Chapter 2—Continuum of Regulatory Responses

Insurance regulators can access a broad continuum of regulatory responses when determining the appropriate regulatory response to an identified issue or concern. The continuum can be used to guide the decision-making process when regulators move from analysis to a regulatory response. This chapter will provide considerations for selecting regulatory responses to specific situations, as well as provide lists and descriptions of the categories of continuum actions.

A. Considerations

The substantive nature of regulatory concerns may be clarified by evaluating responses to select questions. Answers to the questions categorized below may help set the stage for prioritizing regulatory projects and for then choosing the most appropriate response.

1. Questions to Evaluate

Consumers

- How immediate is the concern? What is the likelihood or severity of any potential consumer harm?
- What is the nature and potential scope of the harm to consumers?
- How extensive is the issue? Does the concern involve one regulated entity or multiple regulated entities?

Regulators

- Do other state, federal or self-regulating organizations also have responsibility over the concern or an interest in it? Is this an issue that should be resolved by the affected jurisdiction independently, with the combined efforts of a few or multiple affected jurisdictions, or should the concern be referred to another jurisdiction?
- Has the concern already been addressed by another jurisdiction? If so, can that resolution be applied to other impacted jurisdictions?

Regulated Entities

- How do company self-audit or best practices organization reviews speak to the concern?
- What is the regulated entity's history for proactive and responsive market conduct compliance?
- What types of market conduct actions have been effective with this or similar entities in the past?

Actions

- What type and volume of information is needed to evaluate the concern and recommend corrective action?
- If an analyst or examiner discovers information or activities that raise suspicions of fraudulent activity, what steps should be taken?
- Should the regulatory response include an enforcement action, restitution, or process and procedure changes?

2. Scale of Response

When deciding which response is most appropriate for the situation, it is also important to determine toward whom the response should be directed. One common target would be a single insurer, although addressing multiple insurers within a holding company group may be more efficient at times. Some groups are comprised of almost completely autonomous operations, while others function within the same operating system or location and under the same management.

Health groups may have a centralized holding company that dictates policies and practices, while connected with numerous small, state-admitted entities. An insurance company or group should be able to indicate how the specific entity is set up. In some cases, the response is best focused on a regulated entity other than an insurer, such as a third-party administrator or producer entity. Some issues may be industry-wide or nearly industry-wide, calling for an appropriate multi-jurisdictional response.

3. Goals of Response

When determining the most appropriate responses, pursue goals similar to the following:

- Stop practices that are harmful to consumers and prevent future harm to consumers;
- Address the issue as widely as possible, with minimal impact to regulated entities that have not contributed to the problem; and
- Remediate harm to impacted consumers. The form of remediation is generally determined through the administrative/legal process. In many cases, the regulated entity will voluntarily propose corrective measures once a noncompliant or incorrect process has been identified. Gathering information to show specific impact can assist the administrative resolution.

4. Measures of Success

When comparing several options that appear to meet the above goals, consider these measures of success to help guide the final decision. Determine if the response is:

- Appropriate: Does the response correspond appropriately to the identified problem?
- Cost-effective: Is the regulatory response cost-effective for both the department and the regulated entity? Does the regulatory response leverage regulatory resources?
- Timing: Does the proposed response accommodate deadlines or time requirements, if any?
- Least intrusive: Is the response the least intrusive way to effectively resolve the matter of regulatory concern?

5. Assigning Regulatory Staff

Who should be assigned to conduct continuum of regulatory responses such as those discussed below? The answer will differ among insurance departments. Individuals with market conduct examination or consumer affairs investigation backgrounds are among those individuals that would be appropriate.

Skills needed, in addition to an understanding of insurance practices to be reviewed, are good letter and report writing skills, good verbal communication skills, and an understanding of insurance department policies and procedures. Additionally, a thorough understanding of issues surrounding treatment of confidential versus publicly available information is important.

B. Regulatory Responses

The continuum of regulatory responses can be roughly divided into four categories: Contact, Examination, Enforcement and Market Actions (D) Working Group. The continuum is not a "ladder," whereby one step must be taken prior to advancing to the next. Rather, it should be viewed as a range of decision-making options.

A brief discussion of each category follows. Examples are provided only for clarity and should not be considered the sole use for each type of response. Note: The principles outlined in Section D Confidentiality in Chapter 8—Examination Introduction of this handbook can also be applied to the continuum of regulatory responses.

1. Contact with the Regulated Entity

Contact with the regulated entity will include the following components:

- Statutory authority for making the request;
- A clear explanation of the concern, along with the specific insurance laws or regulations related to the matter;
- A clear expectation of what action is being requested;

- If requesting information, an explanation of how that information will be used and the statutory protections for confidential information;
- A date by which a reply is expected, along with to whom the response should be sent; and
- A clear explanation of how any billing of investigatory work will be addressed.

The continuum begins with the contact category, dealing with various opportunities to connect directly with the regulated entity, such as:

- Correspondence;
- Interrogatories;
- Interviews with the entity;
- Contact with other stakeholders;
- Targeted information gathering;
- Policy and procedure reviews;
- Review of self-audits and self-review documents; and
- Review of voluntary compliance programs.

This category of continuum actions would be recorded in the appropriate NAIC database to enable regulators to share information about regulatory responses other than examinations and enforcement actions.

Correspondence

Once a potential or fully identified problem has been detected, regardless of any other continuum options chosen, correspondence will typically be the initial response. For some issues, correspondence may be all that is needed. A letter or email may be used to discuss such issues as a perceived negative trend in complaints or a specific problem that needs immediate attention.

A distinct advantage of using correspondence is that the problem can be quickly reviewed and addressed by the insurer. In addition, having documentation of the discussion will also serve as a record in the event the problem is not corrected and is subsequently escalated to another continuum option. However, correspondence may not be the best response if a regulated entity has resisted regulatory communications in the past.

Practical examples of using correspondence include:

- Reminding the regulated entity of a specific regulatory requirement after insurance department consumer affairs staff notes cases of noncompliance; and
- Advising an insurer of increasing complaint ratios noted during the market analysis process.

If correspondence does not satisfactorily address the regulatory concern, further regulatory responses should be considered.

Interrogatories

An interrogatory is simply a set of questions used to evaluate an insurer's handling of compliance or processing issues, and can be tailored to a very specific need for information. Interrogatories are a good option when attempting to determine compliance with a particular rule or law. Surveys, certifications or questionnaires might be included in an interrogatory.

Practical examples of using interrogatories include questionnaires regarding:

- Claim handling practices related to automobile total loss valuation, reimbursement of sales tax and special costs, and branding of salvage titles;
- The company's plan of action to comply with a particular new statute; and
- Compliance with annuity suitability requirements.

Interviews with the Regulated Entity
In the form of a face-to-face meeting or conference call, interviews with the entity are useful when there is a need for open dialogue, discussion or clarification. It provides both the regulator and the regulated entity with an opportunity to ask questions, provide clarification and verbalize each point of view about compliance matters. Interviews with company personnel can be useful to obtain information about specific company divisions or functions.

The most formal method of interview would be taking a statement under oath. Before conducting a statement under oath, review the insurance department's policies and procedures or seek advice from insurance department counsel to become familiar with state-specific requirements. General standards may require that persons examined under oath be permitted representation by counsel and be permitted to have access to a transcript of the proceeding.

Interviews may also be advantageous when the state has determined that the insurer is conducting business outside its standard operating policies and procedures. This option may require specific knowledge of the regulated entity's policies and procedures to understand that the analysis results indicate a deviation from those policies and procedures.

Interviews might also be conducted to resolve questionable market analysis findings. That is, should market analysis findings indicate that the regulated entity might be engaged in problematic practices, interviews may be conducted to give a state a better understanding of these activities. As with the option to correspond with an entity, interviews may not be the best response if a regulated entity has resisted regulatory communications in the past.

Practical examples of performing an interview with the regulated entity include:

- Making a phone call to an insurance company compliance officer to discuss concerns relating to the company's change in marketing strategy;
- Requesting a meeting with a company underwriting manager to learn first-hand how the company uses loss history information; and
- Setting up a recorded statement under oath to ask a claims examiner about company instructions and procedures relating to the handling of problematic claims.

Contact with Other Stakeholders
There may be occasions when the state feels that input is necessary beyond what is gained from talking or corresponding with company officers and decides to contact specified members of the public. The state will need to obtain information from the company to contact its current or past policyholders and claimants, while most states will have current contact information for a company's producers. These contacts can be made by mail or by phone and should be intended to uncover very specific information about the company and the potentially harmful behavior under investigation.

Practical examples of contacting other stakeholders:

- Contacting producers to ask for their perspective about training provided by the company; and
- Contacting consumers who purchased a specific insurance product to ask how the product was presented and sold to them.

Targeted Information Gathering
Targeted information gathering may take the form of a survey or data request. A useful survey should include clear and understandable questions. Where possible, it will be helpful to limit the scope of a survey to one or two insurance company functional areas.

Should the state determine that additional data is required from the regulated entity, the NAIC uniform data requests should be followed. If there is a need to deviate from the uniform data requests to capture specialized information, the need for additional data should be explained and justified to the regulated entity.

Also, if possible, be mindful of time constraints faced by insurance companies. For example, requesting a response date that is near the Market Conduct Annual Statement (MCAS) due date may create an undue workload and unnecessary cost upon an insurer.

Practical examples of targeted information gathering include:

- Requesting a data file from a health insurer to analyze compliance with prompt-pay requirements; and
- Requesting producer mailing lists and mailed materials to assess the company's dissemination of state-required information to its producers.

Policy and Procedure Reviews

For some cases, policy and procedure reviews may be a workable alternative to the traditional market conduct practice of performing sampling and file reviews. A review of written policies and procedures may also be supplemented with a review of a minimal number of files to help ensure that policies and procedures have actually been implemented. Reliance on such a review is dependent upon the company's inclusion of the compliance issue within its written policies and procedures.

Practical examples of the use of policy and procedure reviews include:

- Review of a company's written guidelines relating to protecting privacy of consumer financial and health information; and
- Review of a company's written guidelines that address mandatory training of producers who sell policies under the National Flood Insurance Program (NFIP).

Reviews of Self-Audits and Self-Review Documents

One use of self-audits involves a review of an insurer's existing internal market conduct audit programs. Use of this technique will vary by state; if uncertain, regulators should consult their insurance department's legal counsel. Additional discussion may be found in the NAIC white paper *Regulatory Access to Insurer Information: The Issues of Confidentiality and Privilege*. An advantage to reviewing self-audit reports is to prevent duplication in the review of compliance issues already actively managed by the insurer.

A disadvantage to use of these documents is that scrutiny of an insurer's self-audit reports may place a damper on such self-audit practices because of fear that the insurer will be penalized for identifying mistakes and that such mistakes will ultimately subject the insurer to liability. One practice to consider is to learn the scope and structure of a company's self-audit program, rather than conduct a review of the resulting self-audit reports themselves.

Practical examples of the use of self-audits and self-review documents include:

- Requesting that an insurer identify all health claims with a specific medical procedure code to correct a systematic payment error for the preceding 12 months; and
- Determining which functional areas and subject matters have been evaluated by a company's self-audit program during the preceding 12 months to enable a regulator's market conduct review to focus on company-neglected issues and concerns.

Voluntary Compliance Programs Review

The review of reports from a regulated entity's compliance programs or reports produced by best practices organizations such as the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) may be performed. These types of reviews might be helpful where the scope of the best practice organization's review is substantially similar to the scope of the issue, problem or concern that a state wishes to address. States are encouraged to familiarize themselves with the best practice organization's review processes and, particularly, whether the review process includes verification of compliance with documented policies and procedures.

Such organizations are generally willing to provide a list of participating entities and to share their review standards and methods with regulators. By comparing those review standards with examination review standards, regulators can make better decisions on how to focus the scope of a review. Regulators should also determine how their specific state laws apply to best practice organizations and accreditation services. It is possible that certain accreditation services are required for licensure purposes—for example, managed care utilization review and provider credentialing.

Practical examples of reviewing voluntary compliance program documents include:

- Reviewing the URAC documentation when researching an increase in health insurance-related complaints.

2. Examinations

The examinations category is possibly the most familiar of the continuum categories, and the bulk of the chapters in this handbook are devoted to addressing examination practices in great detail. Unless an examination is required by law in a state, there are often more efficient and cost-effective methods to respond to marketplace issues. However, at times an examination will be the best choice among the continuum options. As stated previously, states should enter any continuum actions into the appropriate NAIC database.

Even within examinations there are many levels and choices available. Decisions need to be made as to:

- Timing of examination;
- Penetration level of examination;
- Location of examination; and
- Participation level of examination.

Timing of Examination

Once the need for an examination has been decided, timing of the examination and notification of the entity will need to be determined. There are three general approaches to timing, and each fits a specific need:

- Statutory examination: Regularly scheduled examination based on state statute;
- Scheduled examination: An examination for cause, providing the entity with prior notice, typically 60-90 days, of when the examination will begin and all pertinent details about what will be reviewed; and
- No-knock examinations: An examination without prior notice being sent to the examined entity. This choice is used when a regulator feels that providing an entity with advance notice of an examination would result in the entity destroying evidence of violations, or creating false information to give the impression of compliance.

Examination Type

It will also need to be determined exactly what will be reviewed. Should the focus be narrow to only the issue that prompted the examination, or wide to encompass all entity functions? There are two recognized divisions:

- Targeted examinations: An examination of one or two areas of business (e.g., an examination of a company's marketing and sales practices); and
- Comprehensive examinations: A review of most, if not all, market conduct areas within an entity (e.g., a five-year statutorily required examination of a domestic insurer).

Location of Examination

Once the scope of the examination has been determined, the location of the examination will logically follow based on the examinations needs:

- Desk examinations: A review of specimen copies or electronic documents at a location other than the regulated entity's offices, e.g. a regulator uses the Internet and electronically provided samples to conduct a review of an entity's advertising materials; and
- On-site reviews: A review conducted in the regulated entity's offices, necessary for review of original documents and actual transactions, e.g. a review of mail processing practices or complaints logs.

Often examiners will utilize a combination of desk and on-site reviews to conduct an effective review while reducing the travel time and costs associated with having a regulatory team on-site for prolonged stays.

Participation Level of Examination

When analyzing the scope of an issue, the breadth of the concern across the company and the likelihood of the issue being found in other jurisdictions should also be evaluated. Collaboration with other jurisdictions is discussed in detail in its own chapter later in this handbook; however, it is worth mentioning here:

- Single State: A review of a regulated entity's actions limited to the jurisdiction conducting the review (e.g., a review of an entity's compliance with a statute enacted in the preceding year;
- Joint Effort: A review conducted by two or more jurisdictions of a single entity or issue (e.g., an examination of a small regional insurer by two bordering states into claims adjustments involving both states; and
- Multi-jurisdictional: An examination of one or more regulated entities by multiple jurisdictions (e.g., an investigation led by a few states for the benefit of all 56 jurisdictions into a large national insurer's practices related to sales of life insurance targeting specific ethnic groups).

Multi-jurisdictional examinations can be conducted in all of the different variations mentioned above. For example, a multistate examination might be conducted as a targeted desk examination or might be an on-site investigation. They are increasing in popularity with both regulated entities and regulators because of the resources saved. Due consideration should always be given to referring multijurisdictional endeavors to the Market Actions (D) Working Group. The Working Group is discussed later in this chapter and also in the chapter titled Collaborative Actions.

As mentioned earlier, this handbook has several chapters devoted to the details of how to conduct investigations and examinations. Please see the applicable chapters relating to investigations and examinations for an in-depth discussion of those types of reviews.

~~**3. Enforcements**~~ ***In the June 14 call, TX recommended moving Section B.3. Enforcements to Section C. Closure of this chapter, on page 10 of this document***

~~On occasion, an enforcement action will clearly be the most practical solution for addressing cases of noncompliance. The types and combinations of enforcement actions are virtually unlimited, although a few general types are captured in this list. Any action of this type should be recorded in the appropriate NAIC database:~~

- ~~Informal agreements;~~
- ~~Voluntary compliance plans;~~
- ~~Administrative complaints;~~
- ~~Cease and desist orders;~~
- ~~Ongoing monitoring/self-audits;~~
- ~~Remediation plans;~~
- ~~Negotiated settlement agreements and consent orders;~~
- ~~Restitution;~~
- ~~Administrative fines/penalties;~~
- ~~Post-investigation or follow-up examinations; and~~
- ~~Probations/suspensions/revocations of license.~~

~~**Informal Agreements**~~

~~An informal agreement to change practices or implement procedures can be either written or verbal. Such an agreement would be most appropriate for situations involving noncompliance with technical regulatory issues and where no significant harm has occurred to consumers or other stakeholders. Such an agreement could include such things as amendment of business practices, forms or rating plans.~~

Voluntary Compliance Plans

An agreement with the regulated entity to establish a voluntary compliance plan would go beyond implementation of a single change in procedures or practices. Such an agreement may include self-monitoring, self-audits and possibly reporting back to the regulator after an agreed-upon period of time.

Administrative Complaints

An administrative complaint is filed when the insurance department has reason to believe that a regulated entity is engaging in noncompliant behavior. The document will allege that a violation of insurance law has occurred or may occur and provide for an administrative hearing where both parties are allowed to present evidence and testimony about the allegations.

Cease and Desist Orders

An order can be issued by the insurance department to a company to prohibit a person or business from continuing all operations or certain targeted operations or violations of law. Such an order would be issued when harm to consumers is considered imminent and quick action is perceived to be necessary. The insurance department then may bring the company in for an administrative hearing to determine future action.

Ongoing Monitoring/Self-Audit

After identification of a systematic compliance error being made by an insurer, regulators may request that the insurer conduct a targeted market conduct self-audit. This permits an insurer to take corrective action and to report its findings to the regulator. Additionally, as part of settlement agreements or after final examination reports, a company may be required to submit regular audits covering the areas of concern. The audits would be submitted to the regulator over a period of one or more years to help ensure continued compliance in the area of concern.

Remediation Plans

In cases where harm can be measured and corrected, remediation may take the form of such actions as premium refunds, supplemental claim payments, removal of unapproved, or incorrectly administered restrictive endorsements or policy change options. Obtaining remediation for policyholders, claimants and parties affected by an adverse situation should generally be a primary goal. Where possible, remediation should be undertaken for all affected jurisdictions. This will reduce or eliminate the need for duplicate regulatory responses.

Negotiated Settlement Agreements and Consent Orders

A negotiated settlement may be used to arrive at a mutually agreeable conclusion to a matter of concern. Such an agreement is typically negotiated and placed into a written consent order by the insurance department's legal counsel. The agreed-upon settlement may include such components as remediation, voluntary forfeitures (fines), agreements to cease and desist, agreements to implement action plans, self-reviews, and possibly reporting back to the regulator after an agreed-upon period of time. The settlement agreement may or may not lack an administrative determination that a specific violation has occurred and may or may not also indicate that the regulated entity neither affirms nor denies the specific allegations. The agreement is made as a means to resolve the conflict. Multiple states may also be involved in negotiated settlements, in which case those regulators involved may wish to consult the Market Actions (D) Working Group created document *Best Practices for Multistate Settlement Agreements*.

Restitution

When a company's actions or omissions have done harm to policyholders, claimants or the department of insurance, the state may require that compensation is made for that harm. The scope and extent of the harm may be determined through self-reporting, any of the continuum actions, or through single or multistate examinations. Compensation is made for actual loss or damage that was sustained.

Administrative Fines and Penalties

An administrative adjudication should follow insurance department or state guidelines. A typical action would follow the filing of a petition or formal complaint against the regulated entity, setting a time and place for an administrative hearing. The regulated entity would be provided an opportunity to offer testimony and evidence before a hearing officer, who would decide the outcome of the action. Likewise, the regulatory representative

~~would present evidence and request a finding or determination along with a request for resolution. Occasionally, a voluntary consent agreement may be reached prior to an administrative hearing. A regulated entity could be required to pay both restitution and a penalty so that actual financial harm is repaired and the entity is also punished for the violations that caused the financial harm.~~

~~**Post-Investigation or Follow-Up Examinations**~~

~~There may be instances when a regulated entity modifies procedures in order to respond to a state's determination of a violation through an investigation or examination. However, the state may not be assured that the change will stay in effect over a long period of time and is not comfortable with the company self-monitoring. In such cases, the state may elect to schedule a series of targeted examinations to monitor the issue over an extended period of time until a comfort level is reached.~~

~~**Probations/Suspensions/Revocations of License**~~

~~Depending on the severity and frequency of specific violations, or the variety of violations, a state may take action against a regulated entity's authority to operate in the state. Probation is often ordered for entities guilty of more minor violations or first offenses, which allows them to continue the business of insurance under supervision. For a more serious charge, the license may be suspended to prohibit any performance of the business of insurance, usually for a specified period of time. If the violations are severe or pervasive in nature, or if probation or suspension has not resulted in a remedy to the issues, the license or authority to conduct the business of insurance may be revoked.~~

~~4~~3. Market Actions (D) Working Group

The Market Actions (D) Working Group was created to give regulators a forum for issues found that should be addressed on a national level. The Working Group meets at each NAIC meeting, as well as holds periodic conference calls and communicates as needed on issues. Membership is made up of a select number of regulators from across the country selected based on their skills, experience and ability to participate in national level activity.

Information Sharing

Each state commissioner appoints a Collaborative Action Designee (CAD) to handle or coordinate the communication to and from the Market Actions (D) Working Group and with other CADs about multistate issues. Most member jurisdictions of the NAIC have signed the Information Sharing and Confidentiality Agreement; the list of signatory jurisdictions may be found in StateNet. Generally, that agreement can be referenced in any exchange of information rather than requiring states to sign individual confidentiality agreements with each other.

Additionally, regulators should be familiar with their state insurance code provisions to determine the extent of materials that may be shared with other state insurance regulators, other state agencies and federal agencies, as some compliance issues may involve multiple jurisdictions or multiple agencies.

Practical applications of information sharing include:

- Entering into a confidentiality agreement and sharing information with banking regulators to evaluate a licensed agency that has sold unregistered investments to insurance clients; and
- Sharing information under the NAIC confidentiality agreement with another state when both states' market analysis processes have identified similar concerns about a licensed insurer.

Referral to the Market Actions (D) Working Group

Issues of concern that have been developed through market analysis or by other channels may be referred to the Market Actions (D) Working Group. When there is a likelihood that the issue affects multiple jurisdictions and cannot be readily or simply resolved to answer the concerns of all affected jurisdictions, a Request for Review (RFR) can be submitted to the Market Actions (D) Working Group. The RFR may be initiated by one or more states, by a commissioner or deputy commissioner, by a Collaborative Action Designee (CAD), by NAIC staff or self-reported by an entity. The RFR asks the referring state(s) not only for the particulars of the issue and the entity (ies), but also for recommendations for continuum-based regulatory responses.

Practical applications of submitting an RFR to the Market Actions (D) Working Group include:

- Several states identify a company with the same issue, and they believe a united request for voluntary compliance will resolve the issue for all impacted states; and
- One state has completed a continuum action with a company for an issue that potentially impacts many states and believes the same resolution can be applied to those states with an action initiated through the Market Actions (D) Working Group.

National Analysis

In addition to responding to issues brought before the group, the Market Actions (D) Working Group annually coordinates a national analysis project using Market Conduct Annual Statement Data that proactively looks at the country's insurers for signs of developing issues. When issues are found, a volunteer jurisdiction will investigate the concern and report back to the group, completing an official referral if necessary.

C. Closure

No matter which continuum of regulatory response option is used to address a situation, regulators will be faced with the decision of how to bring closure to an issue. ***TX 7/10/17 comments recommended incorporating the following lead-in language:*** Each jurisdiction has different considerations and methods for bringing closure to an issue. In some instances, taking enforcement or disciplinary action, or even initiating civil litigation, may be necessary to achieve compliance or resolve the issue. On other occasions, the following listed methods of closure may be appropriate:

~~A discussion of some of the most common methods of closure, listed below, follows:~~

- Determining that no further action is necessary;
- Communicating the insurance department's position;
- Providing information to producers;
- Referral to other agencies, fraud prevention divisions or law enforcement;
- Initiating consumer outreach or education initiatives;
- Ongoing, nonstructured monitoring; and
- Requesting legislative or regulatory rule changes.

Regulators should be aware of and abide by protocols established by their insurance department, commissioner and general counsel relating to the use of various closure outcomes. Insurance departments may have established procedures for communications with media or other governmental agencies and for the distribution of public information. Public information officers, governor liaisons, legislative liaisons, general counsels, deputies and commissioners are all possible sources of information regarding any such protocols within a state insurance department.

When deciding upon a method of closure or outcome, it is helpful to consider not only the nature of the issue and how it has affected consumers, but also the manner in which the issue was discovered and how it was addressed by the regulated entity. It would seldom be prudent to penalize a regulated entity that voluntarily communicated about a problem discovered by way of self-audit, if the regulated entity also took steps to rectify the problem and provided remediation as needed.

TX 7/10/17 comments recommended adding the following subheading in this location:

1. Closure Without Initiating Action or Litigation

Determining That No Further Action Is Necessary

Justification for taking no further action might include such reasons as: (1) determination that company actions were handled in accordance with insurance laws or statutes; (2) there was no violation of insurance law; or (3) that a single problematic issue resulting from a miscommunication was acknowledged and addressed. Additionally, a regulatory response could produce findings that ease concerns raised by market analysis. If an initiative was recorded in the appropriate NAIC database at the beginning of the issue, notes would be added to the entry, and it would then be closed.

Communicating the Insurance Department's Position
A written communication expressing the insurance department's position on a matter can serve not only as clarification, but also as a potential warning or admonishment. It can place the regulated entity on notice that future occurrences may be dealt with in a stricter fashion. This outcome would be finalized in the appropriate NAIC database, and the entry closed. Any such communication should be clear and specific to the issue at hand. For examinations, this generally takes place in the form of a report of examination. For other types of regulatory responses, a closing letter to management may be appropriate.

Alternatively, the issue may be of wider concern than a specific company, and the insurance department will want to convey its position more broadly. The use of targeted mailings, newsletter articles, bulletins and website notices may allow regulators to widely address a concern or provide information relative to new issues, interpretations, relevant case law, implementation policies for new laws, or discussion of new industry practices or technologies. Education is an effective regulatory tool that can be used to provide information to the insurance industry. Two primary forms of education are insurance department communication and proactive outreach.

Practical examples of insurance department communications include:

- Issuing a formal bulletin to clarify the insurance department's interpretation of a specific law;
- Posting an advisory letter to respond to multiple requests for information about a specific compliance issue;
- Providing access to insurance laws and regulations through the insurance department's website;
- Listing helpful suggestions for responding to insurance department inquiries on the insurance department's website; and
- Discussing specific regulatory concerns in an insurance department's quarterly newsletter.

Providing Information to Producers
The insurance department may also wish to convey information to producers, agencies and brokers. In addition to the possible use of mailings and notices, the department may choose a more proactive type of outreach. Outreach mediums include speaking engagements, insurance department-sponsored seminars and training events, press releases, interviews with the media, articles for publication, billboards and advertisements, brochures, and radio spots. Identifying the target audience and tailoring the delivery to that audience are keys to a successful outreach campaign.

Practical examples of producer outreach include:

- Sponsoring a seminar aimed at insurance compliance professionals to discuss changes to variable life insurance law;
- Participating in an industry or regulator-sponsored trade organization seminar to share information about a new rule affecting market regulation; and
- Requesting trade organizations place periodic reminders in their publications about the importance of flood insurance.

Referral to Other Agencies, Fraud Prevention Divisions or Law Enforcement
Occasionally, regulatory issues or concerns may cross agency boundaries within the state. Common examples include securities, banking, motor vehicle registration and financial responsibility, health and human services, consumer protection functions of attorneys general, and senior protection agencies. It is helpful to know who within the state insurance department may have established channels of communication with other applicable agencies. It is also helpful to have a general understanding of the functions within those agencies and how they might apply to insurance.

Any indication of insurance fraud, whether directed against an insurer by an outside person or implemented from within the insurance organization, should immediately be reported to the applicable fraud prevention division. Referrals to law enforcement may be warranted when infractions such as theft by deception or forgery are noted.

Initiating Consumer Outreach or Education
Insurance departments have a unique opportunity for determining which insurance-related issues are confusing or unclear to consumers. It is important to use the insurance department's established guidelines for media contact and generally best to coordinate any media outreach with the department's public information officer. Newspaper and magazine articles, press releases, outreach at public events, and speaking engagements can help provide consumers with tips on how to be more "savvy" about insurance. Publishing a brochure explaining a certain confusing insurance product and requiring its distribution at point of sale can help prevent abusive sales techniques and unsuitable sales.

Practical examples of consumer outreach or education initiatives include:

- Initiating a "Fight Fake Insurance" campaign to inform consumers about the danger of fraudulent and unauthorized health insurers;
- Developing media news releases to teach consumers how to best file insurance claims after a natural disaster; and
- Use of billboards to remind the public that insurance fraud is a crime.

Ongoing, Nonstructured Monitoring
Ongoing, nonstructured monitoring is often appropriate for issues with a high-dollar or high-volume impact. This is especially true if the regulator is not assured that the initial corrective action will be applied continuously and consistently. For example, a claims payment problem that was corrected by programming the correct reimbursement rate for a single medical procedure code into the computer system will probably not need further monitoring. A similar claims payment practice that involves numerous codes or repeated instances might warrant the planning of ongoing monitoring. Deliberate monitoring may also be appropriate when the regulatory response is not conclusive about the extent or nature of an identified problem.

Requesting Legislative or Regulatory Rule Changes
A market conduct issue may be discovered for which no regulatory authority exists to address the concern or when the law has not kept pace with changing market conditions. Sometimes a practice is identified that is perfectly legal, but is causing harm to consumers or disrupting the marketplace. If the issue is approached correctly, insurers are willing to change the practice in question as long as they can be assured of a level playing field. At other times, these situations are identified when new types of insurance, new marketing mechanisms or industry use of emerging technology and tools are introduced and problems need to be addressed on a broader basis through rulemaking, legislative changes and the development of NAIC model laws.

Most insurance departments will have an established protocol for discussion and proposal of new statutes and regulations, generally requiring that all such proposals be channeled directly to the insurance department commissioner. When evaluating the need for change, it is helpful to review existing NAIC model laws and regulations and to request feedback from other states to see if anyone has already addressed the concern. The NAIC, consumer advocacy groups and insurance trade organizations can also be valuable sources of information.

Practical examples of requesting legislative or regulatory rule changes include:

- Addressing the need for advertising regulations in Internet sales; and
- Addressing the need to amend existing insurance statutes to address new types of insurance or marketing arrangements.

TX 7/10/17 comments recommended adding the following subheading in this location:

2. Closure Through Enforcement Methods, Disciplinary Action or Litigation

In the June 14 call, TX recommended moving Section B.3. Enforcements to Section C. Closure of this chapter. CA also made this same recommendation in their April 20 comments.

On occasion, an enforcement action will clearly be the most practical solution for addressing cases of noncompliance. The types and combinations of enforcement actions are virtually unlimited, although a few general types are captured in this list. Any action of this type should be recorded in the appropriate NAIC database:

- Informal agreements;
- Voluntary compliance plans;
- Administrative complaints;
- Cease and desist orders;
- Ongoing monitoring/self-audits;
- Remediation plans;
- Negotiated settlement agreements and consent orders;
- Restitution;
- Administrative fines/penalties;
- Post-investigation or follow-up examinations; and
- Probations/suspensions/revocations of license.

Informal Agreements

An informal agreement to change practices or implement procedures can be either written or verbal. Such an agreement would be most appropriate for situations involving noncompliance with technical regulatory issues and where no significant harm has occurred to consumers or other stakeholders. Such an agreement could include such things as amendment of business practices, forms or rating plans.

Voluntary Compliance Plans

An agreement with the regulated entity to establish a voluntary compliance plan would go beyond implementation of a single change in procedures or practices. Such an agreement may include self-monitoring, self-audits and possibly reporting back to the regulator after an agreed-upon period of time.

Administrative Complaints

An administrative complaint is filed when the insurance department has reason to believe that a regulated entity is engaging in noncompliant behavior. The document will allege that a violation of insurance law has occurred or may occur and provide for an administrative hearing where both parties are allowed to present evidence and testimony about the allegations.

Cease and Desist Orders

An order can be issued by the insurance department to a company to prohibit a person or business from continuing all operations or certain targeted operations or violations of law. Such an order would be issued when harm to consumers is considered imminent and quick action is perceived to be necessary. The insurance department then may bring the company in for an administrative hearing to determine future action.

Ongoing Monitoring/Self-Audit

After identification of a systematic compliance error being made by an insurer, regulators may request that the insurer conduct a targeted market conduct self-audit. This permits an insurer to take corrective action and to report its findings to the regulator. Additionally, as part of settlement agreements or after final examination reports, a company may be required to submit regular audits covering the areas of concern. The audits would be submitted to the regulator over a period of one or more years to help ensure continued compliance in the area of concern.

Remediation Plans

In cases where harm can be measured and corrected, remediation may take the form of such actions as premium refunds, supplemental claim payments, removal of unapproved, or incorrectly administered restrictive endorsements or policy change options. Obtaining remediation for policyholders, claimants and parties affected by an adverse situation should generally be a primary goal. Where possible, remediation should be undertaken for all affected jurisdictions. This will reduce or eliminate the need for duplicate regulatory responses.

Negotiated Settlement Agreements and Consent Orders

A negotiated settlement may be used to arrive at a mutually agreeable conclusion to a matter of concern. Such an agreement is typically negotiated and placed into a written consent order by the insurance department's legal counsel. The agreed-upon settlement may include such components as remediation, voluntary forfeitures (fines), agreements to cease and desist, agreements to implement action plans, self-reviews, and possibly reporting back to the regulator after an agreed-upon period of time. The settlement agreement may or may not lack an administrative determination that a specific violation has occurred and may or may not also indicate that the regulated entity neither affirms nor denies the specific allegations. The agreement is made as a means to resolve the conflict. Multiple states may also be involved in negotiated settlements, in which case those regulators involved may wish to consult the Market Actions (D) Working Group-created document *Best Practices for Multistate Settlement Agreements*.

Restitution

When a company's actions or omissions have done harm to policyholders, claimants or the department of insurance, the state may require that compensation is made for that harm. The scope and extent of the harm may be determined through self-reporting, any of the continuum actions, or through single or multistate examinations. Compensation is made for actual loss or damage that was sustained.

Administrative Fines and Penalties

An administrative adjudication should follow insurance department or state guidelines. A typical action would follow the filing of a petition or formal complaint against the regulated entity, setting a time and place for an administrative hearing. The regulated entity would be provided an opportunity to offer testimony and evidence before a hearing officer, who would decide the outcome of the action. Likewise, the regulatory representative would present evidence and request a finding or determination along with a request for resolution. Occasionally, a voluntary consent agreement may be reached prior to an administrative hearing. A regulated entity could be required to pay both restitution and a penalty so that actual financial harm is repaired and the entity is also punished for the violations that caused the financial harm.

Post-Investigation or Follow-Up Examinations

There may be instances when a regulated entity modifies procedures in order to respond to a state's determination of a violation through an investigation or examination. However, the state may not be assured that the change will stay in effect over a long period of time and is not comfortable with the company self-monitoring. In such cases, the state may elect to schedule a series of targeted examinations to monitor the issue over an extended period of time until a comfort level is reached.

Probations/Suspensions/Revocations of License

Depending on the severity and frequency of specific violations, or the variety of violations, a state may take action against a regulated entity's authority to operate in the state. Probation is often ordered for entities guilty of more minor violations or first offenses, which allows them to continue the business of insurance under supervision. For a more serious charge, the license may be suspended to prohibit any performance of the business of insurance, usually for a specified period of time. If the violations are severe or pervasive in nature, or if probation or suspension has not resulted in a remedy to the issues, the license or authority to conduct the business of insurance may be revoked.

