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The California Consumer Privacy Act and the Insurance Industry:

Key Take-Aways for Insurers and Insurance Regulators

One of the greatest legal and compliance risks facing the insurance industry today is the ever-evolving landscape of privacy and data security laws. The California Consumer Privacy Act ("CCPA") is widely regarded as the most sweeping privacy law in the United States and will impact how insurers collect, store, sell and

process the personal information of California consumers. Other states are likely to soon follow suit — there are currently at least eleven other states with pending privacy legislation that incorporate CCPA-like concepts and requirements.

Herein we examine the history of the CCPA, its key provisions, its current legislative status (let's just say, "it's complicated") and practical takeaways for insurers and insurance regulators. Spoiler Alert: Insurers should not be delaying compliance efforts. Recent experience with the General Data Protection Regulation ("GDPR") of the European Union ("EU") has demonstrated that it takes time and forethought to prepare for compliance with broad changes to privacy regulation. Despite the remaining uncertainties in the law, insurers should be ramping up for CCPA compliance now. Likewise, state insurance regulators should take note as compliance with state privacy regimes may end up within their purview.

History of the CCPA

In 2017, California privacy advocates, responding to the Cambridge Analytica scandal and the EU's GDPR, introduced a ballot initiative called "The Consumer Right to Privacy Act of 2018." Given the ballot measure's sweeping reforms and the challenge of amending laws passed in California through direct ballot initiatives, the California legislature agreed to pass very similar legislation in exchange for the ballot initiative's withdrawal. The CCPA was passed unanimously on the last day to withdraw a ballot measure and signed by the Governor the same day. Almost immediately the legislation, which was drafted and passed in haste, drew criticism from both the business community and the California Attorney General. The California legislature is working to address criticisms this legislative session, in advance of the law's January 1, 2020 effective date.

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Key Elements of the CCPA

To whom and what does it apply to?

The CCPA applies to “businesses” that “collect, or determine the purposes and means of processing,” the “personal information” of a California “consumer.”

Subject “businesses” include any legal entity that is organized or operated for the profit or financial benefit of its shareholders or owners that meets one of the below thresholds, (Cal. Civ. Code §1798.140(c)(1)), or who controls or is controlled by a business meeting this definition and that shares common branding with the business. (Cal. Civ. Code §1798.140(c)(2).)

- 1. Gross revenue threshold.** Annual gross revenue in excess of \$25 million;
- 2. Collection threshold.** Annually buys, receives, sells, or shares the personal information of 50,000 or more consumers, households or devices; or
- 3. Sales threshold.** Derives 50% or more of annual revenues from selling consumer personal information.

A “consumer” is any natural person who is a California resident. (Cal. Civ. Code §1798.140(g).) As currently drafted, this includes California resident employees. Insurers that are used to viewing “consumers” through the lens of the Gramm-Leach-Bliley Act (“GLBA”) and the Insurance Information and Privacy Protection Act (“IIPPA”) will note that an individual does not need to seek or obtain a product or service from the business, or enter into a transaction with the business, to qualify as a consumer under the CCPA.

One of the greatest legal and compliance risks facing the insurance industry today is the ever-evolving landscape of privacy and data security laws.

Personal information under the CCPA, as currently drafted, is much broader than under other privacy laws. Under the CCPA, personal information includes information that “identifies, relates to, describes, is capable of being associated with, or could reasonably be linked directly or indirectly, with a particular consumer or household,” (Cal. Civ. Code §1798.140(g)), including but not limited to:

- Identifiers such as real name, alias, postal address, unique personal identifier, online identifier Internet Protocol address, email address, account name, social security number, driver’s license number, passport number, or “other similar identifiers”;
- Any categories of personal information already described under California law;
- Characteristics of protected classifications under California or federal law (e.g., race, religion, sexual orientation, gender identity, gender expression, age, etc.);
- Commercial information, including records of personal property, products or services purchased, obtained, or considered, or other purchasing or consuming histories or tendencies;
- Biometric information;
- “Internet or other electronic network activity information,” including, but not limited to, “browsing history, search history, and information regarding a consumer’s interaction with an Internet Web site, application, or advertisement”;
- Geolocation data;
- Audio, electronic, visual, thermal, olfactory, or similar information;
- Professional or employment-related information;
- Education information (as defined in the Family Education Rights and Privacy Act); and
- “Inferences drawn from any of the information identified” above “to create a profile about a consumer reflecting the consumer’s preferences, characteristics, psychological trends, preferences, predispositions, behavior, attitudes, intelligence, abilities, and aptitudes.”

What does it require?

The CCPA creates a series of consumer rights that come with corresponding business obligations.

Right to Know. The CCPA gives consumers the right to request the categories and specific pieces of personal information collected, sold or disclosed. (Cal. Civ. Code §1798.100(a)(c).) Correspondingly, a business must: (1) at or before the point of collection, inform consumers about the categories of personal information collected and purposes of use; (Cal. Civ. Code §1798.100(b)); (2) make methods available for consumers to submit a request for personal information; (Cal. Civ. Code §1798.130(1)); (3) in response to a consumer request, disclose and deliver the personal information “free of charge” within 45 days. (Cal. Civ. Code §1798.130(2).)

Right to Opt-Out. The CCPA gives consumers the right to opt-out of a sale of their personal information to a third party. (Cal. Civ. Code §1798.120(a).) Correspondingly, a business must: (1) provide a clear link on its homepage and in its privacy policy titled “Do Not Sell My Personal Information” that sends the consumer to a website to opt-out of sale of their personal information; (Cal. Civ. Code §1798.135(a)(1)); (2) respect the decision to opt-out for at least 12 months before requesting that the consumer authorize the sale of personal information again; (Cal. Civ. Code

§1798.135(a)(4);) (3) ensure all individuals responsible for handling consumer inquiries about the business's privacy practices be informed of the right to opt-out and how to direct consumers to exercise the right. (Cal. Civ. Code §1798.135(a)(3).)

Right to Delete. The CCPA gives consumers the right to request that a business delete personal information it has collected about the consumer. (Cal. Civ. Code §1798.105(a)). Correspondingly, businesses must: (1) disclose the right to delete on its website and in its privacy policy; (Cal. Civ. Code §1798.105(b);) (2) subject to applicable exceptions, delete the consumer's personal information from its records and direct any service provider to delete the consumer's personal information from their records. (Cal. Civ. Code §1798.105(d).)

The CCPA also prohibits businesses from discriminating against any consumer for exercising their rights under the new law, including denying a consumer goods or services, charging a different price for a good or service, or providing a lower quality of goods or services. (Cal. Civ. Code §1798.125(a)).

Exemptions

The CCPA has some notable exemptions that impact the insurance industry, including:

Health information. The CCPA exempts "medical information" governed by the Confidentiality of Medical Information Act and "protected health information" collected by a covered entity or business associate under the Health Insurance Portability and Accountability Act ("HIPAA"). It also exempts health care providers and covered entities governed by HIPAA, to the extent the provider or covered entity maintains patient information in the same manner as medical information/protected health information. (Cal. Civ. Code §1798.145(c).)

GLBA Exemption. The CCPA exempts personal information collected, processed, sold, or disclosed pursuant to the federal GLBA and implementing regulations. This exemption does not apply to the provisions granting consumers a private right of action. (Cal. Civ. Code §1798.145(e).)

Driver's Protection Act. The CCPA exempts personal information collected, processed, sold or disclosed pursuant to the Driver's Privacy Protection Act. This exemption does not apply to the provisions granting consumers a private right of action. (Cal. Civ. Code §1798.145(f).)

Insurers should note that these exemptions are only partial. Despite being entities subject to GLBA, insurers remain subject to the CCPA if they engage in information collection, processing, and sale activities outside of the GLBA, which they almost certainly do. The CCPA defines personal information and consumer much more broadly than the GLBA. For example, insurers that are tracking web page visitors, IP addresses, browsing history and/or collecting geolocation data, to name just a few, need to analyze the CCPA's requirements.

Importantly, the GLBA exemption does not apply to the private right of action provided under the CCPA. The private right of action allows consumers to seek statutory damages if the consumer's information "is subject to an unauthorized access, exfiltration, theft, or disclosure as a result of the business's

violation of the duty to implement and maintain reasonable security procedures and practices." (Cal. Civ. Code §1798.150.) Accordingly, despite exemptions, insurers are still subject under the CCPA to potentially significant damages if they experience a data breach.

Proposed Amendments

California lawmakers began amending the CCPA almost immediately after its passage. As it currently stands there are over thirty proposed amendments making their way through the California legislature. These amendments include revisions and clarifications to the definition of personal information, for example, Assembly Bill 25 excludes information collected in the course of employment. Senate Bill 561 expands the consumer private right of action beyond simply data breaches to violations of the CCPA and removes the ability for violators to "cure" before the Attorney General can hold them accountable through an enforcement action.

One amendment, Assembly Bill 981 ("AB 981"), is particularly relevant to the insurance industry. The amendment would exempt insurance companies, agents and support organizations that are subject to the IIPPA from the CCPA, except for the limited private right of action for data breaches or for any business activity not subject to IIPPA. However, AB 981 would incorporate specific CCPA concepts into the IIPPA, including mirroring CCPA definitions for personal information, granting a limited "right to know," "right to opt-out" and "right to delete," and requiring insurers to provide certain disclosures and privacy notices. Importantly, the bill seeks to retain the California Insurance Commissioner as the single enforcer/regulator for any privacy related violations by insurers.

AB 981 is supported by a coalition of insurance companies and brokers and opposed by consumer groups such as Consumer Watchdog and Californians for Consumer Privacy, the group which originally backed the ballot initiative that led to the CCPA. Advocates contend that the CCPA will impose overlapping privacy protection regimes on the insurance industry, create regulatory conflicts and duplicative and confusing notices and disclosures, creating uncertainty for consumers. Opponents contend that efforts to incorporate CCPA-like protections into IIPPA fall short, there is no need for an exemption for an entire industry when the CCPA itself could be amended to address any conflicts, and insurers are accustomed to following multiple statutory schemes. The bill has passed in the Assembly Insurance Committee and the Assembly Privacy and Consumer Protection Committee and will next be considered in the Senate.

Effective Date/Enforcement

The CCPA goes into effect on January 1, 2020. However, the "drop dead" date on compliance remains a moving target. Enforcement actions by the California Attorney General will be barred until six months after the publication of the final regulations (which are yet unpublished) or July 1, 2020, whichever is earlier. As currently drafted, the CCPA will be primarily enforced by the Attorney General with only a limited private right of action for data breaches of non-encrypted/non-redacted information resulting from a business's failure to implement reasonable security procedures and practices. (Cal. Civ Code 1798.150(a).)

As noted above, amendments are currently pending to expand the private right of action and eliminate businesses' ability to cure violations identified by the Attorney General.

Key Take-Aways for Insurers

Notwithstanding AB 981, and despite the remaining uncertainties, the core elements of the CCPA are unlikely to change and will impact the insurance industry. Insurers that wait for the law to be fully amended to begin compliance efforts may find themselves scrambling to meet deadlines, particularly if an expanded right of private action goes into effect on January 1, 2020. There are concrete steps that insurers can take now to prepare themselves for CCPA compliance that can be refined as the law takes its final form.

- **Perform Data Classification/Mapping for CCPA Expanded Definition of Personal Information.** Insurers will need to survey systems and processes considering the CCPA's expanded definition of what information is considered "personal" to determine what information they collect, how it is used and what may or may not be subject to exemption.
- **Update Privacy Policies & Notices.** The CCPA requires transparency regarding the rights conferred under it and about the categories of personal information collected and how they are used.
- **Determine whether you are selling (or disclosing "for money or other valuable consideration") personal information, and, if so build opt-in/opt-out functions and procedures.** The CCPA allows consumers to opt-out of the sale of their personal information. Insurers will need to provide a function on their website to allow for this and develop procedures for handling opt-out requests.
- **Identify Third Parties and Update/Supplement Contracts.** The CCPA allows businesses to share personal information with service providers (a defined term) without it being considered a sale (from which a consumer could opt-out). However, to qualify as a service provider the written agreement between the parties must contain certain provisions. Insurers will need to analyze the data flow in their third party relationships and amend written agreements accordingly.
- **Review Incident Response Plan.** The CCPA includes a private right of action in the event of a data breach but individuals must first notify the business of the alleged violation and provide 30 days to cure (unclear how a data breach can be "cured"). Proposed amendments are likely to amend the private right of action; however, insurers may wish to revisit their incident response plan to ensure it emphasizes rapid detection, containment and mitigation.
- **Develop Policies and Procedures for Governance Program.** The new information rights will necessitate new, or changes to existing, internal privacy programs. Insurers should consider designating a role with responsibility for CCPA compliance and oversight. Insurers will need to have processes in place to receive and track consumer requests regarding personal information. Insurers may wish to consider workforce training, particularly for workers that will be handling individual requests.

Key Take-Aways for Regulators

As currently written, the California Attorney General remains the primary enforcer of the CCPA. However, multiple pending amendments to the CCPA are designed to change this, including AB 981, which would make the California Insurance Commissioner the primary enforcer of CCPA-like requirements with respect to insurance institutions. As other states follow in California's footsteps insurance regulators may find themselves at the forefront of privacy protection. ■

About the Author:

Stephanie Duchene is a partner in Mayer Brown's Los Angeles office and a member of the Insurance group. She focuses her practice on representing insurance companies, producers and other insurance licensees and insurance-related service providers in complex and sensitive regulatory matters, including negotiating and resolving significant single and multi-state examinations and investigations, counseling clients on compliance with licensing, claims handling, marketing and advertising rules, and advising clients on the development of new insurance products from initial concept through regulatory approval and into the market. She advises clients on all lines of insurance, including accident, life and health, property and casualty, as well as surplus and excess lines. Additionally, she regularly counsels insurtech companies, traditional carriers and non-insurance entities on the intersection of insurance law and innovation in the industry.



Letter from the President



Martha Long

Hello IRES!

It seems like a few short months since IRES members converged on San Antonio, Texas. The year has flown by and in August we will be in Spokane, Washington, the City of Choices. The Tracks promise to be exciting and informative. With an A list of instructors some who familiar faces and some instructors who are new to CDS.

Here at IRES we volunteer our time to the organization in order 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. One way we do that is through education opportunities for Regulators and Compliance professionals.

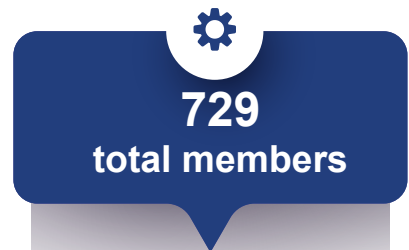
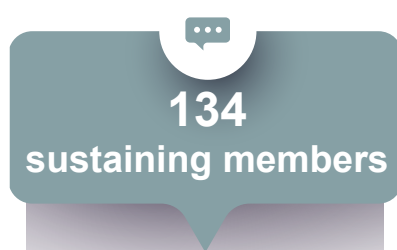
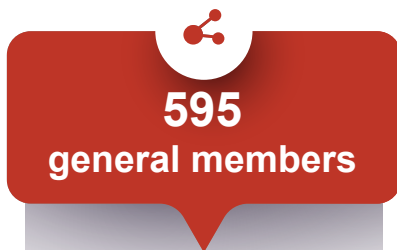
IRES and the IRES Foundation are not the same organization, but we are fortunate to share similar goals. The Foundation shares our goal of providing quality education opportunities to Insurance Compliance Professionals. I was fortunate to be able to update the IRES Foundation at their annual IRES Foundation School held in Buckhead, Georgia in March. I want to thank them for allowing me some time to update them about our activities and I want to provide you with a similar update.

IRES has awarded 17 new AIE's and seven new CIE's and one CICSR. So if you know a new designee, congratulate them on completing a piece of their career path. If you are working on a designation, keep up the good work, your goal is attainable.

Our MCM Classes are going strong. We have conducted or confirmed an unprecedented 5 MCM classes in 2019. That is 108 individuals so far since the CDS in San Antonio, who can now proudly display the MCM designation. Thanks to our hosts for the MCM classes in 2019. You are a big part of the Success of the MCM program. If you missed the MCM in Des Moines (February), Atlanta (March), San Francisco (April) there are more opportunities coming your way before the end of the year. An MCM will be conducted in Spokane in August and in Baton Rouge in November, so watch our website for more information. Thank you Pieter Williams and the MCM team these are amazing numbers.

Our membership in IRES continues to thrive. As of this month we have 729 members. That number is made up of 595 general members and 134 sustaining members. With new members signing up every day. I want to thank our State Chairs, you help keep our membership informed and active. We appreciate your time and effort in shaping our organization. ■

Thanks for your commitment to making IRES a great organization.



OP-ED: The Unique Role of a Pharmacist in the Regulatory World

My name is Uma S. Dua, a pharmacist by trade for the past 22 years. I have worked in the regulatory industry for approximately five of those 22 years. Over the years I have worked with several firms and I hope to elaborate on some common questions I have been asked as well as provide some insight into the role a pharmacist has in the regulatory space.



Uma S Dua, PharmD

What is a PharmD vs BS Pharmacy vs a RPh vs PhD? Is there really a difference?

There is a difference in education between the BS Pharmacy and PharmD degree. All pharmacists can have the RPh designation (Registered Pharmacist), which allows them to legally dispense drugs after passing the pharmacy boards. These include the North American Pharmacist Licensure Examination (NAPLEX) and the Multistate Pharmacy Jurisprudence Examination (MPJE). Some pharmacists further their education with a post-graduate residency or fellowship focusing on various specialties, that provide additional knowledge and experience. For international pharmacists from foreign countries, the requirements are even more extensive.

A PharmD stands for Doctor of Pharmacy, which is a degree. As of 2006, the Bachelor of Science in Pharmacy (BS Pharmacy), also a degree, was phased out to be replaced by the Doctor of Pharmacy. The PhD is a Doctor in Philosophy degree for someone interested in research and is different from a PharmD.

Acceptance to a PharmD program is competitive, with most schools requiring students to take a pharmacy college admissions test (PCAT) and complete 90 credit hours of university coursework in the sciences, mathematics, composition, and humanities before entry into the Pharm.D. program. The PharmD program differs from a BS Pharmacy in that the PharmD has extensive clinical coursework requirements and hands-on clinical practice experience. This is in the form of additional rotations in a multitude of healthcare settings, with a greater emphasis on clinical pharmacy practice pertaining to pharmacotherapy optimization.



Every pharmacist has ongoing 30 hours of continuing education credits (CEs) that must be met every two years post-graduation.

What role does a Pharmacist play in the regulatory industry?

The pharmacist can make an impactful role in the regulatory industry. With the passing of the Affordable Care Act, there are several federal statutes that dictate the basis for a pharmacy policy form review for prescription benefits (on and off-exchange plans) in the marketplace. In this role, the pharmacist is required to create templates to respond to issuers and review the justification or rationalization forms as a portion of the review.

Along the same lines, a pharmacist who performs pharmacy formulary reviews utilizes what are called "tools," developed by contract vendors via CMS, to include non-discrimination reviews utilizing the formulary clinical appropriateness tool ("CAT"), the formulary outlier review ("FOR") tool, the treatment protocol calculator ("TPC") tool, and the drug count tool ("DCT").

Pharmacists should understand why these tools are being used, nuances, and how to interpret the outputs as well as the information provided from the issuer. Along the same lines, the pharmacist should know which conditions play a key role, based on specific clinical guidelines utilized for each condition, how often these guidelines are updated, as well as what is

considered acceptable and what is considered to be non-compliant. It is imperative to perform these reviews accurately and consistently, as Pharmacists are responsible for providing responses to the issuers verbally and/or in writing, as well as providing continuous quality improvement feedback to CMS. The pharmacist may be required to work closely with other Quality Assurance team members to ensure continuous enhancement of this process year after year.

I have come across some of these reviews being performed incorrectly during the market conduct analyses portion of the review. The pharmacist should understand many layers of complexities of this analysis to incorporate what they are reviewing and why they are reviewing certain aspects.

What are the ideal qualities a pharmacist should exhibit for mental health/substance use disorder parity reviews? Do I really need a Pharmacist to perform the reviews?



There are no guiding principles specific to pharmacy by the National Association of Insurance Commissioners. There is not a one size fits all to these reviews. The most critical qualities that cannot be taught are analytical skills, a sense of curiosity, experience performing these type of reviews, as well as extensive experiences in both managed care and clinical training.

Managed Care Organizations use specific non-quantitative treatment limitations (NQTs) such as utilization management techniques to manage the formulary design for prescription drugs. The pharmacist should review if the factors utilized in the behind the scenes decision-making processes for these pharmacy benefits are equal for both MH/SUD & M/S conditions. The pharmacist should have a strong understanding of the “as written” and “in operations” portion of the review, what aspects are included in both, and how they differ.



Common questions to ask are, what are considered NQTs in the issuer world? What are considered evidentiary standards and what are other factors? How do I apply these to pharmacy reviews?

The most common mistake made is the assumption that a roadmap can be created from the pharmacy benefit reviews. Due to the complexity of MH/SUD reviews and the comparison to Medical Surgical (M/S) conditions, it is not suggested to focus on certain M/S conditions, as a lack of parity may be overlooked. Another common mistake is to create spreadsheets of utilization management techniques such as tiering alone to determine parity. Many factors are involved, such as clinical guidelines, utilization management techniques, various operations components, written documents, financial factors, workflows, along with many written and oral documents. It is analogous to peeling back the layers of an onion.

Out of the countless reviews I have performed for large carriers, there was no silver bullet solution in conducting the reviews. And by trying to create one may result in overlooking critical parity violations. In many instances, there may be a lack of parity, but not a lack of discriminatory violations. The pharmacist should be privy to state and federal statutes, as well as non-discriminatory statutes. The pharmacist should know the rules/regulations but also be able to interpret the law and lay out the violations in a systematic manner that is defensible to internal and external stakeholders, especially to the legal experts that represent the managed care organizations.

The pharmacist must stand his/her ground, defend his/her violation(s), and lay them out in a logical manner that speaks to the clinical experts at the highest level of the managed care organizations. At the same time, this must be balanced with the regulatory and legal interpretations that solidify the weight of the violations. It is tricky to document the findings in great

detail that provides comprehensive clinical details to the managed care pharmacists using sound scientific knowledge, and that is laid out in a systematic fashion that is easily digestible to the non-clinical experts in the regulatory space. It is critical to articulate the findings to the managed care organizations and defend the violations to ease any concerns or questions that the client, company, and internal stakeholders may have. This may require multiple verbal and written conversations.

The key to a sound review is knowing what data to ask for and when. This ensures both a thorough and efficient review. The complexities of performing a MH/SUD and a M/S review can be time-consuming, yet have to be performed in on time and within budget. A common error I have come across is using a one-size fits all for company documentation of processes/procedures in a market conduct management review involving pharmacy reviews. What may work for non-pharmacy reviews may not work for pharmacy reviews.

In every review I have performed, I walk into uncharted territory, and apply my past experiences and lessons learned to future projects. I don't know all the answers, but I thrive on understanding the areas unfamiliar to me. I have never performed a review with the end result being no violations found. As regulators, we don't seek out to find a lack of parity, but to say the issuer operates with perfection is also far-fetched.

A passion for the regulatory space and a desire to constantly keep learning are key factors to long-term success. There is a tremendous amount to learn in the parity world and the learning curve is steep and long. Knowing you are making a difference in the parity space and ensuring that there is equality in benefits provided for patients with MH/SUD is what makes it all worth it. ■

About the Author:

Uma S Dua, PharmD, MCM, is the CEO of Dua Enterprises, Limited, a WOSB/MBE (certification in process) and is an executive pharmacist in the regulatory/audit industry with a market conduct certification along with extensive experience performing mental health (MH) & substance use disorder (SUD) reviews for many large insurance carriers, trained by experts such as The Kennedy Forum and The American Psychiatric Association. Dr. Dua has extensive experience in various areas of pharmacy, including clinical, Affordable Care Act, managed care, and revenue-cycle, to perform efficient pharmacy reviews while providing exceptional service.



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Zoning In



Kathy Donovan

Northeast Zone

Connecticut

On Apr. 11, 2019, the Connecticut Insurance Department issued an updated Notice on crumbling foundations to all insurers writing homeowners and condominium insurance. This "2019 Update" reminds insurers of various provisions of state law concerning prohibitions on declinations, cancellation and nonrenewal of homeowners insurance policies related to crumbling foundation claims and coverage inquiries. Specific reference is made to Section 38a-316d(c) which includes, in part: "the cancellation or nonrenewal of a homeowners insurance policy or an increase in the premium of such policy is prohibited if the cancellation, or increase is based solely

on inquiries made on such policy or a claim filed under such policy that resulted in a loss coverage payment by the insurer of less than five hundred dollars or in no loss coverage payment."

Additionally, the Department addresses crumbling foundation cancellation, nonrenewal or premium increase issues with respect to the use of Comprehensive Loss Underwriting Exchange (CLUE) claim information or any other sources of claim-related information, underwriting rules or guidelines approval requirements, as well as property in a current state of unrepair or under repair.

Delaware

Domestic/Foreign Insurers Bulletin 108, dated Mar. 28, 2019, focuses on the use of prescription information in underwriting and, in doing so, advises carriers that "underwrite and issue individual accident and sickness policies, life insurance policies or annuity contracts that certain prescriptions, such as naloxone and emtricitabine/tenofovir, are different from other prescriptions and should be treated differently for underwriting purposes." Specifically, the Department expects that carriers "will not reject or otherwise adversely evaluate any application solely because the applicant may have obtained either: (1) Certain medications that are not relevant to a potential applicant's health, or (2) Other medications prescribed to prevent certain illnesses or diseases."

Massachusetts

The Workers' Compensation Rating and Inspection Bureau of Massachusetts Circular Letter No. 2348, dated Apr. 4, 2019, announces the establishment of an Audit Noncompliance Charge (ANC) which would enable workers' compensation insurance carriers to apply an optional ANC to employers insured in the voluntary market that do not allow the insurer to examine and

audit their records. Approved for a two-year pilot program as described in the Revised Stipulation under Docket No. R2018-01, the ANC is optional and applies only to new and renewal workers' compensation policies written in the voluntary market with an effective date between May 1, 2019 and Apr. 30, 2021 (Pilot Period). The Circular Letter sets forth various features of the ANC, special conditions, data reporting requirements and pilot period information.

Southeast Zone

Arkansas

HB 1074 requires newborn screening for spinal muscular atrophy to be added to the list of required testing. The bill mandates that a health benefit plan that is offered, issued, or renewed in this state shall provide coverage for newborn screening for spinal muscular atrophy by a healthcare professional on or after Jan. 1, 2020. It further mandates that the coverage for newborn screening for spinal muscular atrophy (1) is not subject to policy deductibles or copayment requirements; and (2) does not diminish or limit benefits otherwise allowable under a health benefit plan.

SB 309, effective 90 days after legislature adjourns, amends Arkansas' "Unfair methods of competition and unfair or deceptive acts or practices" provisions by specifying that unfair discrimination "includes refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of coverage available for life insurance to an individual, or charging an individual a different rate for the same coverage, solely because of the individual's status as a living organ donor; specifies that with respect to other conditions, a person who is a living organ donor shall be subject to the same standards of sound actuarial principles as a person who is not a living organ donor."

Mississippi

Effective July 1, 2019, SB 2831 enacts the "Insurance Data Security Law." New requirements include developing, implementing, and maintaining a written information security program, performing risk assessments, determining security measures including cybersecurity risk assessment in the ERM process, training personnel, using due diligence in selecting third-party service providers, informing board of directors of its duties, records retention, annual certifications and establishing a written incident response plan. While the effective date of the bill is July 1st of this year, there are other future deadlines set for compliance with various provisions.

South Carolina

Issued Apr. 3, 2019, Bulletin 2019-02 addresses rescissions of life insurance policies and reminds insurers about required procedures. The Department notes that "Section 38-63-220(d) provides a specific process for rescission (i.e., vacating) of the policy. According to the language in the statute, any rescission of the life insurance policy within the two-year contestability period based upon alleged false representations contained in the insured's application must be accomplished through

“proceedings to vacate a policy” and must commence within the two-year timeframe set forth in the statute.” Additionally, the Bulletin states that “a letter or other notice to the insured stating that the policy has been canceled or rescinded does not qualify as a proceeding to vacate a policy. It is a judicial proceeding commenced to cancel the policy or have it declared null and void.”

Virginia

Effective July 1, 2019, HB 1883 revises two sections of the Virginia Insurance Code regarding adverse underwriting actions applicable to personal automobile policies. Specifically, Section 38.2-2212 is amended to provide that no insurer may refuse to renew a motor vehicle insurance policy solely because of the status of the person as a foster care provider or a person in foster care. Section 38.2-2213 is amended to provide that no insurer or agent may refuse to issue a motor vehicle insurance policy solely because of the status of a person as a foster care provider or a person in foster care.

Midwest Zone

Michigan

The Michigan Catastrophic Claims Association (MCCA) issued a press release on Mar. 27, 2019 which stated the assessment to be paid by auto insurance companies has been set at \$220.00 per insured vehicle for the period July 1, 2019 to June 30, 2020. This latest fee per insured vehicle is comprised of \$177.00 to cover anticipated new claims and expenses, with the remaining \$43.00 addressing a \$3.9 billion estimated deficit related to existing claims.

Wisconsin

Issued Jan. 16, 2019, Bulletin 2019-1 provides information to property and casualty insurers concerning disaster planning, preparedness and response if a disaster occurs. The stated purpose of the Bulletin is to: (1) Proactively provide the Department with a snap shot of the insurance companies that may have exposure to a particular catastrophic loss; (2) Provide information the Department needs to effectively and promptly take action to assist consumers, businesses and regulated entities if and when disaster events occur; and (3) Describe the data that Property and Casualty insurers will be expected to provide upon request.

Also included in this Bulletin is key information on the duties and responsibilities of company disaster liaisons, pre-disaster data survey (including required steps to request that certain information be classified as a trade secret), post-disaster actions and required “post-disaster” claim data.

Western Zone

Colorado

Effective June 1, 2019, 3 CCR 702 Reg. 4-1-8, titled “Concerning the Disclosure Requirements for Life Insurance Illustrations”, is revised. Included in the multiple changes is a requirement applicable to instances where the policy is issued without the

use of an illustration. Insurers are then required to send a basic illustration conforming to the policy as issued with the policy and signed and dated by the applicant or policy owner and producer or other authorized representative of the insurer. Also included in the revised regulation is a requirement that the annual report provided to policy owners for policies marketed without an illustration must now include the DOI’s contact information.

Idaho

Effective July 1, 2019, SB 1097 requires the issuer of a health benefit plan to provide benefits for routine patient care costs to an enrollee in connection with an approved clinical trial. The bill does provide for certain limitations on coverage and provides that the issuer of a health benefit plan is not required to provide benefits for routine patient care services provided outside the plan’s health care provider network or outside Idaho, unless the health benefit plan otherwise provides such benefits. An additional key measure in this bill addresses cost-sharing, in that covered benefits may be made subject to a deductible, coinsurance, or copayment requirement comparable to other deductible, coinsurance, or copayment requirements applicable under the health benefit plan. Applicable insurers are prohibited from cancelling or refusing to renew coverage under a plan solely because an enrollee in the plan participates in a clinical trial.

Utah

Effective May 14, 2019, HB 194 amends Section 31A-22-305 and addresses the statute of limitations for an action under a contract for uninsured motorist coverage. Specifically, “notwithstanding Section 31A-21-313, an action on a written policy or contract for uninsured motorist coverage shall be commenced within four years after the inception of loss.” A further amendment provides for applicability to all claims that have not been time barred by Subsection 31A-21-313(1)(a) as of May 14, 2019. ■

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.

Short-term, Limited Duration Insurance

In August of 2018, the Federal Government released the Final Rules regarding Short-term, Limited Duration Insurance (STLDI). The Final Rules amended the definition of STLDI to further delineate these plans as excluded from the definition of individual health insurance coverage. The Final Rules also lengthened the maximum duration for coverage of STLDI.

Background:

Short-term, limited-duration insurance is a type of health insurance coverage that was designed to help individuals fill temporary gaps in coverage. These plans were not designed to be a substitute for comprehensive individual health insurance. In 1997, the Tri-Agencies (Department of the Treasury, the Department of Labor, and the Department of Health and Human Services) issued regulations implementing the portability and renewability requirements of HIPAA. Those regulations defined STLDI as "health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract."

The previous Rules restricted the plans to three months in duration and virtually eliminated the enrollee's ability to automatically renew the policy. The rule also allowed for the policy to be something less than 12 months, with an expiration date that is specified in the contract, considering any extensions that are elected by the policyholder without the insurer's consent. Because, these plans are not considered comprehensive individual health insurance, they are generally exempt from the requirements of the Patient Protection and Affordable Care Act (PPACA), such as: inclusion of Essential Health Benefits (EHB's); prohibitions of Annual or Lifetime limits; and prohibitions of imposing pre-existing limitations.

Additional differences between major medical and STLDI include: Major Medical insurance provides coverage for durations of a year or more and can be renewed. STLDI plans only provided coverage for a specified limited timeframe. Major medical insurance has prescribed limitations on cost sharing and out-of-pocket costs, whereas STLDI does not have similar limitation requirements. Major medical insurance includes limitations on the Minimum Loss Ratios (MLR's) which dictate how an insurance company must spend premium dollars on claims and expenses to improve health care. STLDI does not have requirements on MLR's, therefore can utilize premiums for greater profits of the insurance company, versus initiatives for cost containment and improved health care. Additionally, major medical policies are required to contain patient protections which allow coverage for treatment of Mental Health and Substance Use Disorder, Maternity Coverage and Emergency Services. STLDI plans can exclude or limit coverages for these benefits. For major medical insurance, state requirements vary by market segment, while STLDI plans vary by the duration of coverage.

Final Rule impacts:

With the Final Rules came new changes. The most notable changes in the Final Rule include: extending the initial coverage period to be up to 364 days versus the previous allowance of three months; renewability allowed up to total of 36 months with the same carrier and the policy; notice to consumers required regarding type of coverage being provided (but, no consumer acknowledgement required); severability clause allows the regulation to survive even if the 36-month renewability is invalidated by a federal court; "Renewability guarantees" are permitted to extend coverage without underwriting at time of renewal; renewal guarantee permits coverage to be extended beyond 36 months but requires a new contract of coverage and effective date (which can be exact same policy form issued during first 36 months); coverage is not subject to ACA minimum standards (e.g. can have pre-existing condition exclusion and no minimum benefit requirements); and states are permitted flexibility to regulate Short Term Limited Duration Medical Insurance.



Holly Blanchard

State options:

States have begun to look at the flexibility options to determine the appropriate consumer protections for their marketplaces. Options that have been considered or enacted include: specifying that benefit periods can only be a maximum of 12 months for initial coverage period or any period less (such as 3 months or 6 months); allowing or not allowing renewability of initial coverage period for up to 36 months; allowing or not allowing coverage guarantees to extend coverage period beyond the maximum coverage period permitted; allowing or not allowing pre-existing condition exclusions, underwriting, or major medical benefit mandate coverage; requiring a more conspicuous and comprehensive consumer disclosure than prescribed by the federal regulation; requiring a consumer acknowledgment to understanding scope of coverage, exclusions and limitations, cost of coverage, and that coverage does not meet state or federal minimum standards for primary medical insurance; requiring a detailed outline of coverage to be provided prior to application/enrollment; requiring a producer attestation to having provided outline of coverage, explained scope of coverage, exclusions and limitations, and cost of coverage; requiring issuers to retain customer and producer disclosure statements with each policy issued pursuant to state record retention laws; requiring an annual issuer certification that all STLDI coverage issued in the state complies with the state's laws and regulations for the coverage and a listing of all STLDI policies forms issued in the state during the certification period; requiring products to provide expense-

CONTINUED ON PAGE 12

based benefits rather than fixed indemnity benefits; requiring marketing materials for the coverage to be approved by the state prior to use; and prohibiting STLDI plans into their marketplace.

Concerns:

While STLDI serve a valid need for consumers to obtain transitional coverage lawmakers, insurance regulators, insurance carriers, consumer advocates and consumers have all expressed concerns with the viability of these plans. Each group has pointed out issues with consumer confusion surrounding these products. The confusion stems from deceptive or misleading marketing in which carriers do not prove clear delineation of the benefits of the plans, nor do they disclose that these plans are not mandated to provide comprehensive coverage outlined in the Affordable Care Act. As such, consumers are opting for more affordable coverage provided under STLDI plans not realizing they could be losing access to basic protections such as coverage for Prescriptions, Mental Health and Substance Use treatments, and Maternity Benefits. Additionally, because the prohibition for penalties for pre-existing conditions do not apply to STLDI plans, consumers may have limited or excluded coverage for their most expensive treatments.

Surveys show that most consumers look for cost effectiveness over comprehensive protections when shopping for health insurance making STLDI plans an attractive choice. These consumers also indicated that if given the option, they would continue their coverage of STLDI plans for as long as legally allowed instead of paying more for comprehensive major medical coverage. Opponents of STLDI fear that this will perpetuate consumers financial exposure because the longer they do not have comprehensive insurance, the greater the risk of a serious illness or injury occurring that will not be covered by limited plans. Additionally, opponents believe that continuation of STLDI plans also pose a medical risk to consumers because of the limited or non-existent benefits for preventive services.

In March of 2019, the Federal House Energy & Commerce Committee opened an inquiry into STLDI plans to better understand the risk of these plans. Through this inquiry, they requested applications, underwriting documents, health questionnaires and medical data utilized by the carriers for the sales and continued service of limited plans. As the inquiry continues, the landscape may also continue to change for these products.

Current State:

Currently, few regulations have passed regarding the marketing and sales of STLDI, however initiatives are being considered across the country. Examples of the initiatives that are occurring include:

Washington State adopted a rule limiting the sales of STLDI to three-months which cannot be renewed. Additionally, STLDI medical plans can last no more than three months and cannot be renewed. Further, a consumer can have STLDI coverage for no more than three months in a 12-month period. Insurers selling STLDI medical plans must provide consumers with a specific disclosure form that clearly states the limitations of the coverage and prompts consumers to check to see if they are eligible to purchase coverage through Washington's Exchange before they


buy a STLDI medical plan. STLDI medical coverage must offer major medical coverage with a maximum total payment of at least \$1 million. Any pre-existing condition look-back period cannot exceed 24 months. Consumer coinsurance cannot exceed 50 percent, and any insurer offering an STLDI medical plan must offer at least one plan with a deductible of \$2,000 or less. STLDI application forms, policies and rates must be approved by OIC prior to being offered or sold. Also, STLDI medical plan rescission and cancellation is limited to defined circumstances with requirements for adequate consumer notice.

California, Massachusetts and New York prohibit the sales of STLDI.

Vermont is currently proposing a Final Rule that will incorporate greater consumer protections including requirements for coverage of the ten Essential Health Benefits, as well as state mandated benefits into any STLDI.

In Colorado, STLDI must cover state mandated benefits, including maternity. Additionally, starting in April 2019, premiums for older enrollees are capped at three times the premiums for younger enrollees. STLDI plans must cover the ACA's essential health benefits. Policies must be guaranteed-issue. Pre-existing conditions can still be excluded, but only if they were diagnosed, treated, or symptomatic in prior 12 months. STLDI plans must have loss ratios of at least 80 percent as of April 2019.

CONTINUED ON PAGE 13



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YES, I'M STILL AN EXAMINER... 3 MONTHS IN AS A MARKET CONDUCT EXAMINER.

Where do I start?

I have to say this is one of the most interesting, challenging, and fulfilling career positions I have had the pleasure of doing. Knowing, or should I say learning, all that is entailed with an Examiner's responsibility is massive. Although I am still new to the position, I am now uttering acronyms without a second thought, but I haven't passed that language class quite yet. The learning is multi-layered, and I am after 3 months of being in this position, I have been able to get deep in the weeds on some hot-button issues. Third Party Administrator oversight, Company complaints and grievances (yes, there is a difference), Producer Licensing, Data integrity, are just touching on the scope of a comprehensive exam. Then there are Claims, what is there to say about Claims? A lot!



Nicole McClain

So how do we as examiners find the right balance? Since this is a multi-layered and evergreen process, I've updated my list of recommendations for new health examiners:

1. **Organization is key.** Creating folders, whether on the computer or in print, is very important. You must know where to access the information you are seeking.
2. **Listen.** When your co-workers are discussing experiences and prior exams, it is important to listen to what they are saying. Every exam is different. Every claim is different. Every Company is different.
3. **Take notes.** You will reference them frequently.
4. **Ask questions.** Do not be afraid to ask questions and if you still do not understand, ask again.
5. **Never assume.** Look at each COC (Certificate of Coverage). There may be minor differences; however, those minor differences are critical in our field.
6. **Breathe.** It is a lot to take in. You may think it will never sink in, but healthcare is an ever-changing world. It will come, and when it does you won't even realize it.

I will end where I started: this work is massive. Whether it's trying to understand specific details of statute or reviewing hundreds of pages of COCs, your day-to-day work is impacting an entire state, and possibly other states as well (I don't think our regulated entities realize it, but we talk to each other!) Most importantly, though, as a regulator, you take on the massive task every day to protect consumers, and if that means going through a statute line by line and comparing it to bits of information in a claim, then it's what we do, and I welcome the challenge. ■

About the Author:

Nicole McClain, Health Market Conduct Examiner, Pennsylvania Insurance Department. Other related Insurance experience include: Claims Adjuster, and P&C sales. Outside interests/talents: Bingo, scratch-offs, and watching sports while doing a scratch off.

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

Additional rules and regulations regarding STLDI continue to be reviewed and adopted in states across the country. As the requirements of these products evolve, so will the continued due diligence for consumer protections. ■

About the Author:

Holly Blanchard is the President of Regulatory Insurance Advisors (RIA), a consulting firm offering expert services for insurance regulation and oversight. Holly has over 20 years of experience in the insurance industry, with most of those years as an insurance regulator. Holly brings extensive market conduct, Affordable Care Act (ACA) and overall regulatory expertise and experience.

IRES Member of the Month

This Issue: Shelly Schuman



Shelly Schuman

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

I am a Market Regulation Manager for The INS Companies. In brief, I supervise market conduct examinations on behalf of INS in multiple states. I liken the job description to herding kittens.

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

I have been an IRES member since 1997. I originally joined when my boss at the time, John Mancini, told me to join. I had just started with the NAIC in the Market Regulation Department and was told it was “good” for me to be a member. Little did I know he was starting me on a journey that would last for more than 20 years!

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

I have been on the CDS Committee for four years with the last three serving as a co-chair. Just this last December, I joined the Board of Directors, Executive Committee and took on the role of Chair of the Accreditation and Ethics Committee.

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

I have attended the CDS each year except for two since 1997. I was unable to attend the St. Louis CDS because of a brief hospital stay and there was a hurricane that prevented me from going when CDS was in Hollywood, Florida. Otherwise, I have been all over the country attending CDS in various cities, sometimes with my daughters in tow. The CDS that stands out was San Diego in 2001 because the weather was fantastic and it was the last year that Paul DeAngelo attended.

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

The Commissioner Roundtables stand out across several CDS events. The opportunity to hear directly from our nation’s leaders on topics of importance to them is always educational for me. And the keynote session in San Antonio last year was phenomenal too.

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

I’m still working on designations I would like to earn so I hope to earn a few more. I have a number of designations already, but this industry changes so quickly I find it important to continuously learn to stay on top of issues.

When you aren’t working what are your hobbies?

I love the 1985 and 2015 World Series Champion Kansas City Royals and attend 41 games a year (half of the home games). There is something about the sights, sounds and smells of the ballpark that bring me great joy. I also love to spend time with my grandchildren and watching birds at my backyard feeders.

What is your biggest personal or professional accomplishment?

I’m shocked that I still work in the insurance industry after so many years. No one ever says, “I want to grow up and work in insurance.” But, after getting my start by pulling policy files at the age of 17, I have continuously found places of growth and opportunity in this industry. My children think insurance is “boring,” but they have no idea how truly engaging this field can be and I am happy to say I’ve been involved in this industry for more than 38 years.

Get to Know Your State Chair

This Issue: Scott Brian Pendleton, Missouri

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 Scott Brian Pendleton, an Examiner in Charge from Missouri.

Tell us about yourself.

Greetings fellow IRES Members! I am both humbled and honored to be asked to tell you about myself! I was born and raised in Saint Joseph, Missouri where I currently reside. I am the son of John (deceased) and Velma Pendleton. My loving mother is currently residing in the home where I spent most of my childhood. As one of five siblings, I have been blessed with my tremendous two brothers and sisters. They kept me out of a lot of trouble while growing up. I have had the honor of being elected Benton High School Student Body Treasurer, Vice President and later as Student Body President elect, my senior year. I was a member of the National Honor Society, elected Captain of the football team and graduated with Honors in the spring of 1977. After High School, I graduated from Missouri Western State College (Now University) in 1981, with a Bachelor of Science degree in Political Science while minoring in History. I received the "Garth Landis" Tennis Scholarship prior to College. While there, I was elected Political Science Treasurer. I met the love of my life, Linda Metzinger Pendleton for the first time, in a flower shop while purchasing flowers for a prom. She was the salesperson behind the counter. We married in the fall of 1981. We had the joy of raising two wonderful sons, Brian Scott (Christy) and David Garrett Pendleton. We have three amazing grandchildren, Zach, Teagan, and Ryker. I am a former Missouri State Show Me Games Tennis Champion.



Scott Brian Pendleton

I started my career in Insurance three days after college graduation and never looked back. I have over 38 years of experience in the insurance industry. I started as a desk adjuster handling home-owner claims, moved to auto claims and spent many years in the field. Later, I gained experience as a commercial claims adjuster, claims supervisor and managed claims in a health reinsurance office. I then spent the rest of my career starting in the summer of 2000, working for the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) where I am currently employed as a Market Conduct, Property & Casualty Examiner In Charge. It was here where I excelled professionally, because of the people that surrounded me where their wisdom, experience, and uncommon insight. I owe them a debt which cannot be paid. I am a Certified Insurance Examiner. I also currently serve as an IRES State Chair representing Missouri and on the Membership and Benefits Committee as well. I am Chairman of the Board, Deacon, and a Bible Study Teacher at my church. Along with my father, I have had the pleasure of being written about in a fishing related article in Field and Stream Magazine. I love hunting, fishing, bird watching, the outdoors, and watching professional football and baseball. I am a world traveler visiting places and experiencing the people and cultures in India, Greece, Germany, Italy, Thailand, China and Ireland.

How long have you been an IRES member?

I have been an IRES member since January 10, 2001, over 18 years.

What made you get involved as a State Chair?

I was approached by IRES members as there was no State Chair for Missouri at the time. I was asked to take on that important responsibility. I accepted, for the purposes of personal growth, development, and an opportunity meet others within insurance market regulation. I had no idea of the joy I would experience later, not only as an examiner for my state, but as an IRES member to be allowed to interact, exchange ideas, and participate in IRES meetings and projects. As a result, I would encourage others to get involved with IRES and insurance regulation.

What impact do you want to have as a state Chair?

To lessen consumer harm and improve the insurance industry in general for the good of both the consumer, and Insurance Companies.

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

It should consider the following by finding ways to:

- Continue to develop ways to maintain and increase IRES membership
- Working with other Insurance related Professionals outside of IRES to promote IRES goals
- Utilize Marketing techniques to promote IRES and what it stands for
- Working together as one body in a united effort to promote itself
- Working together with insurance companies to develop ways to improve the industry's image and well being
- Maintain a high standard for continued education and ethics
- Do the right thing

Anything else?

The Missouri DIFP values IRES in a great way. I believe other states do as well. I challenge everyone involved with insurance regulation, to contribute what talents that they can to IRES. To vicariously coin a similar phrase from a previous president, "Ask not what IRES can do for you, ask what you can do for IRES!" ■

The Paul L. DeAngelo Memorial Teaching Award Winner

Congratulations to Ignatius Wheeler, Associate Commissioner Examination Division for the Texas Department of Insurance (TDI), the 2019 winner of the Paul L. DeAngelo Memorial Teaching Award presented by the IRES Foundation.

Mr. Wheeler began his regulatory career with the TDI in 1991 as a financial examiner. Over the years, he held various positions including Supervising Examiner, Assistant Chief Examiner, and his current role, Associate Commissioner/Chief Examiner of the Financial Examination Section. Mr. Wheeler is passionate about the industry and is known for his expertise and willingness to share knowledge and perspective with industry and regulators alike. He is very active in several industry organizations, serving in leadership, education and policy making roles.

Please join us in congratulating Mr. Wheeler!

The Paul L. DeAngelo Memorial Teaching Award, presented by the IRES Foundation, annually honors an insurance regulator, or former regulator, who has continually committed himself/herself to insurance regulatory education through his/her commitment to increasing and improving insurance regulatory knowledge.

The IRES Foundation is a nonprofit charitable organization that operates independently of IRES. The Foundation's mission is to promote professionalism and education in the insurance regulatory community and to educate the private sector about state insurance regulation.

To learn more about the Foundation and/or The Paul L. DeAngelo Memorial Teaching Award, visit www.ires-foundation.org



Ignatius Wheeler

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Insurance Company Owned Life Insurance (ICOLI)
 with Don Hale

June 12, 2019 | 1:00 pm CST
Pet Insurance with 3 speakers including John Haworth, Tanya Sherman, and Phil Greven, AVP, Associate General Counsel with Nationwide

June 17, 2019 | 2:00 pm CST
Substance Abuse Medications vs. Opioids... Then and Now with Kirk Stephan with the INS Companies



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

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Stephanie Duchene

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2019**

Editor's Corner

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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- May 29** - **WEBINAR: 1:00 pm CST**
Insurance Company Owned Life Insurance (ICOLI) with Don Hale
- June 12** - **WEBINAR: 1:00 pm CST**
Pet Insurance with 3 speakers including John Haworth, Tanya Sherman, and Phil Greven, AVP, Associate General Counsel with Nationwide
- June 17** - **WEBINAR: 2:00 pm CST**
Substance Abuse Medications vs. Opioids... Then and Now with Kirk Stephan with the INS Companies
- August 18-21** - CDS, Spokane, Washington
- August 21-23** - MCM, Spokane, Washington
- November 6-8** - MCM, Baton Rouge, Louisiana

Visit go-ires.org/events for details and more upcoming events.