REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC’s Executive Committee is required. The NAIC’s Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: ☐ New Model Law or ☑ Amendment to Existing Model

1. Name of group to be responsible for drafting the model:
   Innovation and Technology (EX) Task Force

2. NAIC staff support contact information:
   Denise Matthews
dmatthews@naic.org
   816-783-8007

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

   NAIC Unfair Trade Practices Act (Model #880)
   Section 4(H)(1)

   The Innovation and Technology (EX) Task Force will draft amendments to the NAIC Unfair Trade Practices Act (Model #880), focusing on Section 4H, to clarify what is considered a “rebate” or “inducement”.

4. Does the model law meet the Model Law Criteria? ☑ Yes or ☐ No (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
   
   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☑ Yes or ☐ No (Check one)
      
      If yes, please explain why: Inconsistency in the interpretation of the Model language necessitates revisions to clarify the intent and ensure necessary consumer protections remain in place in light of technologies being deployed to add value to existing insurance products and services.

   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
      ☑ Yes or ☐ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?
   ☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)
   
   High Likelihood Low Likelihood

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Explanation, if necessary: A significant amount of time and discussion has already been devoted to this topic including presentations from all stakeholders and discussion around draft guideline language. That should help in accelerating the development process related to this model language.

6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1  X  2  ☐  3  ☐  4  ☐  5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary:

7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1  X  2  ☐  3  ☐  4  ☐  5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary:

8. Is this model law referenced in the NAIC Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

No

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No.
Section 4. Unfair Trade Practices Defined

Any of the following practices, if committed in violation of Section 3, are hereby defined as unfair trade practices in the business of insurance:

A. Misrepresentations and False Advertising of Insurance Policies. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison that:

(1) Misrepresents the benefits, advantages, conditions or terms of any policy; or

(2) Misrepresents the dividends or share of the surplus to be received on any policy; or

(3) Makes a false or misleading statement as to the dividends or share of surplus previously paid on any policy; or

(4) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates; or

(5) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(6) Is a misrepresentation, including any intentional misquote of premium rate, for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion or surrender of any policy; or

(7) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or

(8) Misrepresents any policy as being shares of stock.
B. False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing
before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or
placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular,
pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement,
announcement or statement containing any assertion, representation or statement with respect to the
business of insurance or with respect to any insurer in the conduct of its insurance business, which is
untrue, deceptive or misleading.

C. Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or
encouraging the making, publishing, disseminating or circulating of any oral or written statement or any
pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the
financial condition of any insurer, and which is calculated to injure such insurer.

D. Boycott, Coercion and Intimidation. Entering into any agreement to commit, or by any concerted action
committing any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable
restraint of, or monopoly in, the business of insurance.

E. False Statements and Entries.
   (1) Knowingly filing with any supervisory or other public official, or knowingly making, publishing,
disseminating, circulating or delivering to any person, or placing before the public, or knowingly
caus ing directly or indirectly, to be made, published, disseminated, circulated, delivered to any
person, or placed before the public, any false material statement of fact as to the financial
condition of an insurer.
   (2) Knowingly making any false entry of a material fact in any book, report or statement of any
insurer or knowingly omitting to make a true entry of any material fact pertaining to the business
of such insurer in any book, report or statement of such insurer, or knowingly making any false
material statement to any insurance department official.

F. Stock Operations and Advisory Board Contracts. Issuing or delivering or permitting agents, officers or
employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares
in any common law corporation, or securities or any special or advisory board contracts or other contracts
of any kind promising returns and profits as an inducement to purchase insurance.

G. Unfair Discrimination.
   (1) Making or permitting any unfair discrimination between individuals of the same class and equal
expectation of life in the rates charged for any life insurance policy or annuity or in the dividends
or other benefits payable thereon, or in any other of the terms and conditions of such policy.
   (2) Making or permitting any unfair discrimination between individuals of the same class and of
essentially the same hazard in the amount of premium, policy fees or rates charged for any
accident or health insurance policy or in the benefits payable thereunder, or in any of the terms or
conditions of such policy, or in any other manner.

Drafting Note: In the event that unfair discrimination in connection with accident and health coverage is treated in other
statutes, this paragraph should be omitted.
   (3) Making or permitting any unfair discrimination between individuals or risks of the same class and
of essentially the same hazard by refusing to insure, refusing to renew, canceling or limiting the
amount of insurance coverage on a property or casualty risk solely because of the geographic
location of the risk, unless such action is the result of the application of sound underwriting and
actuarial principles related to actual or reasonably anticipated loss experience.
   (4) Making or permitting any unfair discrimination between individuals or risks of the same class and
of essentially the same hazards by refusing to insure, refusing to renew, canceling or limiting the
amount of insurance coverage on the residential property risk, or the personal property contained
therein, solely because of the age of the residential property.
(5) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex, marital status, race, religion or national origin of the individual; however, nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits. Nothing in this section shall prohibit or limit the operation of fraternal benefit societies.

(6) To terminate, or to modify coverage or to refuse to issue or refuse to renew any property or casualty policy solely because the applicant or insured or any employee of either is mentally or physically impaired; provided that this subsection shall not apply to accident and health insurance sold by a casualty insurer and, provided further, that this subsection shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract.

(7) Refusing to insure solely because another insurer has refused to write a policy, or has cancelled or has refused to renew an existing policy in which that person was the named insured. Nothing herein contained shall prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance.

(8) Violation of the state’s rescission laws at [insert reference to appropriate code section].

Drafting Note: A state may wish to include this section if it has existing state laws covering rescission and to insert a reference to a particular code section.

H. Rebates.

(1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any life insurance policy or annuity, or accident and health insurance or other insurance, or agreement as to such contract other than as plainly expressed in the policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such policy, any rebate of premiums payable on the policy, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such policy or annuity or in connection therewith, any stocks, bonds or other securities of any company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the policy.

(2) Nothing in Subsection G, or Paragraph (1) of Subsection H shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) In the case of life insurance policies or annuities, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;

(c) Readjusting the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; or

(e) The offer or provision by insurers or producers, by or through employees, affiliates or third party representatives, of value-added products or services at no or reduced cost when such products or services are not specified in the policy of insurance if the product or service:

(i) Relates to the insurance coverage; and

(ii) Is primarily designed to satisfy one or more of the following:

(I) Provide loss mitigation or loss control;

(II) Reduce claim costs or claim settlement costs;

(III) Provide education about liability risks or risk of loss to persons or property;

(IV) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;

(V) Enhance health;

(VI) Enhance financial wellness through items such as education or financial planning services;

(VII) Provide post-loss services;

(VIII) Incent behavioral changes to improve the health or reduce the risk of death or disability of a customer (defined for purposes of this subsection as policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured or applicant); or

(IX) Assist in the administration of the employee or retiree benefit insurance coverage.

(iii) The cost to the insurer or producer offering the product or service to any given customer must be reasonable in comparison to that customer’s premiums or insurance coverage for the policy class.

(iv) If the insurer or producer is providing the product or service offered, the insurer or producer must ensure that the customer is provided with contact information to assist the customer with questions regarding the product or service.

(v) The commissioner may adopt regulations when implementing the permitted practices set forth in this statute to ensure consumer protection. Such regulations, consistent with applicable law, may address, among other issues, consumer data protections and privacy, consumer disclosure and unfair discrimination.

(vi) The availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory. The documented criteria must be maintained by the insurer or producer and produced upon request by the Department.

Drafting Note: States may wish to consider alternative language based on their filing requirements.
If an insurer or producer does not have sufficient evidence, but has a good-faith belief that the product or service meets the criteria in H(2)(e)(ii), the insurer or producer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year. An insurer or producer must notify the Department of such a pilot or testing program offered to consumers in this state prior to launching and may proceed with the program unless the Department objects within twenty-one days of notice.

Drafting Note: This Section is not intended to limit or curtail existing value-added services in the marketplace. It is intended to promote innovation in connection with the offering of value-added services while maintaining strong consumer protections.

(f) An insurer or a producer may:

(i) Offer or give non-cash gifts, items, or services, including meals to or charitable donations on behalf of a customer, in connection with the marketing, sale, purchase, or retention of contracts of insurance, as long as the cost does not exceed an amount determined to be reasonable by the commissioner per policy year per term. The offer must be made in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.

(ii) Offer or give non-cash gifts, items, or services including meals to or charitable donations on behalf of a customer, to commercial or institutional customers in connection with the marketing, sale, purchase, or retention of contracts of insurance, as long as the cost is reasonable in comparison to the premium or proposed premium and the cost of the gift or service is not included in any amounts charged to another person or entity. The offer must be made in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.

(iii) Conduct raffles or drawings to the extent permitted by state law, as long as there is no financial cost to entrants to participate, the drawing or raffle does not obligate participants to purchase insurance, the prizes are not valued in excess of a reasonable amount determined by the commissioner and the drawing or raffle is open to the public. The raffle or drawing must be offered in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.

Drafting Note: If a state wishes to limit (f) to a stated monetary limit the committee would suggest that, at the time of the drafting of this model, the lesser of 5% of the current or projected policyholder premium or $250 would be an appropriate limit, however specific prohibitions may exist related to transactions governed by the Real Estate Settlement Procedures Act of 1974 and the laws and regulations governing the Federal Crop Insurance Corporation Risk Management Agency. States may want to consider a limit for commercial or institutional customers.

(3) An insurer, producer or representative of either may not offer or provide insurance as an inducement to the purchase of another policy or otherwise use the words “free”, “no cost” or words of similar import, in an advertisement.

Drafting Note: Section 104 (d)(2)(B)(viii) of the Gramm-Leach-Bliley Act provides that any state restrictions on anti-tying may not prevent a depository institution or affiliate from engaging in any activity that would not violate Section 106 of the Bank Holding Company Act Amendments of 1970, as interpreted by the Board of Governors of the Federal Reserve System. The Board of Governors of the Federal Reserve System has stated that nothing in its interpretation on combined-balance
discount arrangements is intended to override any other applicable state and federal law. FRB SR 95-32 (SUP). Section 5(q) of the Home Owners’ Loan Act is the analogous provision to Section 106 for thrift institutions. The Office of Thrift Supervision has a regulation 12 C.F.R. 563.36 that allows combined-balance discounts if certain requirements are met.

Drafting Note: Each state may wish to examine its rating laws to ensure that it contains sufficient provisions against rebating. If a state does not, this section may be expanded to cover all lines of insurance.

I. Prohibited Group Enrollments. No insurer shall offer more than one group policy of insurance through any person unless such person is licensed, at a minimum, as a limited insurance representative. However, this prohibition shall not apply to employer/employee relationships, nor to any such enrollments.

J. Failure to Maintain Marketing and Performance Records. Failure of an insurer to maintain its books, records, documents and other business records in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two (2) preceding years shall be maintained.

K. Failure to Maintain Complaint Handling Procedures. Failure of any insurer to maintain a complete record of all the complaints it received since the date of its last examination under Section [insert applicable section]. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this subsection, “complaint” shall mean any written communication primarily expressing a grievance.

L. Misrepresentation in Insurance Applications. Making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money or other benefit from any provider or individual person.

M. Unfair Financial Planning Practices. An insurance producer:

(1) Holding himself or herself out, directly or indirectly, to the public as a “financial planner,” “investment adviser,” “consultant,” “financial counselor,” or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters or trust and estate matters when such person is in fact engaged only in the sale of policies. This provision does not preclude persons who hold some form of formal recognized financial planning or consultant certification or designation from using this certification or designation when they are only selling insurance. This does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

(2) (a) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in Paragraph 3, or solicitation of the sale of a product or service that

(i) He or she is also an insurance salesperson, and

(ii) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case.

(b) The disclosure requirement under this subsection may be met by including it in any disclosure required by federal or state securities law.

(3) (a) Charging fees other than commissions for financial planning by insurance producer, unless such fees are based upon a written agreement, signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the party to be charged at the time the agreement is signed by the party.

(i) The services for which the fee is to be charged must be specifically stated in the agreement.
(ii) The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement.

(iii) The agreement must state that the client is under no obligation to purchase any insurance product through the insurance producer or consultant.

**Drafting Note:** This subsection is intended to apply only to persons engaged in personal financial planning.

(b) The insurance producer shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the commissioner upon request.

N. Failure to file or to certify information regarding the endorsement or sale of long-term care insurance. Failure of any insurer to:

(1) File with the insurance department the following material:

(a) The policy and certificate;

(b) A corresponding outline of coverage; and

(c) All advertisements requested by the insurance department; or

(2) Certify annually that the association has complied with the responsibilities for disclosure, advertising, compensation arrangements, or other information required by the commissioner, as set forth by regulation.

O. Failure to Provide Claims History

(1) Loss Information—Property and Casualty. Failure of a company issuing property and casualty insurance to provide the following loss information for the three (3) previous policy years to the first named insured within thirty (30) days of receipt of the first named insured’s written request:

(a) On all claims, date and description of occurrence, and total amount of payments; and

(b) For any occurrence not included in Subparagraph (a) of this paragraph, the date and description of occurrence.

(2) Should the first named insured be requested by a prospective insurer to provide detailed loss information in addition to that required under Paragraph (1), the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than reasonably required to underwrite the same line or class of insurance. The insurer shall provide information under this subparagraph to the first named insured as soon as possible, but in no event later than twenty (20) days of receipt of the written request. Notwithstanding any other provision of this section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information.

(3) The commissioner may promulgate regulations to exclude the providing of the loss information as outlined in Paragraph (1) for any line or class of insurance where it can be shown that the information is not needed for that line or class of insurance, or where the provision of loss information otherwise is required by law.

**Drafting Note:** Loss information on workers’ compensation is an example in some states of loss information otherwise required by law.

(4) Information provided under Paragraph (2) shall not be subject to discovery by any party other than the insured, the insurer and the prospective insurer.
Drafting Note: This provision may not be required in states that have a privacy act that governs consumer access to this information. Those states considering applying this requirement to life, accident and health lines of insurance should first review their state privacy act related to issues of confidentiality of individual insured information.

P. Violating any one of Sections [insert applicable sections].

Drafting Note: Insert section numbers of any other sections of the state’s insurance laws deemed desirable or necessary to include as an unfair trade practice, such as cancellation and nonrenewal laws.
PROJECT HISTORY

UNFAIR TRADE PRACTICES ACT #880

1. Description of the Project, Issues Addressed, etc.

The NAIC’s Innovation and Technology (EX) Task Force began discussing rebating issues in 2018 during the NAIC Summer National Meeting in Boston, MA, particularly because of the increased interest in offering value-added products and services such as risk mitigation devices and related services that are not necessarily addressed within the applicable insurance policy language. After finding that state interpretation and application of anti-rebating laws varies and after reviewing the history of the NAIC’s Unfair Trade Practices Act (#880) along with the history and the intent of the anti-rebating portion, it became clear that applying the anti-rebating laws to the innovation of new insurance products and services could be challenging. The Task Force received presentations and testimony from many stakeholders, including state insurance regulators, producers, consumers, insurance companies and the startup community regarding a wide array of opinions and concerns. They also offered various suggestions for improving uniform application of anti-rebating statutes in the states. Based on this research and hearing from stakeholders, the Task Force members determined it would be appropriate to review Model #880, specifically Section 4(H)(2).

2. Name of Group Responsible for Drafting the Model and States Participating

The Innovation and Technology (EX) Task Force was responsible for the drafting of the revisions to Model #880. The process began with the formation of a drafting group. The group was led by Superintendent Elizabeth Kelleher Dwyer (RI). Seven other states participated in the drafting process: Alaska, Alabama, Iowa, Missouri, North Dakota, Ohio and Washington. Also participating were six industry representatives, including one startup; one state legislator (Rep. Matt Lehman (IN), the president of National Council of Insurance Legislators—NCOIL); and a consumer representative.

3. Project Authorized by What Charge and Date First Given to the Group

The mission of the Innovation and Technology (EX) Task Force is to: 1) provide a forum for state insurance regulator education and discussion of innovation and technology in the insurance sector; 2) monitor technology developments that affect the state insurance regulatory framework; and 3) develop regulatory guidance, as appropriate. This work was done under the specific charge:

The Innovation and Technology (EX) Task Force will:
Develop regulatory guidance, model laws or model law revisions, and white papers or make other recommendations to the Executive (EX) Committee, as appropriate.

At its meeting during the 2019 Summer National Meeting, the Task Force voted to move forward with the Request for NAIC Model Law Development to open Model #880 to amend or add to the language in Section 4(H)(2). The request was adopted by the Task Force in October 2019 and subsequently by the NAIC Executive (EX) Committee in December during the 2019 Fall National meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The drafting group met twice at the beginning of 2020, in January and February, and then stopped meeting for a period of time because of the COVID-19 pandemic. However, it regrouped to meet two more times in May and June. Given the Task Force had already received considerable input from stakeholders regarding this topic, the drafting group was able to move forward expeditiously and disbanded prior to the 2020 Summer National Meeting.
5. **A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)**

The first draft published out of the drafting group was posted for comment on June 23. Twenty-one comment letters were submitted, and Superintendent Dwyer reviewed the changes made based on those comments during the Task Force’s meeting on Aug. 7. A new draft was posted and exposed for comment on Aug. 10. Seventeen comments were reviewed, and a new draft was posted on Oct. 30. During the Task Force’s meeting on Nov. 4, Superintendent Dwyer again reviewed each substantive comment, noting whether it was accepted or rejected in the latest draft. Comments regarding the Oct. 30 draft were again requested and accepted. Seven comments were reviewed, and interested parties were given an opportunity to present their points orally. Additionally, Task Force members and interested parties had the opportunity to ask questions or pose challenges to those points during a meeting on Nov. 30. Five presentations were made. Following the meeting on Nov. 30, another draft was posted on Dec. 2. During its meeting on Dec. 4 and with 44 members of the Task Force in attendance, the revised language was adopted, with Nevada dissenting and California, Hawaii, Idaho and New Jersey abstaining.

6. **A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response)**

While the genesis for drafting this revised language was primarily the need to clarify intentions related to the acceptability of the offering of things of value in the best interests of the consumer and to mitigate risk associated with what is being underwritten, value-added products and services, Section H(2)(e), the group also took on drafting clarifying language related to producer and insurer marketing including non-cash gifts meals, charitable donations on behalf of a customer, raffles and drawings, Section H(2)(f).

Since the term “value-added” is relatively new, there was considerable discussion regarding its use. Ultimately, the drafters and most of the state insurance regulators and interested parties agreed it was the appropriate term and needed no further defining.

There was considerable debate and discussion regarding the list in Section H(2)(e)(ii). The term “primarily designed” was discussed very thoroughly as the early use of the term “primarily intended” gave some state insurance regulators concern given the difficulty in determining “intent.” There seemed to be consensus that “designed” was a much better term to use in this case. The list itself was heavily debated both in terms of it being comprehensive and there not being a “catch-all,” as well as in terms of the value-added product or service needing to satisfy at least one of the listed criteria.

The cost discussed in Section H(2)(e)(iii) was also heavily debated. In the end, in addition to other language in that section, it was determined to be appropriate to include a drafting note that notes states may consider alternative language depending on their filing requirements. There was great care given to there being deference or to acknowledging some states may already have statute or regulation language that addresses or sets out permitted practices.

There was also a lot of discussion regarding Section H(2)(e)(vii). The debate was primarily around differences of opinion regarding whether offering the value-added product or service would need to be preapproved by the Department of Insurance (DOI). The concern on the part of industry was slowing down the ability to move forward with a pilot or testing something new, which led, ultimately, to the decision to require notification to the DOI, with a 21-day time period for the DOI to object.

In Section H(2)(f), great care was given to the specific terms used in this section. Given the history with this issue specific to the dollar amount, a drafting note was included to offer a suggested monetary amount but ultimately left to the state. In addition, this section addresses commercial or institutional customers as there was a great deal of discussion around excluding commercial lines from this section altogether, considering the notion that a transaction between sophisticated purchasers and sellers does not require this type of oversight.

Lastly, Section H(3) is intended to make clear that original rebating language intended to prevent abuses related to inducement to purchase or renew is still in effect, and this new language should not be construed to change that.
7. **List the key provisions of the model (sections considered most essential to state adoption)**

Section H(2)(e), Section H(2)(f) and Section H(3)

8. **Any Other Important Information (e.g., amending an accreditation standard)**

No other items are identified at this time.