



Testing Private Passenger Automobile Rates

Peeling Back the Onion

How can a state insurance regulator be assured that an auto insurer is adhering to its filed rating plan? All states and the District of Columbia, except Wyoming, perform "front end" rate regulation. That is, they require insurers to file the rates and rating plans used to determine auto insurance premiums.¹ From time to time, states also conduct so called "back end" rate regulation, driven by a number of market factors, including the perceived use of not-at-fault accidents for improper surcharges, the need to test compliance with new laws or an increase in consumer complaint activity, to name a few. Regulators may call a targeted market conduct examination that includes testing a sample of policies to ensure that the premiums charged to policyholders were developed in accordance with filed rates.

Kent Dover
CIE, CPCU, ALMI, AMCM

Traditionally, the testing of rate filings for private passenger auto was a fairly straight forward and moderately time consuming task for market conduct examiners. Today, it can be more akin to deciphering the Enigma machine (an encryption machine used during WWII). With the advent of ever more sophisticated insurance and credit scoring models, multi-variate tiering schemes, and the use of "big data," one might argue that private passenger auto rating algorithms are among the most complex in structure of all the property and casualty lines. For a regulator or examiner, validating premiums charged to auto insurance consumers has become a monumental task. An examiner must truly "peel the onion" to understand how the rating plan works, then perform scores of basic to complex mathematical calculations to ensure the rating plan is used as filed. No simple task.

The 2019 NAIC Market Regulation Handbook ("Handbook"), Chapter 20, General Examination Standards, includes the following Underwriting and Rating Standard 1, which states, "The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity's rating plan." The Standard's Review Procedures and Criteria section includes the following:

- Verify all rating factors, including class, territory, symbol assignment, surcharges, deductible factors and increased limit factors.
- Calculate the policy premium to verify it is in accordance with filed rates.²

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November 6-8 - MCM
Baton Rouge, Louisiana

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1. "Summary of State Laws Related to Auto Insurance," December 2013. Posted at www.naic.org/documents/committees_c_d_auto_insurance_study_group_related_auto_law_summary.pdf.

2. 2019 NAIC Market Regulation Handbook, Chapter 20 - General Examination Standards



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1. **Has the regulated entity tested its own rating system?** If so, when, what were the results and was documentation of the testing retained and available for review? The examiners should consider performing a risk assessment including interviews of senior underwriting managers for information about controls that ensure the rating system priced policies correctly. Were any internal operational audits of the rating system performed? If so, request copies and review them. If the regulated entity can demonstrate that its rating system was sufficiently tested and produced correct rates during the examination period, then that may impact the examination scope and eliminate or mitigate the need to perform further rate testing.
2. **What is the examination period?** A shorter examination period will reduce the time required to complete the testing for the same number of sampled policy files, since there will be fewer rate and rule filing changes and fewer program changes. Testing rates used over a period of three or more years as compared to a one year period will add significant time and cost to the examination.
3. **What will the rates be tested against?** Ideally, rates should be tested against copies of the regulated entity's rate and rule filings that were effective for policies issued during the examination period. The regulated entity's rating manuals, if used, should be validated against the rate filings. Since the rate and rule filings are generally made in SERFF, it is a simple matter for the regulated entity to produce complete copies of all the filings needed to validate rates.
4. **How deep to dive?** Many major automobile insurers are using credit scores or insurance scores in their rating algorithms or underwriting models.³ Since the models that produce the scores are often filed with the regulator, the regulator should consider whether the rate validation review performed by the examiners will include testing the model to determine if the score used in the premium calculation matches the score reproduced by the examiners using the model. Such testing should be performed by or under the supervision of a credentialed property and casualty actuary. Alternatively and depending upon the examination objectives, it may be sufficient to request a listing of the variables used in the scoring model to ensure that no prohibited variables are used. The regulator should also consider whether the regulated entity is required to retain a record of the risk-specific variable attributes used to develop the score, or whether retention of the model's output, the score alone, satisfies record retention requirements. The regulator may opt to accept the insurance score at face value, not test its development, and perform the rate testing with the caveat that development of the insurance or credit score was not tested.
5. **What should be the scope of the test work?** The regulator should consider testing a portion of each policy premium rather than testing the entire premium for each sample policy tested. For example, consider if the examination objectives can be met if testing is limited to the first listed vehicle on each policy. Or would the examiners be required to validate the rating of all the vehicles listed on every sample policy? Testing all vehicles and all coverage features for every sample policy will significantly increase the cost of the examination and may not be necessary.
6. **How many sample policies should be tested?** Given the complexity of today's rating algorithms, it may not be practical or cost effective in all cases to fully test a sample of policies based on Handbook sample sizes. Consideration should be given to the scope of the examination. If a group of affiliated companies is being examined, there are usually multiple policy programs involved. For example, consider an examination scope period of three years, a family of five insurers tested with a mix of standard and preferred programs and rate changes once a year. Obviously, the examination effort required will be far greater than an examination of a single, non-standard insurer over an examination period of one year. In lieu of testing the entire sample, the regulator may want to consider alternatives to traditional testing methods, such as using IT resources to test the rating software, algorithms and change management procedures, including the entity's pre-production testing of programming changes.
7. **Can the regulated entity produce a rating worksheet for each sample policy?** In many cases, the regulated entity's initial program rate filing will include some rating examples and/or a rate order of calculation ("ROC") exhibit that illustrates all the rating variables for all policy coverage features (Bodily Injury, Property Damage, Other than Collision, Collision, etc.) and the mathematical calculations required to compute the premium. The regulator should request the regulated entity produce a ROC document for each sample policy that shows the computation of the premium. The amount of premium computed should equal the premium shown in the sample policy. If the regulated entity is able to produce these rating worksheets, the examiner can validate the rate steps, rates and all rating factors contained in the worksheet against the applicable rate filing and risk attributes contained in the policy underwriting file. If the regulated entity is unable to produce the rating worksheets, the examiner will need to create one using the regulated entity's rate filing as a guide.
8. **How long will this take?** Assuming the review includes testing the insurance or credit scoring model, the time required to validate the premium charged for a single policy will hinge on many factors, including: (1) the relative complexity of the model, (2) the relative complexity of the tiering scheme, (3) presence or absence of a ROC document, (4) the relative clarity of the rate filing, (5) the relative complexity of the ROC and other rating factors, (6) whether or not the underwriting characteristics of the risk are readily available, and (7), most importantly, the level of cooperation received from the regulated entity. Giving consideration to these factors, the time required to perform the review of the first policy will range from a few hours to as long as several days in an extreme case. There is no magic number since every regulated entity is different. Once the first policy review is completed, the time required to perform subsequent reviews should range on average between 30 minutes to four hours. In extreme cases, even subsequent reviews may require most of a day to complete a single policy review. Review time is substantially reduced when the insurance scoring or credit scoring model is not included in the review or the rating process is being tested through alternative approaches, as mentioned above.

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3. "Credit-Based Insurance Scores: Impacts on Consumers of Automobile Insurance – A Report to Congress by the Federal Trade Commission," July, 2007. Posted at www.ftc.gov/sites/default/files/documents/reports/credit-based-insurance-scores-impacts-consumers-automobile-insurance-report-congress-federal-trade/p044804facta_report_credit-based_insurance_scores.pdf

Below are some useful tips for testing private passenger auto rates. This assumes that the examiner will request a dataset of the entire population of new and renewal auto policies issued during the examination period that contains standard data call elements⁴, including the policy premium at policy issue, and that the examiner will select a subset of policies from the population data for rate testing:

1. Gain a basic understanding of the regulated entity's auto insurance programs and tiering approach by reviewing copies of all underwriting and rating manuals effective during the examination period.
2. Request a listing of all rate and rule filings necessary to support the rates used for all policies with a policy effective date that lands within the examination scope period. This includes the filings that contain the insurance scoring or credit scoring model.
3. Request a complete SERFF "PDF Pipeline" copy of each filing listed that includes the entire filing, all exhibits, supporting documents and filing correspondence. Specify how you would like each pdf file to be labeled.
4. Each SERFF filing contains a "Disposition" showing the filing effective date for new business and the effective date for renewal business policies. The rates in the filing must be used for all policies with effective dates on or after the effective dates in the filing, unless the rates and rules are superseded by a newer filing.
5. The policy effective date determines which rate filings are applicable. Filings with new and renewal effective dates after the policy effective date do not apply to that policy as initially issued.
6. Keep in mind that multiple rate and rule filings may apply to a single policy. Usually, many rating rules contained in the initial program filing continue to apply years later, even if there have been rate and/or rule changes to other elements of the program made in subsequent filings.
7. Request that a representative from the regulated entity walk the examiner through the ROC document and be available to assist with any questions about the premium calculation.
8. Request the regulated entity furnish a separate ROC document in editable Excel or similar format for each sample policy being tested that shows all the rating steps in the proper sequence, including the rates and rating factors used at each step for all coverage features and the final policy premium. The final policy premium in the ROC must match the policy premium contained in the policy population dataset and must be supported by the filings. The examiner should request that the ROC include the underwriting attribute or characteristic from the sample file that supports the selection of the rating factors used and the source of those attributes.

Finally, assuming that the insurance score or credit score is accepted at face value, one of the more difficult aspects of the rate review is piecing together how a particular score is associated with one or more rating factors. Regulated entities often use coding systems in their rate filings that can make it difficult to follow the trail. The score derived from the model may be associated with a singular rating factor (i.e., one of many rating factors in the ROC used to determine the coverage premium), may be associated with one of many factors used to determine a tier rating factor (the tier rating factor is also typically a singular rating factor), or may be used as both a singular rating factor and as part of the tiering factor. Another difficult aspect of some rating plans is in understanding the construction of the tier rating factor, which may be a separate factor from the credit score factor. Some tiering plans include dozens of underwriting variables that are often combined in a number of matrices that may produce codes that are then associated with rating factors. The tier factor is usually the product of all the variable factors that are combined according to the filed tiering plan. The examiner is tasked with ensuring that the risk attributes of a particular policy are properly associated with the filed rating factors used to develop the premium. Usually, both the insurance score or credit score factor and the tier factor are applied against the coverage feature base premiums per vehicle, but may not be applied against all coverage features on the policy.

REGULATED ENTITIES OFTEN USE CODING SYSTEMS IN THEIR RATE FILINGS THAT CAN MAKE IT DIFFICULT TO FOLLOW THE TRAIL.

With consideration given to the topics raised in this article, any market conduct examination of a regulated entity's automobile rating plan should be grounded in a good understanding of what to expect when delving into the process of validating private passenger auto premiums charged to consumers. ■

About the Author:

Kent is employed as a senior manager with Risk & Regulatory Consulting, LLC where he coordinates, manages and leads a team providing market conduct examinations of regulated entities on behalf of state insurance departments. Kent has also led multiple regulatory filing consulting projects for a state insurance regulator and has performed internal audits of managing general agencies for an industry client. Before joining RRC, Kent served most recently as Chief Market Conduct Examiner for the New Hampshire Insurance Department.

⁴ During the July 15, 2019 NAIC (D) Committee Conference Call, the Committee adopted a "Revised Private Passenger Auto In Force Standardized Data Request" that will likely be accepted by the NAIC and added to the next version of the Handbook.

Letter from the President



Martha Long

Hello IRES!

I can't believe it's almost been almost year since the last CDS! In just a few short weeks I hope to see many of you in Spokane, WA. There is still time to register. The CDS Committee has done a great job putting together informative track sessions, wonderful food options and there is an abundance opportunity for fun and networking in Spokane.

I have received so much help and encouragement this year I can't possibly thank everyone. I do want to thank the past Presidents of IRES who have remained active and supportive. Their

knowledge and experience is a valuable resource and we are fortunate to have so many of them who continue to support our organization and its goals. I know they will continue to support and advise the next President as they have supported me.

I want to take an opportunity to thank our partners at VPG for supporting our organization and striving every day to improve their services to our members. The year wasn't flawless but I appreciate VPG's positive energy and willingness to think on their feet.

A big thanks to the Executive Committee: Ken Allen, Randy Helder, Leann Crow, Sam Binnum, Kallie Somme, Lisa Brandt, Pieter Williams, and Shelly Schuman. These individuals have provided help and guidance throughout the year. They have led their committees in the daily work of our organization, as well and moving us forward with new ideas and new technology.



Thank you to Holly Blanchard and all the State Chairs who met throughout the year to make sure our members are being heard and to make sure that individuals new to our organization have resources available to learn about we can offer them as new members.

My appreciation to the Board of Directors. You are a dedicated board who brings enthusiasm, great ideas and a willingness to step up and represent our members on the board. It takes commitment and time to help shape this organization so we can provide great learning opportunities as part of an industry that is constantly changing. Thank you for your efforts.

I would like to thank the Members because without our members there is no IRES. Be reminded that there are many volunteer opportunities available on committees, participation on Webinars and at CDS so if you are interested in being more involved please reach out to someone on the IRES Board or at VPG.

I want to leave you with some current IRES numbers to help put our organization in perspective:

- Total members: 720
- General Members: 624 (including 21 retired members)
- Sustaining Members: 96

Since CDS last year IRES has held 5 MCM courses resulting in 154 new MCM designees. We have 2 MCM courses on the calendar, one in Spokane and one in Baton Rouge. We celebrate 8 new CIE's and 20 new AIE's since CDS last year. The AMCM reboot is still in the works with outlines nearing completion.

IRES as an organization continues to work to enhance the efforts of insurance regulators by ensuring professionalism and integrity among the men and women who serve with state or federal insurance regulatory bodies. ■

Thank you all for a great year. See you in Spokane!



624

general members



96

sustaining members



720

total members

Navigating Coordination of Benefits

As health care costs increase and benefits are tightened by narrower networks, some consumers are looking for ways to increase their health coverage. One option is purchasing additional policies to have dual coverage by two health insurance plans. However, there are two separate premiums and two separate deductibles with dual health coverage. The process where a person covered under two health insurance plans may receive claims payouts and payment under both plans is commonly referred to a coordination of benefits (COB).

There are other many types of situations where COB makes sense and are beneficial for the member. This happens, for example, when a husband and wife both work for large employers and choose to have family coverage through both large group health plans at minimal or no cost to their family budget.

The topic for this article is the cumbersome process health insurers are currently following to ensure that every member does not have multiple plans and how claims are either being denied or delayed payment for COB verification.

All of the insurance types are subject to COB policies and procedures. The first step in the process starts with the provider encounter. Provider coding and billing is an important step in the health insurance claims process, but market conduct regulators cannot cite findings or violations for poor provider coding. The COB process can be further complicated if the provider does not properly bill the primary insurance carrier or possibly indicate a secondary insurance carrier when none exists. We must start our regulator review once the health insurance claim is received by the health insurance plan.

Regulators need to be sure to check the plan type when reviewing health insurance data, products, and policies. There are group plans called Administrative Service Organizations (ASO), which means the employer owns the plan and determines benefits. The Department of Labor monitors the ASO type plans. Review the group type, size and plans when conducting a review. Health insurers may often contaminate a state regulator's data universe and sample with simple mistakes. The other type of insurance is commercial insurance which is regulated by state and federal government agencies.

Let's review some examples of coordination of benefits to get a clearer picture.

Our first example is a working mother with partial custody of her 8-year-old, Johnny. Johnny is on the mother's health insurance plan and the ex-husband's plan in accordance with the divorce decree. When Johnny goes to the doctor, the primary health insurance will be determined by whichever parent has the earliest birthday, not the oldest parent. The later birthday parent will be the secondary health insurance plan. That's called coordination of benefits.

A second example involves an automobile accident. You hit a deer with your car, hurt your wrist, pulled several muscles in your back and need to go to a doctor. Some state auto insurance policies must include coverage for car-related injuries, called personal injury protection. In most cases your individual or group health insurance is the primary health plan. So your health plan will pay first, and if there



Heather Harley



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are expenses left over not covered by your plan, your auto insurance will pay those remaining bills. That's called coordination of benefits, too.

The majority of the marketplace is covered by a single health plan. Insurers in your state may be taking additional actions to ensure there are secondary insurance coverage and thereby limiting the claim risk. Some of the issue for consumers may start from the beginning of the claim process. Contract certificate language governing COB varies by state and type of health insurance coverage.

Even if you only have one health insurance plan, COB can create headaches for consumers. A few major insurers also like to check for coordination of benefit dual

coverage when claims are received. The insurer considers the health claim "unclean" or "missing information" and either closes the claim without payment or sends letters back to the insured.

I can tell you from personal experience how COB requirements can be very frustrating. I personally completed 5 separate COB forms when my teenage son had a seizure in October 2018. He was rushed to the hospital by ambulance, admitted for 3 days for testing, and was finally released with a follow up care plan. He was admitted to the hospital for 3 days for a total of \$22,000 of medical bills. He was covered under a health plan with a \$2,500 deductible and 80% coinsurance. A nationwide

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health insurer demanded a four page COB form to be completed before any benefits were payable. We started to receive demand notices from providers and had to make many phone calls and appeal grievances to resolve the COB matter. The provider and facility claim procedure codes did not reference an accident or injury covered by another type of plan such as auto personal injury protection or worker's compensation, however, my claims remained unpaid for over 120 days. When we called for claim status; the customer service response was always the same, "We need to verify coordination of benefits, ma'am." We had to submit the written COB verification four times to the health insurance plan.

Insurers should be able to reasonably determine if their claim risk is covered by another plan and take appropriate action. The insurer's claim data analytics should be carefully reviewed to ensure that "clean" claims are processed immediately and not caught up in unnecessary COB pending requirements for unreasonable delays. There are a few states that may monitor COB requirements, along with prompt pay reviews, but it can be confusing for regulators to determine that the actual delay was caused by a COB verification of single versus dual health insurance coverage. There are other reasons of possible delays so make sure you are reviewing prompt pay in a holistic approach in your next market regulation examination.



Here are a few regulator tips to determine if a prompt payment delay is being caused by COB verification.

- Determine if the situs or issuing health plan state has specific laws and/or regulations pertaining to COB. Check for specific state rules about primary and secondary coverage as well.
- Request a copy of the insurer's company policy for COB claim handling procedures. Look for policy language to determine if the COB form is required or if a verbal phone call from the member is sufficient to establish no other primary or secondary insurance coverage. Many plans require the written form instead of verbal recorded phone call, email, and/or member portal messages.
- Request all of the insurer's claim hold and/or suspend codes for COB based on the claim COB procedures. You may find the specific hold codes within the procedures or a reference to another policy within the Information Technology or data quality and forensics departments. Note: there may be difference codes for various products and plan types so use inclusive language.
- Add a secondary data analysis review to pending health claims over 60 to 90 days to check for COB suspend codes. Sample phone call recordings with claim delays over 100 days requesting status from members and/or providers.

These are just a few helpful suggestions to determine if COB is a possible violation or finding for your next examination. ■

About the Author:

Heather M. Harley, AMCM, FLMI, HIA, AIRC, ACIP, ACS, MHP, HCSA, DHP, HCAFA, LTCP, currently functions as Manager of Market Regulation. Ms. Harley oversees market conduct examinations, proposals, special projects, and has robust and continuous experience with reviewing health insurer compliance with applicable laws and regulations. Heather joined InsRis as an Examiner in 2009 and has worked on examinations and compliance projects for many different states. She has extensive and comprehensive ACA and mental health parity experience working in the state of Pennsylvania, Illinois, and has also been actively engaged on examinations in Florida, where she has managed ACA compliance reviews and specialized in health product lines including HMO/PPO group, individual, POS, Medicare supplement and specified disease, working in both industry and regulation. Through these experiences and her ongoing insurance training, Heather provides the team with a strong knowledge of health insurance company operations and ACA compliance. Prior to joining InsRis, Mrs. Harley worked for Guggenheim Life and Annuity Company where she served as Assistant Vice President of Administration and was responsible for mail operations, agency licensing, contracting, call center, and customer relations. Mrs. Harley also worked for CNO Financial Group (formerly known as Consecro) where she functioned as 2nd Vice President/Director of Compliance and performed regulatory compliance risk management, market conduct examination consent order remediation, civil and congressional investigative demands and internal audit remediation. She has provided initial and continuation strategy for legal projects from an executive management level for top risk areas. Mrs. Harley has significant knowledge and experience in the key functional activity areas of claims, premium, legal/compliance, new business, underwriting, sales/marketing, complaints/appeals/grievances and the specific business lines of property/ casualty, commercial, life, annuity (fixed and variable) as well as the following types of insurance companies: private, publicly traded and mutual legal reserve. She holds a Bachelor's degree in Business Administration from Indian Wesleyan University – Indianapolis.

Zoning In



Kathy Donovan

Northeast Zone

Maine

SP 321, effective Sept. 19, 2019, enacts discretionary clause provisions. Specifically, neither an individual nor a group health insurance policy, contract or certificate, including, but not limited to, a disability income insurance policy, contract or certificate, may contain "a provision purporting to reserve sole or absolute discretion to the insurer to interpret the terms of the contract, to provide standards of interpretation or review, to determine eligibility for benefits, to determine the amount of benefits or to resolve factual disputes." Additionally, an insurer may not enforce a provision in a policy, contract or certificate that was offered, executed, delivered or issued for delivery in Maine

and has been continued or renewed by an individual policyholder in Maine "that purports to reserve sole or absolute discretion to the insurer to interpret the terms of the contract, to provide standards of interpretation or review, to determine eligibility for benefits, to determine the amount of benefits or to resolve factual disputes."

New Jersey

Issued June 24, 2019, Bulletin 19-07 provides guidance to insurers that "issue accident and sickness insurance, disability, life insurance, or annuity contracts, where medical underwriting is permitted, as to the use of certain prescription drug information in those underwriting processes" and reminds insurers that New Jersey law provides that "no person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any policy of life insurance." The Department of Banking and Insurance advises insurers that "applicants should not be adversely evaluated based on the applicant having obtained prescription drugs for conditions that are not relevant to an applicant's health or actual risk."

Southeast Zone

Alabama

HB 283, effective Jan. 1, 2020, mandates that homeowners insurers "offer a fortified bronze roof endorsement to upgrade a non-fortified home, which is otherwise eligible for a fortified standard, to a fortified standard identified in Section 27-31D-2, when the insured incurs damage covered by the policy requiring the roof to be replaced." Additionally:

- The endorsement shall upgrade the non-fortified home consistent with the fortified requirements for the geographic area in which the non-fortified home is located.

- The endorsement offer shall be made at the time of writing a new policy on a non-fortified home and at the time of first renewal of an existing policy on a non-fortified home following the effective date of this section.
- Insurers shall file their endorsement form and accompanying rates for approval by the Department of Insurance at least 90 days before the effective date of these provisions.

Florida

OIR-19-03M, issued July 19, 2019, addresses current pharmacy benefit manager contract requirements. Under Florida law, a contract between a Pharmacy Benefit Manager (PBM) and an insurer or HMO must require that the PBM:

- Update the maximum allowable cost pricing information (MAC list) at least every seven calendar days, and
- Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

The OIR reminds insurers and HMOs of "their obligation to ensure that such contractual language is present in any contract entered into or renewed with a PBM on or after July 1, 2018, and that the PBM is complying with these required terms." various provisions

North Carolina

A Department of Insurance Memorandum dated June 17, 2019 provides guidance concerning motor vehicle repairs selection by claimants, specifically reminding insurers that in addition to the state prohibition against "steering" a consumer to a particular motor vehicle repair shop, there is also a requirement that a "policy covering damage to a motor vehicle shall allow the claimant to select the repair service or source for the repair of the damage." The Department further reminds insurers that "a company or agent cannot discourage in any way (such as suggesting that the repairs will be costlier, less timely, or of poor quality) a consumer from choosing a specific shop for repairs."

Midwest Zone

Iowa

Effective June 12, 2019, the Insurance Division adopted new provisions under 191-15.66 applicable to participating immediate and deferred income annuities including:

- Illustrations shall not assume any future improvement in the applicable dividend scale (or scales, if more than one dividend scale applies, such as for a flexible premium annuity);
- Illustrations shall reflect the equitable apportionment of dividends, whether performance meets, exceeds or falls short of expectations;

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- If the dividend scale is based on a portfolio rate method, the portfolio rate underlying the illustrated dividend scale shall not be assumed to increase;
- If the dividend scale is based on an investment cohort method, the illustrated dividend scale shall assume that reinvestment rates grade to long-term interest rates, subject to specific conditions, including disclosure requirements, further described in the adopted rule.

Michigan

Issued June 28, 2019, Bulletin No. 2019-11-INS addresses “Disputes Between No-Fault Automobile Insurers and Health Care Providers,” with specific reference to Public Acts 21 and 22, enacted on June 11, 2019 and the revised Section 3112 that now provides: “A health care provider listed in Section 3157 may make a claim and assert a direct cause of action against an insurer, or under the assigned claims plan under sections 3171 to 3175, to recover overdue benefits payable for charges for products, services, or accommodations provided to an injured person.” Additionally, Public Act 21 requires the implementation of reimbursement rate caps beginning July 1, 2021. However, until implementation of reimbursement rate caps occurs, “an insurance carrier need pay no more than a reasonable charge.” The Bulletin furthers adds “that a health care provider can charge no more than that”, as in a reasonable charge. This bulletin supersedes Bulletin 2018-13-INS, issued on June 6, 2018.

Nebraska

The “Children of Nebraska Hearing Aid Act” was enacted under LB 15. Effective Jan. 1, 2020, certain health insurance plans that are delivered, issued, renewed, extended, or modified will be required to provide coverage under this Act to each insured child. Mandated benefits and provisions include:

- Specified items and services must be covered for persons affected by a hearing impairment and must be covered on a continual basis, to the extent that benefits paid for such items and services during the immediately preceding 48-month period have not exceeded \$3,000.
- Coverage provided to insured children under this act must be subject to the same deductible, copayment, and coinsurance as similar covered items and services under the health insurance plan.
- Plan may not refuse or deny coverage, refuse to renew or reissue coverage, or terminate coverage for an individual with a hearing impairment who is less than 19 years of age, based on such hearing impairment.
- Plans will be entitled to a one-year exemption from this act’s requirements if, using a calculation method approved by the DOI, the cost of coverage would likely exceed one percent of all premiums collected under such plan for such plan year.

Western Zone

Arizona

SB 1087 mandates that motor vehicle liability policies issued or renewed beginning on July 1, 2020, except for a policy that is issued to a person who has a valid certificate of self-insurance or partial self-insurance, must include the following mandatory minimum limits:

- \$25,000 because of bodily injury to or death of one person in any one accident;
- Subject to the limit for one person, \$50,000 because of bodily injury to or death of two or more persons in any one accident;
- \$15,000 because of injury to or destruction of property of others in any one accident.
- These minimum limits represent increases from the current amounts of \$15,000, \$30,000 and \$10,000 for each of these coverages.

California

The California Department of Insurance (CDI) issued a Notice dated June 20, 2019 that addresses “Insurer Underwriting Practices for Truvada/PrEP Users” and advises “all insurers and fraternal benefit societies licensed to sell Life, Disability Income or Long-Term Care products in California of their obligation to comply with California law when underwriting Truvada/PrEP users.” The Notice further requests insurers and fraternal benefit societies to review their underwriting guidelines and practices with regard to Truvada/PrEP users to ensure compliance with California law. CDI indicates that it “will continue to review insurers’ and fraternal benefit societies’ underwriting guidelines and practices with regard to Truvada/PrEP users for compliance with California law through its market conduct examination authority.”

Oregon

SB 796, effective Jan. 1, 2020, mandates that an insurer offering a policy or certificate of life insurance, health insurance or long-term care insurance, as defined in ORS 743.652, may not, based solely on the status of an applicant for insurance or an insured as a living donor or a potential donor of a body part, organ or tissue:

- Discriminate in the application of its underwriting standards or rates;
- Decline to provide coverage or limit coverage; or
- Prohibit an applicant for insurance or an insured from donating a body part, organ or tissue as a condition of receiving or continuing to receive coverage.

Washington

The “Balance Billing Protection Act” (HB 1065), effective Jan. 1, 2020, enacts multiple provisions and requirements, including the following issues:

- Balance billing prohibitions;
- Payment for services processes;
- Dispute resolution/arbitration;
- Consumer cost-sharing obligations;
- DOI annual reports summarizing the dispute resolution information provided by arbitrators;
- DOI standard template language for notifying consumers of the circumstances under which they may or may not be balance billed; and
- Required health carriers, health providers, and health facilities website postings.
- The Office of the Insurance Commissioner (OIC) has also started the rule-making process for implementation of various aspects of this Act. ■

About the Author:

Kathy Donovan is Senior Compliance Counsel, Insurance with Wolters Kluwer Financial Services. Kathy has more than two decades of experience in insurance compliance. Her expert commentary on legal and regulatory issues affecting the insurance industry is widely published and she is a regular presenter at various industry events.



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In Memoriam

Michael Hessler

It is with heavy hearts that we inform you of the passing of a longtime friend, colleague, and fellow IRES member, Michael Hessler.

Mike, a former Deputy Director at Illinois Department of Insurance, a founding member of IRES, a long time IRES Board member, the 2006 CDS co-chair, and the 2004 recipient of The Paul L. DeAngelo Memorial Teaching Award. A Chicago Cubs and Notre Dame football fan that always had a fishing story to tell, Mike had a smile for everyone. He was often described as a good friend, straight shooter, teacher, mentor and an incredible boss.

Mike was highly regarded by everyone who ever had the opportunity work with him and will be profoundly missed by those whose lives he touched. ■



Michael Hessler

Market Regulation and Consumer Affairs (D) Committee

This year has proven to be very busy for the Market Regulation and Consumer Affairs (D) Committee. Most of the activities have fallen within the existing charges of the Committee; however, new charges have been added in 2019 and there is the potential for yet even more charges to be assigned to the Committee in 2019.

Market Conduct Annual Statement

As part of the NAIC's State Ahead Strategic Plan, the redesigned Market Conduct Annual Statement (MCAS) application was released to production in March for the collection of MCAS data in 2019. Industry filers experienced an improved user interface with improved filing upload performance. On the technical side, the new application adjusted for peak usage and has positioned the NAIC to provide the necessary support for the collection of data for additional lines of authority or changes to existing MCAS lines of authority. For 2019, the new system supported the new collection of lender-placed auto and homeowners insurance. States participating in the collection of MCAS data will begin collecting Disability Income MCAS data in 2020. Another important change for MCAS includes the Market Regulation and Consumer Affairs (D) Committee's adoption of the new private flood blank. This new blank includes the collection of data for claims, underwriting, lawsuits, and complaints. Assuming the NAIC Executive Committee and Plenary adopt the blank, the NAIC will support the states' collection of 2020 flood data in 2021.

Short-Term Limited Duration Data Call Template

The Market Regulation and Consumer Affairs (D) Committee adopted the Short-Term Limited Duration Data Call template on July 15. This data call was developed to assist states in collecting information regarding the number of covered lives under individual plans and group plans, the number of times the contract is renewable, and the number of claims submitted, paid, and denied. The data call will also identify if a plan is marketed through an association, the name of the association, and situs of the association plan. It is important to note that the data call is not part of MCAS and was adopted as a template for voluntary state issuance. At the same time, NAIC staff is now working with the Market Analysis Procedures (D) Working Group to identify the level of state interest and the level of technical support needed from the NAIC to facilitate a collaborative data call among multiple states. Depending upon the level of interest, it is possible the data call could eventually become part of the Health MCAS blank.

Standardized Data Calls

The Market Conduct Examination Standards (D) Working Group has been extremely busy and recently finalized an insurance data security pre-breach checklist for inclusion in the reference documents of the NAIC Market Regulation Handbook and an insurance data security post-breach checklist for inclusion in

the general examination standards of the Handbook. In addition to its work on the data security checklist, the Working Group completed the following standardized data calls: (1) Revised Private Passenger Auto In Force Standardized Data Request; (2) Revised Private Passenger Auto Claims Standardized Data Request; (3) Revised Personal Lines Declinations Standardized Data Request; (4) Revised Homeowners In Force Standardized Data Request; and (5) Revised Homeowners Claims Standardized Data Request.



Tim Mullen

The Market Regulation and Consumer Affairs adopted the data security checklist and the data calls during its July 15th conference call.

Voluntary Market Regulation Certification Program

While there has been little discussion about the Voluntary Market Regulation Certification Program, it is important to remember the following 18 jurisdictions participated in the pilot program: Alaska, Arkansas, Indiana, Iowa, Kansas, Missouri, Montana, Nebraska, New Hampshire, New Jersey, Oklahoma, Oregon, Texas, Vermont, Washington, West Virginia, Wisconsin, and Wyoming. Again, the pilot jurisdictions conducted 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. The Market Regulation Certification (D) Working Group, chaired by John Haworth (WA), will present its recommendations from the pilot program to the Market Regulation and Consumer Affairs (D) Committee. The Committee will then decide what, if any, additional action will be recommended to the NAIC Executive Committee.

Best Practices for Consumer Disclosures

During the NAIC Spring National Meeting, the Market Regulation and Consumer Affairs (D) Committee was assigned a new charge to review the Best Practices and Guidelines for Consumer Information Disclosures, which the NAIC adopted in 2012. This charge was given to the Market Regulation and Consumer Affairs (D) Committee in response to a request from the NAIC Consumer Representatives for the NAIC to ensure there is a consistent approach to the development of effective consumer disclosures across NAIC committees, task forces and working groups. The Market Regulation and Consumer Affairs (D) Committee is soliciting comments on potential revisions to the Best Practices and Guidelines for Consumer Information Disclosures and will begin reviewing these comments at the NAIC Summer National Meeting.

Webinar Information

Keep an eye out for updates with details in your email and on IRES website.

SHORT-TERM, LIMITED DURATION INSURANCE – CONTINUED FROM PAGE 12

Advisory Organization Examination Oversight

The long-standing charges for the oversight of advisory organizations under the Property and Casualty (C) Committee have been moved to the Market Regulation and Consumer Affairs (D) Committee. The change in reporting was made because the Market Regulation and Consumer Affairs (D) Committee has responsibility for the development of market conduct examination standards and the monitoring of multi-jurisdictional market conduct activities. The Advisory Organization Examination Oversight (D) Working Group is charged with the following activities: (1) revise the protocols, as necessary, for the examination of national or multistate advisory organizations; (2) monitor the data reporting and data-collection processes of advisory organizations appropriate measures to ensure data quality; and (3) assist with and coordinate multistate examinations of advisory organizations.

In addition to the change in reporting structure, the Advisory Organization Examination Oversight (D) Working and Market Regulation and Consumer Affairs (D) Committee are considering the following charge requested from Birny Birnbaum (Center for Economic Justice): Ensure that organizations that engage in advisory organization activities are properly licensed and subject to appropriate regulatory oversight. This charge is being considered due to the increase in organizations collecting data and providing pricing, underwriting, and claims settlement tools to insurers. There are concerns that many of these organizations may not be familiar with insurance regulation and may be acting as advisory organizations without proper licensure and regulatory oversight. The Market Regulation and Consumer Affairs (D) Committee will likely make a final decision on the addition of this charge during the NAIC Summer National Meeting.

Privacy Protection Standards

The NAIC has included data, innovation and cyber among its top priorities this year. In addition to the NAIC making these issues a top priority in 2019, action by the EU and some states are creating pressure for national privacy legislation. Consumers have also raised specific concerns with state insurance regulators about consumer access and understanding of data being used by insurance companies. In response to these concerns, the NAIC may evaluate state insurance privacy protections and NAIC Models for potential revision. If this evaluation proceeds, NAIC models for review will likely include the Insurance Information and Privacy Protection Model and the Privacy of Consumer Financial and Health Information Model Regulation. There will be more discussion on potential next steps and more definitive direction at the NAIC Summer National Meeting. These discussions will likely begin within Innovation and Technology (EX) Task Force but may be referred to the Market Regulation and Consumer Affairs (D) Committee.

Involvement in 2019 Activities

As always, I invite and encourage regulators, consumer representatives, and industry representatives to become involved in NAIC activities. Please review the NAIC weblink for the Market Regulation and Consumer Affairs (D) Committee, its three task forces and working groups for updates (https://www.naic.org/cmte_d.htm). ■

About the Author:

Tim Mullen, JD, MBA, CPCU, CIE, MCM 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 of the Kansas City CPCU Chapter.

Education Corner

IMPORTANT CE DEADLINES

The National IRES Continuing Education (NICE) Program deadlines are right around the corner.

REMEMBER, THE DEADLINE TO:

Complete your continuing education | *August 31, 2019*
Request an extension to complete CE | *September 1, 2019*
Submit your continuing education credits | *October 1, 2019*



Jo LeDuc

The NICE Program requires that all members holding an AIE®, CIE®, and/or CICS® earn and report at least 15 hours of qualifying continuing education (CE) credit each year. Items submitted for credit must be completed during the current compliance period September 1, 2018 to August 31, 2019.

If you are a few credits short this year, you can '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 'reach back' CE credits for this reporting period. IRES does not automatically apply excess hours from the prior year to the current reporting period.

If you are unable to complete your CE this year, one-year extensions to complete and report your CE are available. Extensions are not automatic and must be requested prior to September 1, 2019.

To request an extension, visit the IRES website, log-in to your accounts and complete the Extension Request Form (<http://go-ires.site-ym.com/?page=ExtensionRequest>).

REPORT CE CREDITS

To submit CE credit, visit the IRES website and:

1. Log into your IRES account.
2. If you don't automatically land on the page that allows you to your profile, click on your name in the upper right corner. Then click Account + Settings.
3. Click on the Professional Development tab on the navigation rail on the left.
4. While on the Journal Entries tab, click on the +Add Entry button.
5. Complete the CE Submission form.
6. Attach a PDF of your certificate of attendance (or other proof of completion)
7. Click Submit.

EDUCATION

COMPLETE THE CE SUBMISSION FORM

Instructions on how to complete the new CE submission form appear below. For your convenience, a link to these instructions also appears in the Professional Development section of your profile.

IS THIS ENTRY FOR A CERTIFICATE OR PROGRAM?

This should be Yes

CERTIFICATION/PROGRAM: Use the drop-down menu and select NICE Program Requirement

CREDIT TYPE: Select the appropriate Credit Type from the drop-down box based on the type of continuing education you are reporting.

NOTE: AMCM Class, IRES Committee Service, IRES Webinar, and MCM Program credit types should not be entered. Upon successful completion of these items, IRES automatically

ENTRY DATE: Change the entry date to the date you completed the continuing education credit.

DESCRIPTION FIELD: Name of the item for which the credit applies. If possible, include the name of the sponsoring entity.

For example:

- NAIC Accreditation Update Webinar
- LOMA 290 - Insurance Company Operations
- CPCU 520 - Insurance Operations
- CIPR Webinar - The Use of Drones in Insurance

CREDITS: Enter the number of continuing education credits earned.

CREDITS EXPIRE: Except for Reachback credits, credits expire on the last day of the reporting period (August 31st) under which they were earned. Reachback credits would be excess credit earned in the immediate prior period for which you seek credit for in the current period.

For example, if the current reporting year is September 1, 2018 - August 31, 2019:

- Credits earned on September 10, 2018 would expire August 31, 2019
- Credits earned on July 2, 2019 would expire on August 31, 2019
- Reachback credits earned on May 15, 2018 would expire August 31, 2019

SCORE (%): Leave this field blank.

ACTIVITY CODE: Leave this field blank.

ATTACHMENTS: Attach a PDF version of your certificate of attendance (or other proof of completion). You can also attach a copy of the course outline or agenda if needed to support that the course qualifies for CE under the NICE Program.

CHECK THE NUMBER OF CREDITS YOU'VE EARNED

To see how many CE credits have been accepted for the current compliance period, click on the Certifications/Programs tab in the Professional Development section. This tab displays the designations you have earned. In addition, once you have made at least one CE submission for the current reporting period, you will see an area named NICE Program Requirement. This area details how many CE credits have been accepted for each type of credit under the NICE program. Once you have reached a total of 15 accepted CE credits, the status will change from Incomplete to Complete.

SEE WHAT COURSES YOU'VE ALREADY REPORTED

Individual CE submissions appear on the Journal Entries tab of the Professional Development section. Using the filter options at the top of the list, you can easily find what has been reported, accepted and/or what is still pending.

PRINT YOUR CE TRANSCRIPT

You can print your CE transcript using the print Transcript button on the Journal Entries tab of the Professional Development section of your profile. You can either print your entire transcript or just a portion of it by applying filters and using the Print Filtered Entries button. You can also email yourself a copy of your CE transcript or download your entries to a comma separated file.

For full details on the NICE program, see the NICE Program Manual available online at <https://go-ires.org/designation-programs/continuing-education-program-nice/>.

IRES Member of the Month

This Issue: Nancy S. Thomas

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

I work for Regulatory Insurance Services, Inc. performing Financial Analysis duties for the Captive division of the Delaware Department of Insurance.

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

I have been an IRES member almost from the inception of the organization back in 1988. I joined IRES, because I wanted to enhance my career by learning more about market regulation and other branches of insurance. It also gave me an opportunity to meet many other wonderful people in the insurance regulatory field.

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

My first role with IRES began in 1992 as Vice Chair of the Financial Section where I worked with the late Frank Seidel for many years getting speakers for the CDS. Soon after, I was asked to run for the Board of Directors where I served for over 22 years. During that time, I was also Vice Chair of the Finance Committee and now I serve as the chair of the Site Sub Committee. As part of my duties I currently visit and assist in the selection of future sites for IRES, and now in VPG I have a partner and collaborator in this task. I take a great pride and responsibility in that role, as I see every CDS's beginning with a perfect location that can best accommodate our members. I'm proud of the venues where our CDSs were and will be held! This year, our CDS is being held at the Davenport Grand, which is an outstanding property, and part of the Marriott Signature collection.



Nancy S. Thomas

How many IRES CDSs' have you attended and do you have a favorite one?

My first IRES was in Cambridge, near Boston back in 1993 and since that time I probably have attended at least 20 – 25 IRES CDS. I have a few favorite ones, such as Scottsdale Arizona at the Hyatt Gainey Ranch in 2003, Disney World in 1994 and CDS 2018 in San Antonio. The CDS programs are great each and every year, so my memories of CDS rest largely on the city and hotel where we had it.

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

My favorite session is when IRES brings in a motivational speaker. It's nice to get a break from the educational aspect of a CDS and listen to someone who is very successful in their own field. One of my favorite speakers that spoke at our CDS was Terry Bowden, the former Auburn football coach. I remember him being very entertaining, while at the same time sharing his tips for success and leadership.

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

I have had a very satisfying career in financial regulation both as a Financial Examiner and now as an Analyst. My goal is to keep working for as long as I enjoy it, and to learn something new each day.

When you aren't working what are your hobbies?

I am a huge football fan, and a Baltimore Ravens season ticket holder. I love fantasy football and last year I was the winner of 3 leagues. I guess my financial analysis skills transition well. I also love to watch college softball because my husband and I were very involved with my daughter playing in rec council and varsity so many years. Apart from sports I really enjoy taking walks and swimming when the weather is warm. I also like taking cruises with my family and best friends and getting to see new places.

What is your biggest personal or professional accomplishment?

On a personal level, my greatest personal accomplishment is my family, namely my husband Tim, whom I have been married to for 38 years and my daughter Lauren, who is 22 and a senior at the University of Maryland, College Park. By the way, she loves coming to IRES with me and I will be bringing her again this year. Professionally, my one unique accomplishment is that I was the first person to ever be elected and serve on both the IRES and SOFE boards, both for at least 20 years. With SOFE, I also served on the Executive Committee as part of my tenure. I would like to think that my ideas and contributions have made a difference in both organizations. Lastly, receiving the President's Award last year from IRES was a huge surprise and it is a moment that I will always treasure. It is always nice to be recognized by your colleagues. ■

Get to Know Your State Chair

This Issue: Megan Keck, Nebraska

Behind the scenes of IRES, your state chairs are hard at work creating new opportunities and options for our members. To introduce you to these unsung heroes, we will feature a state chair in each addition of the Regulator. This month, our featured state chair is Megan Keck, Market Conduct Examiner and State Chair from Nebraska.

Tell us about yourself.

For six years, I have been a Market Conduct Examiner with the State of Nebraska. My insurance career started as a property-casualty producer, followed by commercial lines underwriting. I have to say, I enjoy regulatory work the best; it never gets boring! IRES has helped me gain knowledge and confidence as an examiner. This year, I am proud to say I have earned the CIE designation.



Megan Keck

What are your thoughts on becoming an IRES member?

Joining IRES is part of getting started as a new examiner. It's the best way to get on a career path toward being a qualified insurance regulatory professional.

What made you get involved as a State Chair?

I became involved as a state chair in order to add an extra layer of communication with IRES and the Nebraska members. I especially want to call attention to the webinars being offered by IRES so we can take advantage of the educational opportunities and the CE credits as a group. By tuning in to the monthly state chair meetings, I can keep abreast of issues and ideas the other states are sharing.

What do you think IRES should consider ensuring that they always are a great organization for Regulators and Industry members?

Right along with the insurance industry, regulatory work is always changing and evolving. We need IRES to continue to be the forum for sharing knowledge and ideas in order to keep up with the continuous changes. What should not change, is the commitment the IRES organization has made to uphold high standards of professionalism, education and ethics. ■

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Content submissions: go-ires.org/news-more/ires-newsletter/submit-content-regulator

Editorial staff: info@go-ires.org

Advertising: info@go-ires.org

Business office: info@go-ires.org

Editorial Staff

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Van Petten Group, Design & Layout Editor

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Martha Long, CIE, MCM

Heather Harley, AMCM, FLMI, HIA, AIRC, ACIP, ACS, MHP, HCSA, DHP, HCAFA, LTCF

Tim Mullen, JD, MBA, CPCU, CIE, MCM

Jo LeDuc, CIE, MCM, CPCU, AIRC, AIC, API, AIDA

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Lori Ruggiero, CIE, MCM, Unaffiliated

Shelly Schuman, AIE, AMCM, CICS, Unaffiliated

Kallie Somme, MCM, Louisiana

Lindsay Swartz, MBA, Unaffiliated

Pieter Williams, MCM, Unaffiliated

SUMMER 2019

Editor's Corner



Stephanie Duchene

It is hot hot hot in most places where this Summer Issue of The Regulator is being read. I hope you are staying cool as you eagerly anticipate the 2019 Career Development Seminar (CDS) coming up August 18-21 in Spokane Washington. I look forward to seeing you all there!

In this issue of The Regulator we have a wonderful look into two very complicated issues – private passenger auto rating and coordination of benefits under health plans. Thank you to Kent Dover and Heather Harley for providing their insights into these tough to tackle topics. We also enjoy getting to know this issue's Featured Member, Nancy Thomas, of Regulatory Insurance Services, Inc., and our featured State Chair, Megan Keck, Market Conduct Examiner with the State of Nebraska. Tim Mullen provides us with an update on what is happening at the NAIC D Committee and, as always, Kathy Donovan keeps us Zoned In on changing laws and regulations.

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®! ■



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