NAIC/CONSUMER LIAISON COMMITTEE

NAIC/Consumer Liaison Committee Oct. 18, 2010 Minutes

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NAIC/Consumer Liaison Committee
Orlando, FL
October 18, 2010

The NAIC/Consumer Liaison Committee met in Orlando, FL, Oct. 18, 2010. The following Committee members participated: Neal T. Gooch, Chair (UT); Elizabeth Sammis, Vice Chair (MD); Jim L. Ridling represented by Ragan Ingram (AL); Jay Bradford represented by Bob Alexander (AR); Steve Poizner represented by Leone Tiffany (CA); Thomas R. Sullivan represented by Barbara Spear (CT); Gennet Purcell represented by Philip Barlow (DC); Karen Weldin Stewart represented by Steve Kinion (DE); Kevin M. McCarty represented by Karen Kees (FL); Susan E. Voss represented by Tom Alger (IA); Sandy Praeger represented by Ted Clark, Cindy Hermes and Linda Sheppard (KS); Mila Kofman and Rick Diamond (ME); Ann M. Frohman represented by Martin Swanson (NE); Brett J. Barratt represented by Kimberly Everett (NV); James J. Wrynn represented by Jack Chaskey (NY); Wayne Goodwin represented by Bob Lisson (NC); Robert L. Pratter (PA); Joseph Torti, III (RI); Alfred W. Gross represented by Jackie Cunningham (VA); Mike Kreidler (WA); Sean Dilweg represented by Eileen Mallow (WI); and Jane L. Cline represented by Bill Kenny (WV). Also participating were: Marcy Morrison (CO); and Roger A. Sevigny (NH).

Other participants were: Elizabeth Abbott (Health Access California); Amy Bach (United Policyholders); Deeia Beck (Texas Office of Public Insurance Counsel); Brendan Bridgeland (Center for Insurance Research); Bonnie Burns (California Health Advocates); Sabrina Corlette (Georgetown University Health Policy Institute); Brenda J. Cude (University of Georgia); Joseph P. Ditre (Consumers for Affordable Health Care); Timothy Stoltzfus Jost (Washington and Lee University); Karrol Kitt (University of Texas at Austin); Peter Kochenburger (University of Connecticut School of Law); Sonja L. Larkin-Thorne (Consumer Advocate); Georgia Maheras (Health Care for All); Stacey Pogue (Center for Public Policy Priorities); Wendell B. Potter (Center for Media and Democracy); Daniel Schwarcz (University of Minnesota Law School); Barbara Yondorf (Colorado Consumer Health Initiative); Kimberly Calder (National Multiple Sclerosis Society); Stephen Finan (American Cancer Society); Howard Goldblatt (Coalition Against Insurance Fraud); Lynn Quincy (Consumers Union); Barbara Rea (Equality State Policy Center); and Mark Schoeberl (American Heart Association)..

1. Presentation: 2010 Commissioner Award

On behalf of the 2010 NAIC consumer representatives, Ms. Cude presented Commissioner Marcy Morrison (CO) and Joel Ario, former Pennsylvania Insurance Commissioner, with the 2010 Excellence in Consumer Advocacy Award for promoting a balance between the needs of consumers while ensuring company solvency.

2. Health Presentations

- Medical Loss Ratio (MLR)

Mr. Jost said consumer representatives appreciated the open transparent and participatory process that the NAIC has pursued in drafting the *Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2010 and 2013 per Section 2718(b) of the Public Health Service Act* (#190) (MLR Regulation), as well as the results of that process. He said it is important that the NAIC proceed carefully to make sure that it fully understands the ramifications of proposals and that the consumers, competitors and providers who will be affected by them receive notice of any proposed changes and be given a chance to respond. Mr. Jost said consumer representatives are troubled that there seems to be a flurry of proposals that favor certain participants in the industry and feel that some of the proposals need further consideration because they are not in the best interest of consumers. He said a good example of the problems that such last-minute proposals can cause is the rebate amendment adopted by the Health Insurance and Managed Care (B) Committee. Mr. Jost said the amendment to rule 10 appears to be a fairly technical amendment; however, it would dramatically change the way in which rolling average rebates would be calculated for years beginning in 2013, and it is not only contrary to the language of the law, but it would also ensure that carriers that choose to price below 80% and 85% MLRs would not have to pay a full rebate to consumers. As such, he urged regulators to take another look at that proposed part of the change to the regulation.

Mr. Jost said the proposed amendment for national aggregation in the large group market is problematic for several reasons. He said it is contrary to the statute, because the term "issuer" is not a term that is used only in Section 2718 of the federal Patient Protection and Affordable Care Act (PPACA), which the NAIC is called on to define. He said it is a term from the Health Insurance Protection and Portability Act (HIPPA) that was incorporated in PPACA by Section 1551 and that has been used by federal agencies for 14 years. He said the term "issuer" appears in the federal regulations in reference to a state-

licensed entity in 100 locations and said he can provide the NAIC with the legal opinion that supports this. He said it is unfair to consumers, because consumers in those states where national plans are not competitive would subsidize consumers or plans in states where there is competition or stiff regulation because it is contrary to the statute as the statute clearly states that "issuer" refers to a state-licensed entity.

Mr. Jost said the consumer representatives strongly oppose changing the confidence level from 50% to 80% for partially credible plans, because most plans in most states in the non-group market and in the small group market are not fully credible. Mr. Jost said there is not a single plan in New York, New Jersey, Maine or South Carolina that is fully credible according to the information they were given. He said increasing the adjustment from the 50% to the 80% confidence level almost doubles the credibility adjustment all the way up the scale and means that there would be far more of an increase in the MLR or decrease in the amount that companies would have to spend to meet the MLR, than all the other issues like accreditation or other quality-improvement issues. Mr. Jost said the rule indicates that, if it is 50% or more likely that a plan is not seriously trying to hit the 80%, consumers should get a rebate. He said that going to the 80% credibility level significantly changes the balance in the favor of the plan and against consumers. Mr. Jost said the compromise proposes to change it only for the transition period; however, this rule only applies for the transition period, so moving to the 80% confidence level for the transition period means changing the rule to the 80% confidence level. He said that the primary purpose of the MLR Regulation is not to generate rebates, but to encourage plans to increase their MLRs. Mr. Jost said consumer representatives believe that the second purpose of the MLR Regulation is to make clear to consumers what proportion of their premiums are actually going to pay for health care and quality-improvement activities. He said that anything that reduces the transparency of MLR reporting subverts the purpose of the statutory process. Mr. Jost said the rule, as reported out of the subgroup, promotes transparency and encourages appropriate pricing. He urged the NAIC to reject the last-minute proposals and to adopt the MLR rule as originally written.

- Model Statute and Rate Reviews

Ms. Maheras said that reviewing rates, explaining rate increases and protecting consumers by ensuring that they are getting value for the money they are spending on premiums is the ultimate goal of the MLR Regulation. She said that base premiums that increase 9% to 12% annually, with the potential of 30% to 50% increases after all rating factors are accounted for, are a burden to individuals and employers. She said that understanding why and how these rate increases occur will lead to more affordable choices for employers and consumers. She said that, pursuant to Section 2794 of the PPACA, the Speed to Market (EX) Task Force is developing a Rate Filing Disclosure Form that will be used to justify unreasonable premium increases. Ms. Maheras said consumer representatives strongly support the work of the Task Force, because the form allows dissection of rates so that administrative and clinical costs can be shown separately. She said that both kinds of information are important, so that consumers can understand all the factors driving increased health care costs.

Ms. Maheras said the NAIC exchanges model act would cover 29 million uninsured Americans by offering affordable health care options, as indicated in the drafting notes, with the states choosing the format of the plans for its constituents. She said sufficient market authority would be gained through the number of uninsured Americans who sign up, which is one of the reasons for combining the individual and small group plans. She said state exchanges also provide each state with the opportunity to increase competition among carriers and provide residents with affordable health plan options. She said that PPACA affords the states the opportunity to customize their exchange for their state and the insurance market, indicating that many of these decision points for policymakers are highlighted in drafting notes throughout the model. She said this model points out that the exchange could be located within a state agency, as a quasi-state agency, or as a non-profit state entity. She said each of these governance structures presents different challenges and opportunities in the operation of the exchange.

Ms. Maheras said that, regardless of the format chosen, the exchange must be accountable to the residents of that state. She said the exchange should comply with open meeting laws and public comment periods for the rules and guidance that it develops, and that it should be transparent, enabling all stakeholders to understand and participate in the decisions being made. She said the exchange structure should provide for a strong consumer voice with an appointed seat on the board and exclude representatives with conflicts of interest. She said that state insurance regulators and the state's Medicaid director should have a formal role in the governance of the exchange, so that a diverse group is included to provide balanced policy guidance to the exchange. She said that an exchange can only hold down insurer costs and move to a structure that offers plans with greater value and quality if it has sufficient market authority. To gain market authority, she said the exchange needs to enroll a significant number of people; therefore, it is important to broaden, not carve up, insurance markets to provide the exchanges with enough covered lives to be able to negotiate good prices and coverage with insurers. She said this is one reason to combine individual and small business health care options program exchanges.

- Exchange White Paper Topics

Ms. Pogue said the Exchanges (B) Subgroup decided to write a series of white papers to give the states recommendations of areas where there might be flexibility in the design or the operations of the exchange. She said a series of white papers drafted by the NAIC on the operation of exchanges that would provide best practices guidance to the states should be given high priority. She said the rules provided in the first paper are on inside and outside market pools to encourage competition and to protect consumers against adverse selection. She said the greatest threat facing the exchanges is adverse selection against the exchanges, as exchanges will be much less attractive for carriers to participate in and premiums will rise for enrollees if there is risk selection. Ms. Pogue said the key to minimizing adverse selection is to ensure that there are identical rules inside and outside the health insurance exchanges. She said the first NAIC white paper on the inside and outside market rules should identify the features in PPACA that reduce the potential for adverse selection. She said the NAIC white paper should look at the regulatory and policy remedies that can be used to mitigate adverse selection. She said specific policy solutions, such as how the states can regulate the individual and small group markets inside and outside the exchange, should also be explored in the first white paper.

Ms. Pogue said the second white paper should be on active purchasing through the authority of certified plans to keep prices down and generate better quality care for consumers, employers and taxpayers. She said the white paper on this role should describe how the states can be granted the flexibility to design either bidding requirements or review and selection practices, as well as how the states can take into account the right fit for local consumers and market conditions. She said this white paper should assert that exchanges can have a competitive process or negotiate with carriers as part of certifying plans. She said the white paper should describe how active purchasing can help states provide more affordable plans to their residents, in addition to achieving other public policy goals, such as encouraging the use of quality measures or encouraging the implementation of payment mechanisms that reduce medical errors and prevent hospital readmissions.

Ms. Pogue said the third white paper would be on the governance of exchanges, as PPACA is silent on this issue—leaving critical decisions on the structure and composition of an exchange governing board to the states. She said the white paper on exchange governance should describe the pros and cons of different entities that can house the exchange and the different legal and administrative issues that could arise with those different options. Ms. Pogue said the paper also should describe options and best practices on how exchange governing boards should be constituted and appointed, as well as how exchanges can avoid conflicts of interest in their decision-making. She said the paper should look at appropriate mechanisms, such as an advisory panel, for getting the input of insurers, producers and/or health care providers.

Ms. Pogue said the fourth white paper should be on the coordination with Medicaid, as PPACA envisions consumers encountering as little red tape as possible, and being able to enroll as quickly as possible, no matter where they apply for coverage. She said the white paper should focus on the states providing the policy decisions and the information technology necessary to ensure that consumers have a positive experience, regardless of the coverage decision they make. Ms. Pogue said the paper should lay out the types of things that exchanges should consider when deciding whether to contract with the state Medicaid agency to process eligibility for the premium tax credits. She said this paper should describe best practices for seamless and secure data transfer; describe the policies and technologies needed to keep documentation requirements to a minimum; and identify how the states can find workable solutions for places where the eligibility requirements in PPACA for Medicaid and the exchange might not line up perfectly.

Ms. Pogue said the fifth white paper should be on the interaction between the exchange and mandated benefits. She said PPACA allows the states to have more benefits in their exchange than the federal minimum essential benefits, but it requires those states with mandated benefits to defray the additional premium cost and cost-sharing credits for exchange enrollees. She said the white paper should identify a methodology that the states can use to determine the net cost of mandated benefits to the cost of adding the benefit, if any, that exceeds the offsetting cost of savings from adding that benefit. Ms. Pogue said the paper should identify best practices that the states can use to build an impartial process to determine whether a particular mandate adds a cost, and by what amount.

She said the sixth white paper should be on the federal exchange that the U.S. government will operate in any state that chooses to not have a state-run exchange. Ms. Pogue said that the states without a state-run exchange will still have a lot of work to do to coordinate information across agencies, stabilize markets and minimize adverse selection. She said the white paper should identify what the states' role will be in relation to a federal exchange to help the states fully evaluate their options. Ms. Pogue said this white paper should look at the federal exchange from a state's perspective and describe the timeline for the development of the federal exchange that would be most helpful to the states by identifying those features of the federal exchange that need to be communicated to states early. She said the white paper should identify what is needed to coordinate state laws to the federal exchange, answer questions regarding state laws to be reviewed, as well as where federal and state laws might overlap or conflict. Ms. Pogue said a big question that has yet to be addressed is how, and to what

extent, the states should be required to address adverse selection against the federal exchange by regulation of the outside market.

Ms. Pogue said a white paper on how to develop the navigator's role in providing consumer assistance with exchanges that would help empower consumers to make informed insurance decisions by providing personal assistance in a culturally and linguistically appropriate manner should be considered. She said that a white paper on addressing the public's confusion regarding the health reform law itself, the provisions and timing on when those provisions take effect, in addition to consumer's long-recognized difficulties with basic insurance concepts and terminology should also be considered.

Ms. Pogue said that Consumers Union did a study that involved extensive consumer testing on the prototype health insurance disclosures that are currently under development by the Consumer Information (B) Subgroup. She said this resource details consumer's reactions to the prototype disclosure forms and provides an in-depth look at what consumer find confusing about health insurance. Ms. Pogue said this study will be distributed to commissioners and will be a great resource to help insurance departments reduce consumer confusion.

- Child-Only Plans

Ms. Corlette said there is a provision in PPACA that prohibits insurance carriers from denying coverage to children under the age of 19; however, many health insurance carriers have recently made decisions to withdraw from the child-only market, in spite of the promises made earlier by those insurance companies to continue to offer child-only health insurance plans. She said the child-only market is a small segment of the individual market, but the children who need these policies are a particularly vulnerable population. She said it is critical that these children have access to the care that they need, so that they can grow into health and productive adults. She applauded the additional guidance that U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius issued making it clear that plans could not discriminate against children with pre-existing conditions, whether they are inside or outside of an open enrollment period. She said it is now up to the states to help children access the care they need and that they have been promised under the law. She said that Commissioner Kreidler and Commissioner Sevigny, as well as California's governor and Legislature, have taken the lead in addressing this issue with insurers in their respective states by mandating that companies offer the child-only health insurance plans. She encouraged insurance commissioners in other states to follow their lead to mandate that companies continue to offer child-only health insurance plans. Commissioner Sammis asked about adverse selection outside the exchanges, if mandated benefits are kept outside the exchanges. Mr. Finan said that the insurance plans currently offered do not offer cancer coverage unless it is mandated and that the states will have to bear the costs of state-specific mandates, so it is likely that the states will stop requiring mandates, rather than pay for them. Mr. Jost said the federal health care reform statute applies to qualified plans, not to plans outside of the exchanges. Mr. Finan said the underlying rule should be that all insurance plans—inside and outside the exchange—are on a "level playing field," because differentiation creates incentives for adverse selection and, in most states, the pool is just too small to tolerate it.

3. Insurance Department Websites Study

Ms. Cude said that Bill Fleming, a doctoral student working under her direction this past year, did a study related to insurance department websites. She said Mr. Fleming's study started with online focus groups of insurance consumers and continued with a content analysis. She said this means Mr. Fleming looked at all 51 insurance department websites in a systematic way, looking for certain information that would be of value to insurance consumers. She said the study indicated that complaint ratios as a level of service are not provided by most of the states; in fact, less than 20% of the states provide these ratios. She said the NAIC is investing a lot of time and resources in working on the complaint coding issues, and producing what hopefully will be results that the state insurance departments can use to provide information to consumers. She said Mr. Fleming's study indicated that some consumers might not be aware of the existence of state insurance departments; therefore, the states' websites need to provide an explanation of the department and what they do, along with a revision date, because things that establish legitimacy—such as a clear indication that it is associated with state government, a clear indication there is a real person who appears to be an authoritative figure associated with it or just having some indication that the information is current (i.e., the date it was updated)—are important to consumers looking at websites. She said that she asked the Market Regulation and Consumer Affairs (D) Committee to consider a future charge of developing best practices to facilitate making it easier for insurance departments to post this information to their website. She also asked the co-chairs of the Property and Casualty Insurance (C) Committee to continue their charge to develop best practices for the design and implementation of consumer premium comparison guides for personal, automobile and homeowners insurance. She said a similar study done by Bob Hunter (Consumer Federation of America) that focused on automobile and homeowners insurance provided a price comparison for insurance policies. Superintendent Kofman said it was a question of uniformity, because that states vary by what can be posted on their public websites.

4. Abandoned Property

Mr. Bridgeland said the NAIC should focus on the escheatment of insurance proceeds and insurance funds to states' abandoned property accounts. He said the amount of funds turned over by insurance companies to state abandoned property funds are substantial and, in difficult economic times like the present, taking steps to help return unclaimed accounts to consumers could help millions of families. He said the 50 states' abandoned property funds hold in excess of $35 billion in unclaimed property. He said the laws governing abandoned insurance funds in many jurisdictions are based on model laws that were developed by consulting firms that examined companies to search for property to be turned over to state funds. He said the consultants receive 10% to 15% of the proceeds, and some of the states have broadened their laws in recent years to require that assets be turned over more quickly and, correspondingly, there has been a reduction in effort to locate owners. He said the states have returned to consumers approximately one-third of the property that escheats to the states; however, the percentage returned varies greatly by state.

Mr. Bridgeland said recordkeeping and research are problematic, as the searches that the states do for the owners of this property are inadequate. He said staff at his organization first became aware of this issue while working on various demutualization transactions over the past decade. He said that, as part of the demutualization process, the converting mutual insurer had to distribute shares of cash to participating policyholders. He said that, during these distribution processes, it was discovered that a number of the large life insurers that were demutualizing had hundred of thousands of policyholders with paid-up policies, mostly small face policies that people lost track of because they had been purchased decades ago to help offset funeral costs. Mr. Bridgeland said that, because of the poor recordkeeping and poor search procedures, billions of dollars in demutualization compensation went unclaimed. He did a tally of more than $2.5 billion just for demutualizations alone that transferred into the states' unclaimed property funds, with most of it in small policies that especially families could use these days. Mr. Bridgeland said the states reacted to this demutualization compensation for amending their abandoned property laws to accelerate the transfer of demutualization funds into the states' unclaimed property funds, which meant hundreds of millions of dollars went into the states' abandoned property funds. He said these funds are often accompanied by an unpaid death benefit, so there is a potential double benefit to consumers from such funds. Mr. Bridgeland said that some research of people in his hometown found a life insurance policy on the father of a family friend that the proceeds had gone unclaimed for more than twelve years. He said the family received several thousand dollars in demutualization proceeds, in addition to the death benefit when the claim was made—money the family could have used when they lost their father at a young age.

Mr. Bridgeland said the new health care reform MLR requirements will result in future abandoned property funds due to refunds and rebates that are not cashed by consumers. He said that a survey he conducted of state controllers resulted in only four states responding that a process was in place for handling health care reform refunds and rebates. Mr. Bridgeland recommended that the NAIC include a disclosure of abandoned property in the annual statement blank, so that insurance regulators could access this information; add a charge along these lines to the appropriate NAIC committee; include draft a white paper; and develop standards and models for the states to utilize in uniformly pursuing the distribution of abandoned property funds to consumers. Ms. Bach asked what would happen to the funds. Mr. Bridgeland said the funds would go to the states according to each state's property rules. Mr. Chaskey said that unclaimed policy value, retained asset accounts (RAAs), death benefits and MLR rebates could go there, as well.

5. Retained Assets and Default Position

Mr. Kochenburger said that not enough is known about how RAAs are used, both in terms of the disclosures and the amount of money held. He said that the Retained Asset Accounts (A/D) Working Group has done an excellent job in providing a lot of information quickly from its report of the preliminary survey results that were issued a few days ago. He said RAAS have become the industry standard default. He said a Nevada court found MetLife's RAA disclosures to be defective, and inherently deceptive, by suggesting that the accounts were money market accounts, but the court found no intentional illegal activity. He said that consumer confidence has been harmed, because consumers do not have access to the information necessary to make an informed decision regarding the distribution of their life insurance benefits. He said consumer representatives recommend that the NAIC delay taking action on this issue until consumer representatives have assessed all of the pertinent disclosure information available to consumers and evaluated what types of information might still be needed. He said that disclosures do not work, especially when a family is in distress over the loss of a loved one and that selection of a lump sum by beneficiaries often ends up as an RAA by default. He said that disclosures should not imply that RAAs are protected by the FDIC, which collects money upfront over time before there is a loss and pays it out when necessary. He said most state guaranty funds are capped at 200% of the policy face amount up to a maximum amount of $250,000 and are assessed from insurers after a loss.

Mr. Bridgeland referred the Committee to a handout he had prepared from a publicly available examination done by the New York State Insurance Department on Phoenix Life insurance Company that said a dormant account, that the company called a Preferred Client Account (PCA), was a money market account that a beneficiary could write checks against, which highlighted that consumer disclosures are not adequate in this area. He said the examination report discusses the length and duration of RAAs. He said the examiner reviewed an inventory of inactive PCAs and that, during the review, the examiner noted that 1,366 accounts were dormant for periods between three and five years. He said these accounts totaled $30,874,265 and there were 110 accounts—with a combined balance of $2,637,797—that had been dormant for more than five years. He said the company does not have any procedures in place to contact the owners of such accounts. He said the examiner recommended that the company investigate all dormant PCA accounts that have been dormant a minimum of three years, in order to determine if any account should be reported as unclaimed funds and eventually remitted to the appropriate states. Mr. Bridgeland said that the page titled "Liabilities, Surplus and Other Funds" shows line three of the annual statement blank, which relates to liability for deposit-type contracts. He noted that part of the problem is that RAAs are lumped into the broader category called deposit-type contracts. He pointed out that a life insurance exhibit in the annual statement that splits out amounts involving life contingencies and not involving life contingencies. He thanked the Financial Condition (E) Committee for adding this draft to their agenda, because not only will this require a disclosure of the amounts of the RAAs in a format that can be reviewed in the annual statement and provide some good regulatory tools, but it also will enhance what has been added to the information about dormant accounts. He said this would help regulators discern how long accounts have been open and how many accounts, if any, are being transferred into unclaimed property funds. He said that it would also provide more information about how long these accounts have been open.

Mr. Schwarcz said that RAAs allow policyholders and beneficiaries a choice of a check or an RAA, and the default question is what happens when that choice is not exercised; i.e., what happens when a consumer does not respond to the company. In that case, an RAA is the only choice currently offered to consumers, because the automatic default is a RAA. He recommended that a new working group be formed to evaluate why the default is for the benefits to go into an RAA if the beneficiaries do not make a choice. He said that a lot of research has been conducted indicating that defaults determine the choices consumers make. He said this issue is being addressed at the federal level, and it is important for the states to consider, as well. He said the National Conference of Insurance Legislators (NCOIL) model dropped the "opt-in" and "opt-out" wording. He said consumers should be required to make a choice, and that company defaults should be set to match expectations. He said that if defaults were to be set for companies, then they should disclose the lump sum available and the value to be gained by selecting an RAA, and then encourage consumers to choose the best option for them. He said the IIPRC standards indicate that the company default is intended to make the best choice for consumers, which, in most cases, is probably a lump sum. He said that empirical data is available, even though the states might frame the default requirement differently; however, 80% of the states chose the lump sum option. As a consumer representative, he said he would recommend to consumers that any life insurance benefits owed to them be paid into a savings account at a bank.

Ms. Bach asked what percentage of unclaimed property is from RAAs. Mr. Schwarcz said this information is not split out in the annual statement blank, so there is no way to determine this amount.

Commissioner Sammis said a comparison of the interest rates paid on funds maintained in RAAs to interest rates paid on funds maintained in bank accounts evaluated by a prospect theory actuary would provide additional information about this issue. Commissioner Sevigny said that unclaimed (uncashed) checks are a possible result of lump sum payments that are not deposited into RAAs. Superintendent Kofman suggested that this presentation also be given to Retained Asset Accounts (A/D) Working Group.

6. Update on Federal Insurance Office

Mr. Kochenburger said the role of the Federal Insurance Office (FIO) is to systematically collect information about the insurance industry on all insurance lines, except for health insurance and possibly to preempt state laws if they are found to be inconsistent with international treaties. He said a director has not yet been appointed by the U.S. Treasury Secretary to the FIO. He said that one of the two key studies that the FIO will undertake when it is constituted is how to modernize insurance regulation. He said this study on how to modernize insurance regulation is a proxy for the battle of federal vs. state regulation, and there is speculation seen in media reports that, depending on who controls the U.S. House and Senate after the November elections, the optional federal charter might be more of a viable option. He said there are a lot of consumer problems with the optional federal charter. He said if it is successful, it will quickly make state-based insurance regulation nearly irrelevant. He said this has been seen with the banks with the optional dual charter. He said that some of the traditional protections that state laws have offered within insurance, such as rate regulation and form regulation, especially on the personal lines, would essentially be eliminated.

7. Update on Discretionary Clauses

Ms. Beck said the U.S. Supreme Court has once again left the states free to regulate discretionary clauses. She invited the states to take up this issue and offered her help, as well as that of her fellow consumer representatives, to any state interested in getting started on this issue.

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

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