WHEN AN UNDERWRITING COMPANY TRANSFERS ITS BUSINESS TO ANOTHER INSURER, THIS CONSTITUTES A “WITHDRAWAL” FROM THE STATE OF NEW JERSEY, AND, WITH CERTAIN EXCEPTIONS, THIS TRANSFER SHALL NOT COMMENCE PRIOR TO ONE CALENDAR YEAR AND NINETY DAYS FOLLOWING THE SUBMISSION OF AN INFORMATIONAL FILING TO THE DOI PURSUANT TO N.J. ADMIN. CODE § 11:2-29.3.).

<sup>24</sup> IDAHO CODE § 72-311(2).

<sup>25</sup> 67 PA. CODE § 221.3(A).

<sup>26</sup> 40 PA. CONS. STAT. §§ 1171.3; 991.2001; 31 PA. CODE § 113.81.

example: An electronic funds transfer (“EFT”) agreement typically grants a particular underwriting company the right to withdraw premium payments from the policyholder’s bank account. After the policy undergoes an affiliate transfer, an entirely different underwriting company will collect the premiums for that policy. Because the new underwriting company is not privy to the previously executed authorization form, that company will not have valid consent to perform electronic fund transfers in connection with that policyholder.

In preparation for performing an affiliate transfer, the insurer should review the ancillary documents associated with the policies slated to transfer underwriting companies. The insurer should attempt to determine whether changes stemming from the affiliate transfer (changed underwriting company, changed policy number, etc.) would render those documents ineffective following the transfer. If so, then the insurer should obtain new copies of the ancillary documents, signed by the insured.

Insurers should also be aware that in some cases, state law specifically addresses whether certain ancillary documents will remain effective following an affiliate transfer. Arizona, for example, does so with regard to uninsured motorist coverage rejection forms. That state requires every motor vehicle liability policy to include uninsured and underinsured (“UM/UIM”) motorist coverage with limits equal to the policyholder’s policy limits for bodily injury or death.<sup>27</sup> Policyholders are, however, free to reject UM/UIM coverage by signing a rejection form which has been approved by the DOI.<sup>28</sup> Arizona law indicates that an insurer may continue to rely on such rejection forms following the “transfer, substitution, modification, or renewal of [the] existing policy.”<sup>29</sup> The statute’s use of the word “transfer” likely indicates that a UM/UIM rejection form will not be rendered ineffective solely by the fact that the policy transfers to another underwriting company.

***i. Comply with the Most Stringent Timing and Mailing Requirements when Sending an Affiliate Transfer “Packet”***

States often require insurers to send several different policyholder notices in connection with an affiliate transfer. Florida, for example, sets forth two notice requirements that apply when an insurer transfers private passenger automobile policies between affiliated underwriting companies. Specifically, the insurer must send:

- 45 days’ prior notice of affiliate transfer<sup>30</sup>; and
- 30 days’ prior notice of the renewal premium.<sup>31</sup>

Typically, it is cheaper and easier for the insurer to combine these notices in a single packet and issues them all at once, rather than sending them separately. This is probably also more convenient for the policyholder.

When an insurer combines multiple notices in a single packet, the packet should be sent in accordance with whichever notifications’ advance notice and mailing requirements are the most stringent. For example, a particular state might require an insurer to provide the policyholder at least 45 days’ advance notice of the affiliate transfer, and at least 30 days’ advance notice of any change in the premium. If the insurer proposes to combine these notices in a single packet, then it would be bound to ensure that the policyholder receives the packet at least 45 days prior to expiration. The same reasoning holds true with mailing requirements. If one

notice in the packet may be sent by first class mail, but another requires a certificate of mailing, the insurer will have to obtain a certificate of mailing for the packet.

***j. Ensure that the Migration does not Result in a Company Writing Lines of Business Outside the Scope of its Certificate of Authority***

Finally, when moving business from one underwriting company to another, the insurer must be certain that new underwriting company is licensed to write the selected lines of business. This recommendation is common sense, but insurers do sometimes overlook this basic requirement.

## Conclusion

Affiliate transfers are widely performed, but have received little attention. Over the past decade or so, state legislatures have begun to address the subject, but there is still very little in the way of publicly available guidance for insurers seeking to transfer blocks of business between entities. This is somewhat frightening, considering the scale of such undertakings and the potential for liability for across-the-board errors in conducting affiliate transfers. While this article is far from an exhaustive study of affiliate transfers, it should help lay some groundwork for insurers considering such undertakings. ■

## About the Author:

**James Talbert** is an associate in the Columbus, Ohio office of Bailey Cavalieri LLC. He focuses his practice on representing insurers in connection with regulatory and corporate matters.



We are saddened to share the passing of a long-time IRES member and Kansas insurance regulator, Marty Hazen. Marty worked in the Property and Casualty Division at the Kansas Insurance Department for over 20 years, and was a proud IRES member most of that time. He

spent many years on the IRES Board of Directors, and was a fixture at the annual CDS.

**Marty will be missed.**

<sup>27</sup> SEE ARIZ. REV. STAT. § 20-259.01(A, B).

<sup>28</sup> ID.

<sup>29</sup> ID.

<sup>30</sup> FLA. STAT. § 627.728(4)(D).

<sup>31</sup> FLA. STAT. § 627.727(2).



# Risk Intelligence: Increase Your Analysis Of Applicants

## Due Diligence And Suitability Criteria For Directors And Senior Leaders



**C.J. Rathbun**

Insurance companies face increasing regulatory requirements and scrutiny in their Corporate Governance, in particular the evaluation of the effective oversight of their Board of Directors. Boards of Directors have a higher standard of due diligence in the industry, including suitability of its directors, than ever before. Some leading practices for an insurance company Board are explored here.

### What's Changed

While regulators have long-focused on the solvency of insurers, they are now interested in much more than the numbers. They now are assessing a

company's structure of decision-making processes – and how a company arrives at those numbers. Even more, they will look at how an insurer's enterprise risk management framework helps ensure the company's sustainability.

Of particular importance is the National Association of Insurance Commissioners (NAIC) Corporate Governance Annual Disclosure (CGAD) Model Act and Regulation, which shines a spotlight on the make-up of a company's Board of Directors. A key requirement of the CGAD is to demonstrate that the Board, as a whole, possesses the core competencies needed to oversee all the key risk areas of the company, and the effectiveness of that oversight. Because of this new law, many companies are creating or updating corporate governance guidelines and suitability criteria for choosing new Board members. In addition, companies are taking a fresh look at their due diligence procedures within the search for new Directors, as well as officers and other senior leaders.

### Compliance Requirements for Insurance Company Due Diligence

The Violent Crime Control and Law Enforcement Act of 1994, Public Law 103-322, H.R. 3355; Title 18, United States Code, Sections 1033-1034 (the Act), lays the basis to determine what kinds of background check compliance procedures should be implemented for all employees and Directors. This Act directs that anyone with a state or federal felony for breach of trust cannot work in the financial services industry, including in "the business of insurance." This means that before a person becomes a Board Director or is hired by the insurer, a full state and federal criminal background check is required, at a minimum.

Another source of important background information for due diligence is credit and financial history. Looking at a credit report and reviewing any outstanding tax liens, bankruptcies and other credit issues can provide a window into an individual's lifestyle, money-handling and overall financial responsibility. Written standards, against which you measure these reviews in your selection criteria, are crucial to ensure you treat all potential candidates fairly and equitably.

These financial insights can reveal important information when deciding on a new Director because of the accountability they will share for the future solvency of the company. Equally important is a demonstrated duty of care toward the company's assets as well as to your policyholders' assets – a fiduciary duty.

Included in a company's standards should be flexibility for exceptions, however. For instance, a bankruptcy resulting from medical bills should be considered in a different light than a bankruptcy for lifestyle debt. Likewise, a 58-year-old who discloses a felony conviction dating from when he or she was 18 may be justified in contacting the Department of Insurance for a waiver to allow them

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— SOMETHING TO REMEMBER —

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to work in the business of insurance, as is allowed in the Act.

Additionally, because the Act has no grandfathering for any felony for breach of trust, the company should consider one additional step beyond standard background and financial checks, which typically cover a certain time period such as five or seven years. This means all applicants for the Board or senior leadership must sign a statement on their application that they have never been convicted of a felony for breach of trust (e.g. misappropriation of funds or a breach of fiduciary duty).

In spite of the requirements of the Act to ensure that no felons convicted of breach of trust are allowed to work in the business of insurance, most insurance companies do not run background checks periodically on their senior leaders or Board members after the initial check.

For Directors and senior leaders, insurance companies typically limit their ongoing due diligence to an annual certification of key compliance requirements and that attestation becomes an important documentation of ongoing due diligence and compliance.

As an added precaution, consider having each member of the Board of Directors and all senior leaders certify to the following items each year, placing a statement similar to this confirmation at the top of the document:

"I attest to my compliance with these requirements with honesty and integrity, and to the best of my knowledge that:"

1. In the past 12 months, I have not been convicted of a felony for breach of trust, and there is no trial pending for felony breach of trust, and no charges are pending.
2. In the past 12 months, I have not been convicted of any criminal action, under state or federal law, and no charges are pending.
3. I have read, understood and have abided by [Company] Standards as communicated in [list sources, such as Code of Ethics and Business Conduct, Conflict of Interest statement, compliance training, H.R. training, etc.] for the past 12 months, and commit to abide by them in the future.

## Suitability Criteria for Members of the Board of Directors and Senior Management

The most rigorous essentials apply to the selection process when seeking to fill senior leadership positions, the president or chief executive officer position, or empty seats on the Board of Directors. The CGAD models, in fact, very specifically address the requirements for Directors and Chair of the Board.

At the broadest level, Board Directors must have the appropriate background, experience and integrity to fulfill their prospective roles in overseeing the company management. Examples of that expertise include appropriate education, experience, intelligence, independence, fairness, moral character, reasoning and judgment for effective leadership.

Some of these terms may seem vague or overly discriminatory – for instance, what level of intelligence is demanded and how is that intelligence defined? While the CGAD lists these characteristics, each company and Board may want to turn these general qualities into more readily identifiable ones. "Intelligence" could

be defined as "possessing a curious mindset, open to lifelong learning," for instance. "Education" does not necessarily require a certain level of schooling, but could be stated as "learned in the areas of expertise used during one or more credible careers".

The Board Committee charged with vetting candidates will also need to assure that the qualifications of a senior leader for the company or a prospective Board member include such attributes as integrity, accountability, informed judgment, financial literacy, mature confidence, and high performance standards.

An excellent way to validate the background of each Director, and continue to document overall Board level competency going forward, is to periodically update Director biographical affidavits and refile, as required, with state insurance departments. The following list of qualities contains examples that might be included in an insurance company's selection criteria for Directors and senior management.

### Any senior leadership or Board role

- Proven integrity
- A record of substantial achievement
- A high degree of leadership experience in a complex organization such as a corporation, financial services company, university, foundation or governmental unit
- A reputation for sound business judgment
- Understanding of the oversight role of the Board and the management workings of the company in the current business and risk environment
- A reputation or record of working as part of a team in an environment of collegiality and trust

### Suitability for Directors

- The ability to appraise management's plans, programs, achievements and shortcomings objectively, with independent thinking
- A capacity for asking difficult or challenging questions with a goal of leading to better outcomes for the entity
- The financial and subject matter expertise required to provide the necessary, effective oversight of a diversified and heavily regulated financial services or insurance business
- Willingness and ability to devote the necessary time to the work of the Board and its committees, including materials review and meeting attendance

**CGAD requires that the Board as a whole possess a number of what regulators see as "core competencies" needed to oversee the insurance company. Examples of core competencies to consider are:**

- accounting or financial proficiency
- sound business judgment
- broad insurance industry knowledge
- documented management success
- recognized leadership
- visionary and forward-thinking
- strategic intelligence

One way to ensure that the Board meets these criteria is to require at least one member of the Board to possess sufficient competence in at least one of these core areas. The Board Committee selecting new Directors will also need to assess a nominee's independence and evaluate whether the nominee's

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skills are complementary to the existing Directors' skills and Board and company needs. In addition, the Board Committee should consider diversity, cultural competence, experience, expertise and such other factors as it deems appropriate.

### Suitability of the Board Chair

The objective criteria used to select the Chair from the pool of Directors might be expanded beyond other Director requirements to include such factors as:

- exemplary service on the Board
- demonstrated duty of care for the company
- proven executive leadership experience
- strong communication skills
- ability to work well with senior leadership
- confidence to lead the Board with a "hands-on, fingers-off" oversight of the company

### What Can Disqualify a Sitting Board Member?

**Felonies:** Reviewing a Director's annual certification with regard to felonies, Code of Ethics and Business Conduct violations, and Conflicts of Interest is an important step towards determining if a Board member has disqualified himself or herself from a position on the Board. Many companies use a broader definition of criminal convictions (not just felony of breach of trust), in which case any criminal conviction might be grounds for automatic termination from the Board.

**Conflicts of Interest:** When an existing Director takes on new employment with, ownership in, or membership on a Board of another financial services entity, insurance company or other related or regulatory entity, that change can result in a conflict of interest. If a Director becomes an active insurance producer in any capacity or a staff member of any organization governed by the same regulatory body as is the insurance company, these dual roles are often considered conflicts of interest that would disqualify that Director.

**Absenteeism:** Documented requirements for Board membership should include attendance and commitment standards. Some consideration can be allowed for attendance via telephone conference call if a member is unable to attend a meeting in person. However, the requirements should set a standard of attendance, committee participation and specific commitment to the work of the Board. A lack of commitment that demonstrates itself with non-attendance, non-review of materials prior to meetings, non-participation in Board training events, or lack of contribution to assigned committee work may all be reasons for disqualification.

The responsible Board Committee (such as a Corporate Governance Committee) should review all of the certifications and documentation with the Corporate Secretary and/or General Counsel and make recommendations regarding possible dismissal of a Director. The Board as a whole (excepting the Director under review) will review and vote on these recommendations.

### Solvency and Sustainability

Consistent use of the types of background checks, financial checks and due diligence described above helps ensure that senior leaders and Board members meet legal and regulatory standards, as well as providing a springboard for company standards. These expectations will establish legal, cultural, ethical and moral standards, as well as emphasizing the protection of consumers

and the company as high priorities.

**How can the company predict its own sustainability? When these key concepts are thoroughly integrated:**

- a. The transparent purposes and goals of the insurer serve all its stakeholders well
- b. High levels of accountability and integrity are expected from its stakeholders
- c. Management functions effectively within the risks and opportunities of the current and future business environment, and
- d. The Board oversees management of enterprise risk with skill and vision

### Summary

Increased regulatory scrutiny in the insurance industry calls for increased internal scrutiny. To help position and solidify your company as a risk-minded culture with high standards of integrity, consider steady, consistent improvement in monitoring your human capital. Every person who represents your company should be informed about, understand and accept the necessity and appropriateness of these controls. ■

### About the Author:

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Lisa Brandt

## IRES Feature Member Lisa Brandt

**Q:** Who do you work for? What is your job title? And in a very short description what are your daily duties?

**A:** I work for the State of Wisconsin Office of the Commissioner of Insurance

(OCI), Bureau of Market Regulation, as the Section Chief for the Rates & Forms Team. I have 5 team members that make the magic every single day. Our team is responsible for Rate & Form filings in Wisconsin. While we are a file and use state, there are many rate and form filings that are fully reviewed. As you can imagine we get all kinds of inquiries and filings in all lines of insurance.

**Q:** How long have you been an IRES Member and what made you decide to join?

**A:** I joined IRES in May of 2012, when I was only 3 months old. Actually, I had only been with OCI for 3 months and found there were many co-workers that belonged to this group called IRES, and I love gardening and flowers so I joined. Seriously, my co-workers were very involved in the organization and it seemed to go hand in glove with what I was doing, so I joined as well and have never looked back!

**Q:** What committees have you served on and what roles did you hold?

**A:** I currently serve on the Education Committee, the Publications Committee, the State Chair Committee, and am the Chair of the Accreditation & Ethics Committee. In the past I have also served as Chair of the Webinar Committee and a member of the website redesign committee. I am also a member of the IRES Board of Directors and the Executive Committee.

**Q:** How many IRES CDSs' have you attended and what was your favorite location?

**A:** I have attended 5 Career Development Sessions. While they were all fantastic, I'd have to say that my favorite location was Portland, what a beautiful area. Funny story, when CDS was held in Charleston SC, it was extremely (did I say extremely) hot! So one of the evenings we rode the shuttle from the hotel into town to walk around the city, do some small shopping,

and when we returned for the shuttle we knew there was ice cream and shaved ice right across the street from where we catch the shuttle so we were REALLY looking forward to that. So, did I mention it was hot in SC??? When we got back to wait for the shuttle, we were in such a melted state we couldn't even walk across the street to get our treats we have craved all day! Seriously, we could not take 1 step further.

**Q:** Is there one session at a CDS that stands out in your mind and why?

**A:** Well this is one tough question! Am I on 60 minutes?? Seriously it is hard to point to one session. I think the first CDS I attended I was so impressed to see so many people working together from all areas of the insurance industry. The sessions and the panels I attended included regulators, commissioners, industry folks, contract examiners; it was just so exciting to see everyone come together to present information that was timely, and pertinent to the attendees. Information that you could take home and put into action! When I returned to the office I was always invigorated and anxious to share what I had just learned with the rest of my co-workers that weren't able to attend. Now that I have been more involved with IRES I see how much work goes into putting this all together and I would like to thank everyone involved as CDS is always a wonderful opportunity to attend, learn and network with others in our industry. I would encourage everyone to attend the annual CDS if they are able!

**Q:** What is a personal or career goal that you would like to accomplish in the next 5 years?

**A:** My previous goal was to achieve professional success in my current department. I feel so fortunate to have been selected to be the new Section Chief for Rates & Forms and will endeavor to meet and exceed the expectations before me. Beyond that, I would like to receive the CIE Designation. While I have been working towards this for some time, something always gets in the way and I get derailed, that's life!

**Q:** When you aren't working what are your hobbies?

**A:** I enjoy bird watching, and generally have 12 – 16 bird feeders in the yard at one time. I have even seen a Pileated Woodpecker in my own yard! I also love to dig in the dirt, mainly flowers now since the cats decided the vegetable garden was a, well you know, something for them to use and not vegetable garden for me! I love animals in general and have always had numerous pets. Currently, I have just (lol) 3 cats but sure hope to get a dog in the near future. I also love to read and create artwork from jewelry. My mother was an artist and a teacher, so I come from a place of learning, exploring and trying new things. Like mom always said, it is amazing that we are here on this beautiful blue green planet.

*I enjoy bird watching, and generally have 12–16 bird feeders in the yard at one time.*

**Q:** What is your biggest personal or professional accomplishment?

**A:** After working in private industry for 30 years (I know I started when I was 7) it was a professional goal to remain in the insurance field and expand into regulation. I achieved this goal in 2012, when I was hired by OCI as an Insurance Examiner. That was the launching board to my current position, and I'm proud of what I have accomplished. I want to thank everyone that helped me get where I am today, the co-workers that mentored me and the leaders that put faith in me. The path in our careers and our lives is never traveled alone, though there are times it feels that way. The people that I have met through IRES have given me confidence and have, in fact, changed my life. ■

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SUMMER  
2018

# Editor's Corner



Stephanie Duchene

We hope you have enjoyed this issue of The Regulator® and are staying cool this summer!

In this issue we have three really excellent articles covering a range of regulatory topics. Birny Birnbaum gives us an insightful look into insurance regulation in the era of Big Data. James Talbert provides us with a guide for migrating insurance policies effectively between legal entities. Finally, C.J. Rathbun discusses due diligence and suitability criteria for Directors and Senior Leaders of insurers.

We also get to know our Featured Member Lisa Brandt from the State of Wisconsin Office of the Commissioner of Insurance who is a very active (and very funny!) IRES member. Tim Mullen keeps us up to date with what is happening with the NAIC Market Regulation and Consumer Affairs (D) Committee. Finally, as always, Kathy Donovan keeps us Zoned In on recent changes in state insurance laws.

Thank you to all our authors and contributors to this Summer issue. Without your volunteer efforts this publication would not be possible! Also, a heartfelt thank you and send-off to Ken Allen who has served as IRES President this past year and who, among many other things, expertly oversaw IRES's transition to our new management company, Van Petten Group.

We look forward to seeing everyone at CDS in San Antonio in August!

Please let me know if you have any feedback on this issue, or ideas for upcoming issues. It's your organization: make sure your voice is heard - right here in The Regulator®! ■