LIFE, ANNUITY, AND RETIREMENT SOLUTIONS INDUSTRY

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LEGAL ISSUES AND DEVELOPMENTS FROM CARLTON FIELDS

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LIFE, ANNUITY, AND RETIREMENT SOLUTIONS APRIL 2021

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EXPECTFOCUS® is a review of developments in the life, annuity, and retirement solutions industry, provided on a complimentary basis to clients and friends of Carlton Fields.

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States Spring Into Action With Best Interest Rules for Annuities

BY ANN BLACK, JAMIE BIGAYER, AND STEPHEN CHOI*

In February 2020, the NAIC approved revisions to the Suitability in Annuity Transactions Model 275, adopting a four-part best interest obligation, including the following obligations: care, disclosure, conflict of interest, and documentation. The revisions to Model 275 also fertilized the producer training requirements and the insurer supervision system with respect to annuity recommendations to consumers. The status of state adoption of changes to their suitability requirements are as follows:

- Adopted: Arizona, Arkansas, Delaware, Idaho, Iowa, Michigan, Nebraska, North Dakota, Ohio, Rhode Island
- Pending: Alabama, Connecticut, Kentucky, Maine, Montana, Nevada,[1] Texas, Virginia

Below is a summary of the differences between the state initiatives and the revisions to Model 275.

To graft with the federal securities laws and the Department of Labor, Model 275 adopted a "best interest obligation" standard. Alabama and Kentucky differ from Model 275 because their state initiatives currently do not use the term "best interest," but the operative provisions of these states' initiatives contain the same four parts as the Model 275 "best interest obligation."

As part of the care obligation, Model 275 requires the producer to communicate the basis of the recommendation to the consumer. During its drafting sessions, the NAIC Suitability Working Group opted not to require this to be in writing. However, Montana specifically requires a producer to "communicate the basis or bases of the recommendation **to the consumer in writing**."

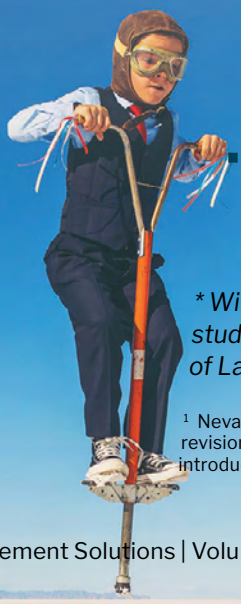
As part of the disclosure obligation, Model 275 requires the producer to provide the following to the consumer:

1. Descriptions of (a) the producer-consumer relationship and the producer's role in the transaction and (b) the sources and types of both cash and non-cash compensation that the producer receives from the transaction.
2. Affirmative statements regarding (a) the products the producer is licensed and authorized to sell and (b) whether the producer is authorized, contracted, or able to sell insurance products for one insurer, two or more insurers, or two or more insurers although the producer primarily contracts with one insurer.
3. Notice of a consumer's right to request other information regarding cash compensation.

Model 275 provides a template for such disclosure in Appendix A and requires the consumer to sign the last page of this disclosure document. However, Maine's proposed changes require the consumer to sign each page of the producer disclosure.

Further updates to Model 275 address (a) new producer training requirements on the revised standard of care and (b) the ability to satisfy those training requirements with "substantially similar" courses. These updates to Model 275, and state differences, are as follows:

- *Training Requirements for Existing Producers* – Under Model 275, existing producers that completed an annuity training course under the prior model will have six months to comply with the new model. Existing producers can come into compliance by completing either (1) a new four-credit annuity training course or (2) a one-credit training course to cultivate an existing producer's knowledge of the new model requirements.
  - Kentucky and Texas leave out the provisions that permit existing producers who have already taken the four-credit course to take only the additional one-credit course.
  - North Dakota pruned away the six-month delay in the implementation of the revised producer training requirement for existing producers that are already licensed.
- *Substantially Similar Courses* – Under the revised Model 275, in addition to having reciprocity of producer training courses between states, producer training requirements can be satisfied by courses that are "substantially similar" to those described in Model 275.
  - Alabama and Kentucky omit the allowance for "substantially similar" courses to satisfy their revised producer training requirements. However, both include reciprocity for courses from another state.
  - Montana weeds out the ability for annuity training courses from other states to satisfy its revised producer training requirements.



** With assistance from Jordan Luczaj, a student at the University of Miami School of Law.*

[1] Nevada's current proposal is not based on the 2020 revisions to Model 275; however, Nevada is expected to introduce a substitute proposal that follows Model 275.

The Gift of Giving: States Move to Amend Their Anti-Rebating Laws

BY ANN BLACK AND JAMIE BIGAYER

On December 9, 2020, the NAIC Executive Committee adopted provisions to section 4(H) of the NAIC Unfair Trade Practices Act (Model 880) allowing insurers and producers to provide consumers with value-added products and services that are not specified in the policy. Massachusetts, New Mexico, New York, and North Dakota are proposing changes to their respective rebating laws, based on the changes to Model 880.

This article will examine the differences between the changes to Model 880 and the state initiatives. (Our previous article "NAIC Task Force Gives Insurers a Holiday Rebating Gift," *Expect Focus – Life, Annuity, and Retirement Solutions* (December 2020) discusses the NAIC framework.) In addition, this article will discuss Washington state's new regulation that, while not amending its unfair practices and frauds act, imposes advertising requirements for products offering noninsurance benefits that incentivize healthy behavioral changes.

Section 4(H) enumerates the types of value-added products or services that may be provided. The states differ from the NAIC as follows:

- Massachusetts includes administrative services as an additional permissible benefit.
- New Mexico requires that the benefits provided be approved by the insurance department before a product or service is offered.
- New York's list of permissible benefits only applies to wellness programs.
- North Dakota requires only that the product or service be *designed* to provide one of the permissible benefits, instead of *primarily designed* as required by the NAIC. Commissioner Doug Ommen described the "primarily designed" standard as "a basic test [that the product or service] is related to the value being added." Whether North Dakota seeks to impose a more stringent requirement with its variation is unclear.

Section 4(H) requires that a value-added product or service be offered (i) to all insureds or (ii) if not to all, (a) based on documented objective criteria and (b) in a manner that is not unfairly discriminatory. The states differ from the NAIC as follows:

- Massachusetts does not include this requirement.
- In New York, value-added services are presumptively permissible if they are offered in a nondiscriminatory manner to all similarly situated insureds, unless "the Superintendent determines, after a notice and hearing, that … but for the offer or delivery of such service, the purchase of such policy or contract would not have taken place."

Section 4(H) allows each state to establish monetary caps on the value of items, services, meals, or charitable donations that are provided. The state limits are:

For products and services with non-enumerated benefits.	MA – capped at $25 ND – capped at $100
For wellness programs that are supported by "data and research that such incentives, in the aggregate, are directed to sharing the benefit of improving mortality risk experience."	NY – no cap

New Mexico does not address monetary limits.

Washington adopted a new regulation to ensure that incentives intended to influence consumer behavior protect policyholders' privacy rights and protect consumers in the administration of life insurance products. Advertisements for individual insurance policies that provide noninsurance benefits that "incent behavioral changes that improve the health and reduce the risk of death of the insured" must contain specific disclaimers that:

1. Provide contact information for the insurer.
2. Inform the insured if the noninsurance benefit includes additional costs or participation requirements.
3. Inform the insured if the noninsurance benefit has additional requirements associated with participation in the program.
4. Inform the insured if the noninsurance benefit has a penalty for terminating participation for the products or services.

While the amendments to section 4(H) were intended to promote uniformity across the states, the states' actions thus far reflect deviations from Model 880. Thus, insurers hoping to make value-added products and services available need to carefully consider the implications of the different regulatory requirements, as more states are expected to take action in 2021.

A Future Without SEC Tolling Agreements?

Some Say "Not So Fast"

BY NATALIE NAPIERALA AND KATELYN SANDOVAL

The SEC routinely requests individuals who may be the subjects or targets of investigations to execute agreements that delay or suspend the time period in a statute of limitations for an agreed period (commonly referred to as "tolling agreements"). This practice generally benefits both parties: the SEC can investigate at its own pace, and the putative subjects or targets have more time to argue why the SEC should not bring an enforcement action against them.

So, what's the problem? Turns out, these tolling agreements may not be enforceable under federal jurisprudence. Under 28 U.S.C. § 2462, "[e]xcept as otherwise provided by Act of Congress, an action, suit or proceeding for the enforcement of any civil fine, penalty, or forfeiture, pecuniary or otherwise, shall not be entertained unless commenced within five years from the date when the claim first accrued."

Pending before the Second Circuit Court of Appeals is an issue of first impression. In *SEC v. Fowler*, Donald Fowler argues that section 2462 imposes a jurisdictional time limit on a court's ability to hear cases, including those involving tolling agreements. He argues that such agreements cannot be used to circumvent the statute's plain language and evade the statute's purpose, i.e., to bar courts from "entertaining" claims brought outside a five-year period.

This novel argument rests, in part, on the statute's rather unconventional wording, which focuses not on the plaintiff's obligation to bring a case within a certain time period but rather on the court's inability to "entertain" a case brought outside the statutory five-year period. This language is unusual in run-of-the-mill statutes of limitations.

If the Second Circuit agrees with Fowler's arguments, the SEC, as well as potential subjects and their counsel, may find themselves in a tenuous position: the SEC may hasten its investigations and bring claims that it might not have otherwise, while targets will have even less negotiating power and less time to present their arguments.

New Era for Variable Product Fund Substitutions

SEC Removes Obstacles

BY TOM LAUERMAN

About 20 years ago, the SEC began scrutinizing variable product fund "substitution" applications in ways that increased both the time required to obtain SEC approval and the conditions necessary to obtain such approval. The Investment Company Act of 1940 ("1940 Act") generally prohibits an insurance company from substituting one fund supporting its SEC-registered variable products (an "underlying fund") for another, unless and until the SEC approves the substitution.

In the past few years, investment advisers to some underlying funds have strenuously objected when insurance companies have proposed to replace those funds. In some cases, this has resulted in costs and delays, cancellation of planned substitutions, and, in one case, a formal SEC hearing on the proposed substitution.

In one welcome development, however, the SEC recently published an industrywide no-action position that allows an insurer to substitute underlying funds without obtaining SEC approval if the substitution is substantially similar to an earlier substitution for which the insurer obtained such approval. For more information, see our recent client alert "SEC Limits Need for Substitution Applications."

In another welcome development, the SEC in December issued an order (Release No. IC-34129) approving certain contested substitutions by two Allianz insurance companies. The order followed an SEC hearing requested by the investment advisers — who were unrelated to Allianz — to some of the funds that Allianz proposed to replace. Because of the hearing, the order was issued by the SEC itself (rather than by the SEC staff pursuant to delegated authority) and made findings favorable to Allianz on a number of matters that are not normally discussed in substitution orders or applications.

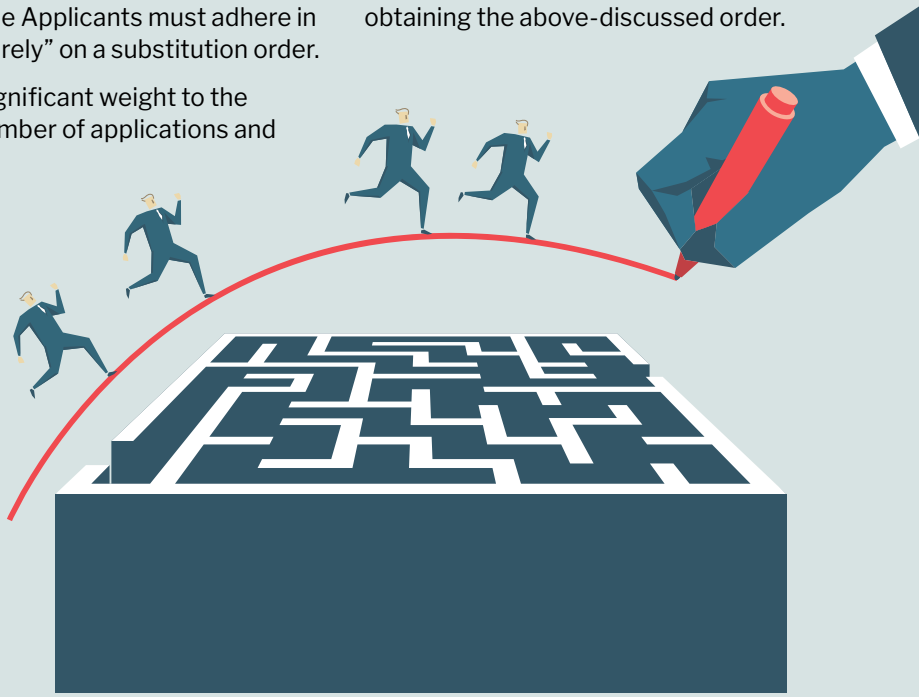
For these reasons, the SEC's issuance of this order is of great interest to insurance companies contemplating substitutions, as well as to any persons contemplating opposing them.

Among other things, the order:

- States the SEC's view that, in the variable insurance context, the 1940 Act's standard for approving a substitution is met if "the substitution complies with certain terms and conditions set forth in the substitution application that have been developed over several decades of the [SEC's] administration" of that standard.
- Recognizes that, contrary to the challengers' assertions, those "terms and conditions are not merely 'representations' of the Applicants; they are substantive requirements to which the Applicants must adhere in order to rely" on a substitution order.
- Gives significant weight to the large number of applications and circumstances the SEC and its staff have considered in developing those terms and conditions.
- Rejects the challengers' assertions that the 1940 Act "requires a substitution to demonstrably benefit investors" or requires the SEC to "examine the effects that a substitution may or may not have on the remaining shareholders" of any replaced fund.
- Holds that SEC approval of substitutions is not limited to "exceptional or exigent circumstances."

These recent developments should facilitate appropriate future substitution transactions that will redound to the benefit of both insurers and variable contract owners.

Carlton Fields represented Allianz in obtaining the above-discussed order.



Converting Mutual Funds to ETFs

A Fertile Field?

BY GARY COHEN

A trend seems to be starting for open-end management investment companies to reorganize into exchange-traded funds. The March 12, 2021, merger of the Adaptive Growth Opportunities Fund, a series of the Starboard Investment Trust, into the Adaptive Growth Opportunities ETF, a series of the trust that was created for that purpose, illustrates what this may entail.

The fund's adviser, Cavalier Investments (doing business as Adaptive Investments), continues as the ETF's adviser.

The shareholders received a Form N-14 information statement, prospectus, statement of additional information, president's letter, and Q&A describing the conversion and the ETF. Shareholders had an opportunity to redeem or exchange their shares in the fund if they did not want to continue as shareholders of the ETF.

The disclosure documents described the shareholder benefits of the conversion as follows:

- Lower expenses through reduced or eliminated transfer agency, shareholder servicing, and state registration fees that more than offset new exchange listing fees and transfer agent and distributor fees unique to ETFs.
- More flexibility in buying and selling shares throughout the day at market prices instead of buying and selling only at the end of the day, although brokerage commissions may be required and market prices may be higher or lower than the ETF's net asset value.
- More transparent structure with portfolio holdings being published each day.
- Greater tax efficiencies.

The conversion did not require shareholder approval because the merger met the conditions of Rule 17a-8 under the Investment Company Act.

The conversion was a tax-free exchange. However, the fund notified shareholders that some brokerage firms may not accept fractional shares. In that case, the existing fund redeemed fractional shares at net asset value immediately after effectuating the conversion and distributed the cash value of the fractional shares to shareholders. The receipt of the cash value was taxable.

Carlton Fields served as legal counsel to the fund's independent trustees and continues to do so for the ETF's independent trustees.

New "Buffered" VA and VLI Investment Options

Will Compete With Index-Linked Options

BY TOM LAUERMAN

At least two insurance companies are adding "buffered" investment portfolios to the lineup of underlying funds that are available to support their variable annuity and variable life insurance policies.

These buffered funds are in many ways similar to the popular "buffered" index-linked annuity and universal life options that insurers have offered under Form S-1 or S-3 registrations with the SEC. The new buffered funds, however, will instead be registered on the same Form N-1A as more conventional underlying fund options, and the variable annuity/life benefits that they support will be registered on the same Form N-4 or N-6 that is used for other interests under such variable products.

Investment Objective

The buffered funds, like index-linked products, offer investors the prospect of earning returns over specified periods of time (outcome periods), based on the performance of a specified securities index. For example, the underlying funds that insurers are currently planning would offer one-year outcome periods (or in some cases five-year periods) that

seek to provide a return that closely approximates the return of the S&P 500 (without reinvestment of dividends), subject to (a) a specified maximum rate of return (i.e., a "cap") and (b) a "buffer" that seeks to provide a specified amount of protection against negative returns over that period.

This type of investment objective was first adapted to registered investment companies via buffered ETFs that we discussed at the time in "Buffer ETFs vs. Index-Linked Annuities," *Expect Focus – Life, Annuity, and Retirement Solutions* (December 2018). We pointed out there that the same concept, in non-ETF form, might be adapted to underlying variable product funds. And that is now happening.

Investment Program

Like other mutual funds, the buffered funds' investment return over any period is determined by the actual change in its NAV and any distributions paid on its shares during that period. The buffered funds' portfolio investments could include, among other things, index funds and various types of derivatives, including customizable put and call options on the S&P 500 that are traded on the Chicago Board Options Exchange (Flexible Options).

Specifically, the buffered funds' portfolio managers will seek to structure and manage each fund's portfolio positions so that its total return over the outcome period will closely approximate the return of the index, subject to the specified cap and the buffer for that outcome period. Investors will have no guarantee, however, that any buffered underlying fund will achieve the return that the fund seeks for any outcome period. Therefore, even if investors maintain their investment in such an underlying fund for an entire outcome period, their investment return and buffer protection may be less than that outcome period sought to provide.

In contrast, under an index-linked VA or VLI option, the issuing insurance company promises that investors who maintain their investment for an entire outcome period will be credited with the index's performance over that period, subject to the cap, buffer, and other terms that apply to that outcome period. If the insurer's return on the assets it invests to support this promise is less than it has promised to investors, the insurance company must bear the loss. Similarly, the insurer can keep any amounts that it earns above the return promised to investors.

Other Differences

The following possibilities that could affect an investor's return or liquidity under a buffered underlying fund generally would not be relevant to investors in an index-linked product.

- Any suboptimal decisions by the subadviser in managing the buffered fund's Flexible Options or other portfolio investments.
- Any illiquidity, unavailability, or difficulty in valuing any of such investments that the buffered fund holds or that its subadviser would like to use.
- The risk of large flows of funds into or out of the buffered fund during an outcome period, which could complicate portfolio management in a way that adversely affects even investors who persist throughout the entire outcome period.

On the other hand, an insurer's costs may be lower in connection with a buffered underlying fund, as compared with an index-linked product option, which could enable the insurer to charge lower fees to investors. For example, the insurer's costs may be reduced because the insurer would not guarantee that the buffered fund would achieve its investment goal over the outcome period, and the cost of registering a buffered fund on the SEC's forms for investment companies may be less than the cost of registering an index-linked option on Form S-1 or S-3.

Spring Is Hot for State Privacy Legislation

BY ANN BLACK AND PATRICIA CARRIERO

It's a hot spring for state privacy legislation. Privacy bills are pending in roughly 20 states, and while Gramm-Leach-Bliley Act (GLBA) exemptions may act as a cool breeze in some, issues remain:

- Some states' legislation has no GLBA exemption.
- Some states' legislation only contains a data-level exemption, meaning non-GLBA data would be subject to the states' privacy requirements.
- Even those states' legislation that contains such an entity-level exemption will not insulate insurers from contractual obligations imposed by third parties who are subject to the legislation.

Virginia is the first state to follow California's lead in adopting comprehensive privacy legislation, but its Consumer Data Protection Act has an entity-level GLBA exemption preventing any direct application to insurers. California, at work again, amended its Consumer Privacy Act (CCPA) by adopting the California Privacy Rights Act (CPRA), effective January 1, 2023. Below is a summary of the CPRA's impact on insurers and the scope of the GLBA exemptions in pending legislation.

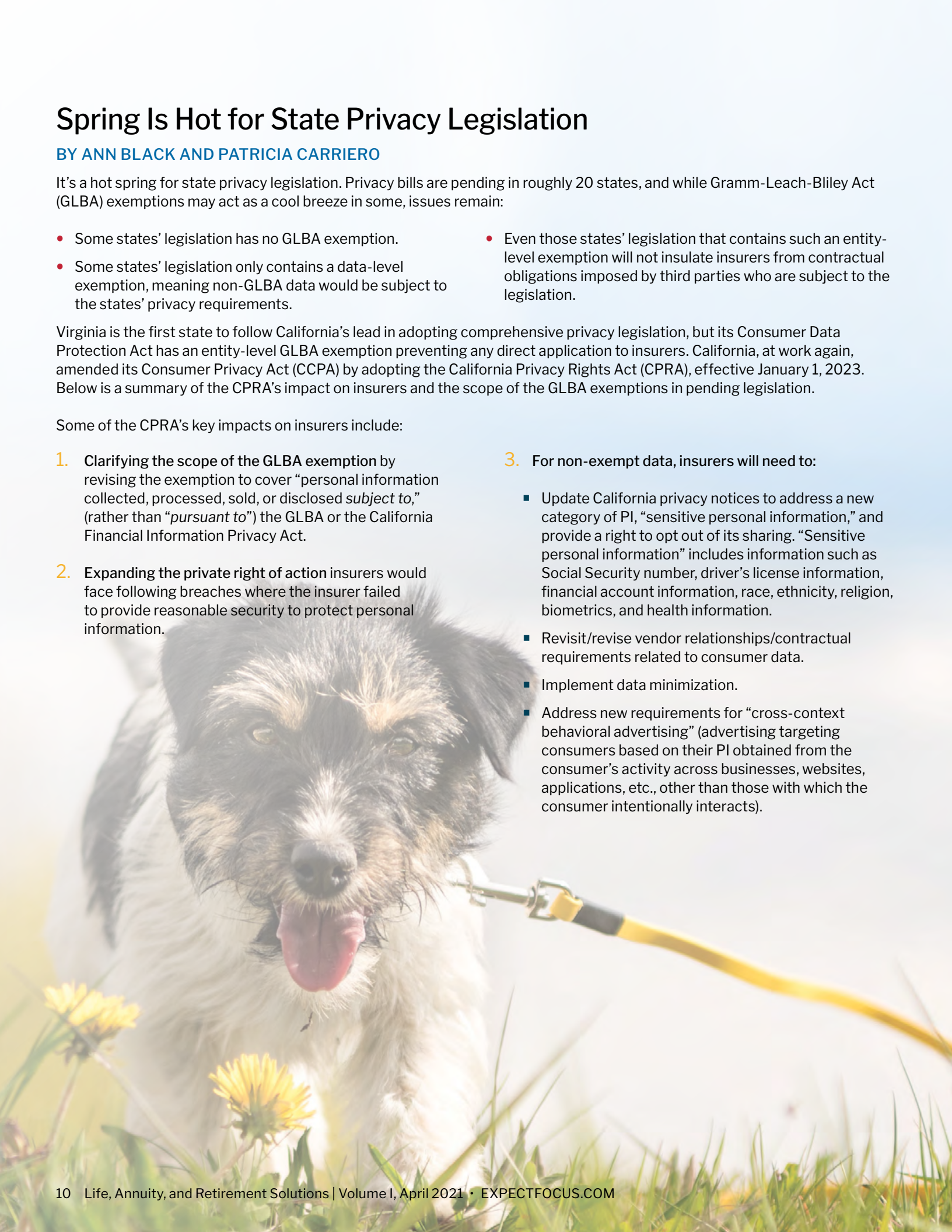
Some of the CPRA's key impacts on insurers include:

1. **Clarifying the scope of the GLBA exemption** by revising the exemption to cover "personal information collected, processed, sold, or disclosed *subject to*," (rather than "*pursuant to*") the GLBA or the California Financial Information Privacy Act.

2. **Expanding the private right of action** insurers would face following breaches where the insurer failed to provide reasonable security to protect personal information.

3. **For non-exempt data, insurers will need to:**

   - Update California privacy notices to address a new category of PI, "sensitive personal information," and provide a right to opt out of its sharing. "Sensitive personal information" includes information such as Social Security number, driver's license information, financial account information, race, ethnicity, religion, biometrics, and health information.
   - Revisit/revise vendor relationships/contractual requirements related to consumer data.
   - Implement data minimization.
   - Address new requirements for "cross-context behavioral advertising" (advertising targeting consumers based on their PI obtained from the consumer's activity across businesses, websites, applications, etc., other than those with which the consumer intentionally interacts).



Pending Privacy Legislation		
State Law/ Bill	**Scope of GLBA Exemption**	**GLBA Exemption**
AL HB 216	Data-level	PI collected, processed, sold, or disclosed pursuant to GLBA
AZ HB 2865	Data-level	Data sets regulated by GLBA
CO SB21-190	Data-level	PI collected, processed, sold, or disclosed pursuant to GLBA, if collection, processing, sale, or disclosure is in compliance with GLBA
CT SB 893	Entity-level	Financial institution or data subject to Title V of GLBA
FL HB 969	Data-level	PI collected, processed, sold, or disclosed pursuant to GLBA
FL SB 1734	Data-level, but Sen. Bradley has suggested that it may function as entity-level	PI collected, processed, sold, or disclosed pursuant to GLBA
IL HB 3910	Limited data-level	PI collected, processed, sold, or disclosed in accordance with GLBA or the Illinois Banking Act (except for private right of action given to consumers whose PI is breached due to business's failure to implement and maintain reasonable security)
KY HB 408	Entity-level	A financial institution or an affiliate of a financial institution that is subject to GLBA
MD SB 0930	Data-level	PI collected, processed, sold, or disclosed under GLBA
MA SD 1726	None	N/A
MN HF 1492	Data-level	PI collected, processed, sold, or disclosed pursuant to GLBA, if collection, processing, sale, or disclosure is in compliance with GLBA
MN HF 36	None	N/A
NJ AB 5448	Entity-level	A financial institution or an affiliate of a financial institution that is subject to GLBA
NY A 680	Data-level	Data to the extent regulated by GLBA
NY SB 567	None	N/A
NY p. 148 of PPGG Bill	Data-level	PI collected, stored, or otherwise used in accordance with GLBA
OK HB 1602	Data-level	PI collected, processed, sold, or disclosed in accordance with GLBA
TX HB 3741	Data-level	PI processed in accordance with GLBA
UT SB 200	Entity-level	Financial institution or affiliate of same governed by Title V of GLBA
WA HB 1433	None	N/A
WA SB 5062	Data-level	PI collected, processed, sold, or disclosed pursuant to GLBA, if collection, processing, sale, or disclosure is in compliance with GLBA
WV HB 3159	None	N/A

Time will tell how many of the above bills pass, the modifications they will undergo before passage, and whether federal legislation, such as the Information Transparency and Personal Data Control Act introduced in Congress by Rep. Suzan DelBene (D-Wash.), which specifically preempts state privacy laws, will pass and nullify them all.

Minimum Standard Nonforfeiture Rate – Green Light, Red Light

BY ANN BLACK AND STEPHEN CHOI

In December 2020, by amending the Standard Nonforfeiture Law for Individual Deferred Annuities (Model 805), the NAIC gave the green light to lower the minimum standard nonforfeiture rate to 0.15% in response to the persistent low interest rate environment.

For insurers filing with the Interstate Insurance Product Regulation Commission (the Compact), this would have allowed the immediate filing of deferred annuity contracts with the 0.15% nonforfeiture rate, because the Compact standards reference Model 805's minimum rate. However, the Colorado Supreme Court's holding in *Amica Life Insurance Co. v. Wertz* put up a red light. In recognition of the holding that Compact standards may not preempt state statutes, the Compact adopted an emergency rule (ER 1) staying the effectiveness of the new rate until April 2021. Then, on March 23, 2021, the Compact adopted an emergency rule (ER 2) giving a partial green light to the use of the lower minimum standard nonforfeiture rate, contingent on state adoption.

During its March meeting, the Compact sought to resolve the conflict between the Model's 0.15% minimum and states' 1% minimum. The Compact is proposing to add to the Compact standards a definition of "nonforfeiture rate" requiring that the minimum rate "be consistent with the minimum nonforfeiture interest rate prescribed in the law of the state in which the policy is delivered or issued for delivery." The Compact decided to publish the suggested amendments to the uniform standards for consideration. While the amendments are pending, the Compact adopted ER 2, replacing ER 1, permitting a 0.15% minimum nonforfeiture rate immediately upon a state's amendment of its nonforfeiture laws to be consistent with Model 805.

As of April 5, the following states have introduced bills to greenlight a minimum standard nonforfeiture rate as low as 0.15%:

- Arkansas
- Delaware
- Hawaii
- Kansas,
- Minnesota,
- Nebraska
- North Dakota
- Oklahoma
- South Dakota
- Utah

Recent Trends and Defense Strategies in Agent Sales Practice Suits

BY BROOKE PATTERSON

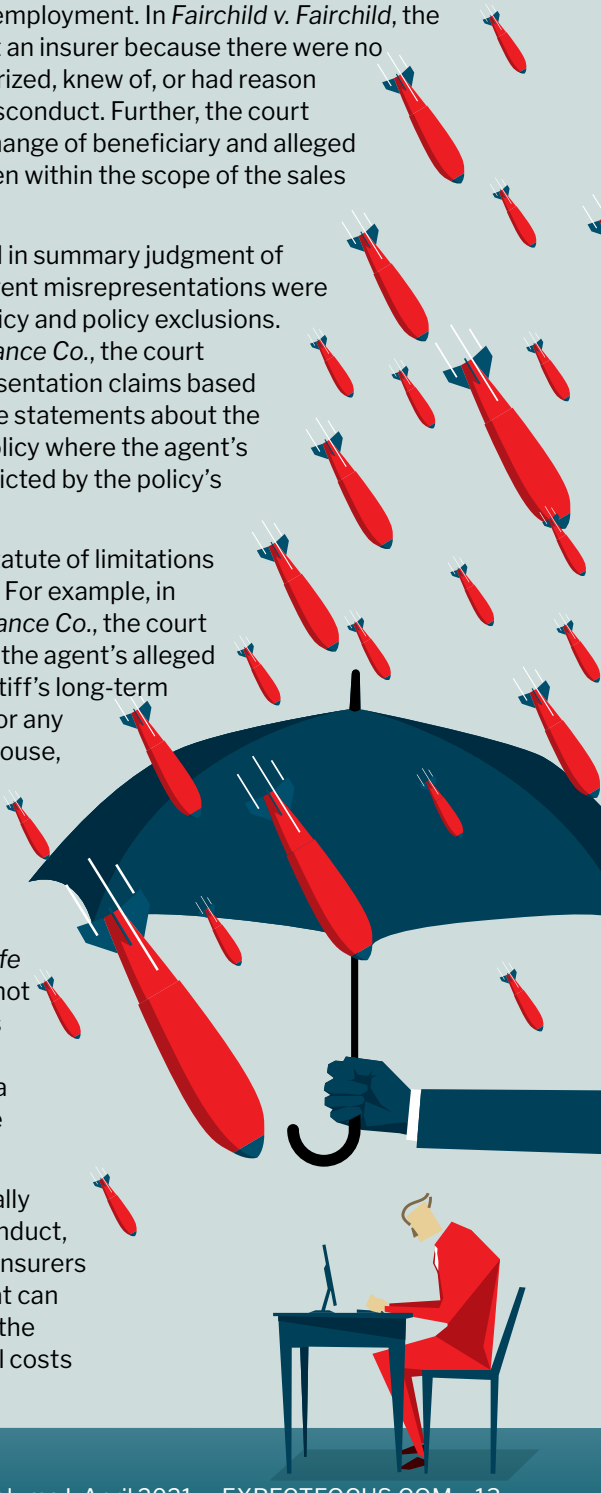
Allegations of misconduct by agents and brokers are a consistent feature of lawsuits aimed at insurance companies. Several recent court decisions illustrate the types of claims insurers have faced and which defense strategies are proving successful.

The claims generally fall into two archetypes: misrepresentations by the insurance agent during the sale of the policy, and fraud by the insurance agent after the sale of the policy. In one recently filed putative class action, for example, the plaintiff claimed that agents were trained and incentivized to trick consumers into replacing whole life policies with universal life policies and that, in doing so, agents misrepresented the terms or benefits of the universal life policies. In another case, the plaintiff sued an agent and insurer, alleging that the agent (who was also the decedent's brother) improperly designated himself as the beneficiary of the decedent's policy or unduly influenced the decedent to make the change.

Chief among these lawsuits are claims for breach of contract, breach of implied covenant of good faith and fair dealing, violations of state insurance statutes, deceptive and unfair trade practices, unjust enrichment, negligent misrepresentation, and fraud.

- Insurers and agents have successfully fended off some of these claims by arguing that insurance transactions are exempt from state deceptive business practices statutes. In *Grammer v. Ferlin*, for example, the court dismissed claims against individual agents, concluding that the conduct and transactions alleged — namely, improperly reducing an insured's coverage when converting her group policy to a personal one and selling her an additional, unnecessary life policy for their own financial benefit — were regulated by the state insurance code and exempt from Georgia's Fair Business Practices Act.
- Insurers have also obtained dismissal of such claims due to the insurer's lack of knowledge of the agent's activities or because the actions were outside the scope of the agent's employment. In *Fairchild v. Fairchild*, the court dismissed all claims against an insurer because there were no allegations that the insurer authorized, knew of, or had reason to know of the agent's alleged misconduct. Further, the court found that an alleged improper change of beneficiary and alleged self-dealing were not actions taken within the scope of the sales agent's employment.
- Insurers have also often prevailed in summary judgment of fraud claims where the alleged agent misrepresentations were expressly contradicted by the policy and policy exclusions. In *Carter v. Companion Life Insurance Co.*, the court dismissed the insured's misrepresentation claims based on the agent's alleged inaccurate statements about the coverage of a health insurance policy where the agent's statements were directly contradicted by the policy's language and exclusions.
- Insurers have had success with statute of limitations and statute of repose arguments. For example, in *Tucker v. Transamerica Life Insurance Co.*, the court dismissed a fraud claim based on the agent's alleged misrepresentations that the plaintiff's long-term care insurance policy would pay for any changes or modifications to her house, because the alleged statements were made 20 years earlier when the policy was purchased.
- And insurers have won summary judgment on fraud claims where, as in *Derrick v. Lincoln National Life Insurance Co.*, the plaintiff could not show that the agent's statements at the time of purchase were a false representation, rather than a prediction of what was a probable future performance or outcome.

While litigation against insurers usually involves actions relating to agent conduct, as these recent decisions illustrate, insurers can employ numerous strategies that can result in favorable decisions early in the litigation and thus minimize potential costs and exposure.



A Rocky Road Ahead for Insurers Using Consumer Data and Models

BY ANN BLACK AND JAMIE BIGAYER

The NAIC's development of guiding principles on artificial intelligence seeks to proactively avoid proxy discrimination, safeguard against other unfairly discriminatory outcomes, and apply risk management to address unfair discrimination. Extending the work of the NAIC, two states have introduced proposals that seek to address unfair discrimination in the use of data or algorithms, giving insurers using data or algorithms a steep climb:

- The Colorado legislature proposed SB 21-169 prohibiting the use of any external consumer data and information source, algorithm, or predictive model that unfairly discriminates against an individual based on race, color, national or ethnic origin, religion, sex, sexual orientation, disability, or transgender status.
- The Connecticut Insurance Department issued a notice on April 14, 2021, reminding all entities "to use technology and big data in full compliance with anti-discrimination laws."

Colorado Senate Bill 21-169

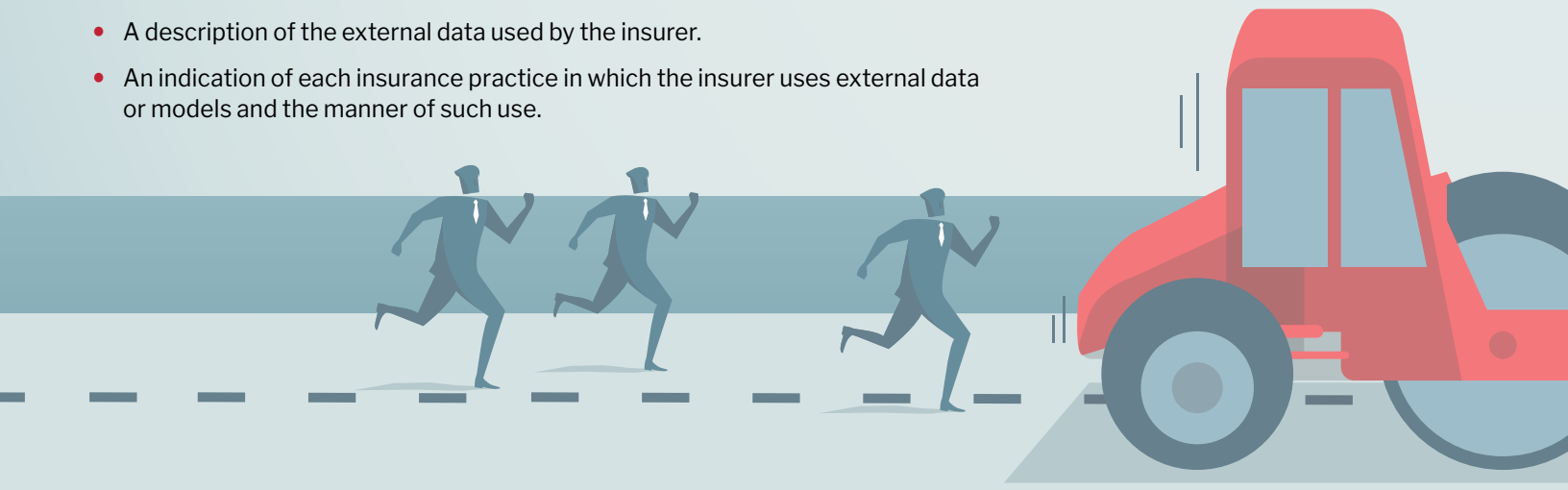
In March 2021, Colorado started its journey by introducing legislation prohibiting certain activity and requiring insurers to submit information on the insurers' use of data and algorithms to the insurance division. Bill 21-169 also grants the commissioner the right to examine and investigate an insurer's use of data and algorithms in any insurance practice and to promulgate rules restricting or prohibiting the use of data and algorithms if it "bears no direct causal relationship to insurance losses" and unfairly discriminates. Bill 21-169 prohibits:

- Considering an individual's race, color, national or ethnic origin, religion, sex, sexual orientation, disability, or transgender status ("protected status").
- Directly or indirectly using any external consumer data and information source, algorithm, or predictive model that unfairly discriminates on the basis of protected status.

If an insurer is using any external data or model, Bill 21-169 also requires insurers to submit with the insurance division:

- A description of the external data used by the insurer.
- An indication of each insurance practice in which the insurer uses external data or models and the manner of such use.
- An attestation that each external data or model used by the insurer does not (a) intentionally or unintentionally use information concerning a person's protected status or (b) result in proxy discrimination based on a person's protected status.
- An assessment of whether the use of any external data or model may result in unfair discrimination based on a person's protected status, and if so, an indication of the actions that the insurer has taken to minimize the risk of such unfair discrimination, including ongoing monitoring.

The Colorado proposal could be a sign of a rocky road ahead and raises a number of questions for the industry.



What Factors Can an Insurer Consider?

Bill 21-169 establishes a wide range of statuses that are protected and which cannot be considered for any "insurance practice." Insurance practice is defined broadly to include marketing, underwriting, pricing, utilization management, reimbursement methodologies, claims settlement, and fraud detection. While Bill 21-169 includes statuses that have long been considered protected, it goes further by including disability. If disability remains a protected status, this may eliminate certain types of benefits or features from being offered in Colorado. For example, if the proposed insured is not currently disabled, a waiver of premium, monthly deductions, or payments in the event of a subsequent disability is a common benefit. If, however, disability may not be considered as part of underwriting, then these types of disability benefits will likely not be offered to any Colorado insureds, putting them on unequal footing.

What Is the Impact of "Indirectly"?

Insurers may use third-party data, algorithms, or both as a part of their underwriting process. The "indirectly" language extends the prohibition against unfair discrimination on the basis of protected status to data and algorithms supplied by third parties. Thus, insurers using third-party data vendors will need to:

- Understand the data used by third-party vendors as well as the operation of the third party's algorithm.
- Require that the third-party vendors comply with the prohibitions of Bill 21-169.
- Document steps taken to minimize the risk of the third-party vendors' failure to comply with the requirements of Bill 21-169.

How to Avoid and Monitor for the Unintentional Use of Discriminatory Data Points and Proxy Discrimination?

Possible means to comply with the above-discussed requirements to avoid and monitor for discrimination include:

- As posited by consumer advocate Birny Birnbaum, monitoring and testing outcomes.
- As suggested by the Society of Actuaries: (i) devote resources to assess potential bias in the external data or models to be used; (ii) exclude all known proxies for protected statuses; and (iii) ensure that decisions are based on principles of actuarial justification and fairness.

Must There Be a Direct Causal Relationship?

The Colorado proposal gives the commissioner the power to restrict the use of external data or models that do not have a causal relationship to insurance losses and result in unfair discrimination. Of note, the Casualty Actuarial Society (CAS) argues that correlated — not causal — variables provide more accurate premiums and are thus more desirable. CAS notes that eliminating correlated non-causal variables may produce less accurate ratings. Bill 21-169 by its terms grants the commissioner power only to restrict external data or models that are not causally related to the risk and result in unfair discrimination. Therefore, consumer data that does not bear a causal relationship to the risk appears to be acceptable if it does not result in unfair discrimination. Thus, this provision may not make the trek as daunting as it may seem.

CONTINUED →

Connecticut Department of Insurance April 14 Notice

While Connecticut is supportive of the insurance industry's use of technology and expanding amounts of data, it nonetheless reminded insurers that they have a "continuing obligation to use technology and big data responsibly and transparently in full compliance with federal and state anti-discrimination laws." Of particular importance from the notice:

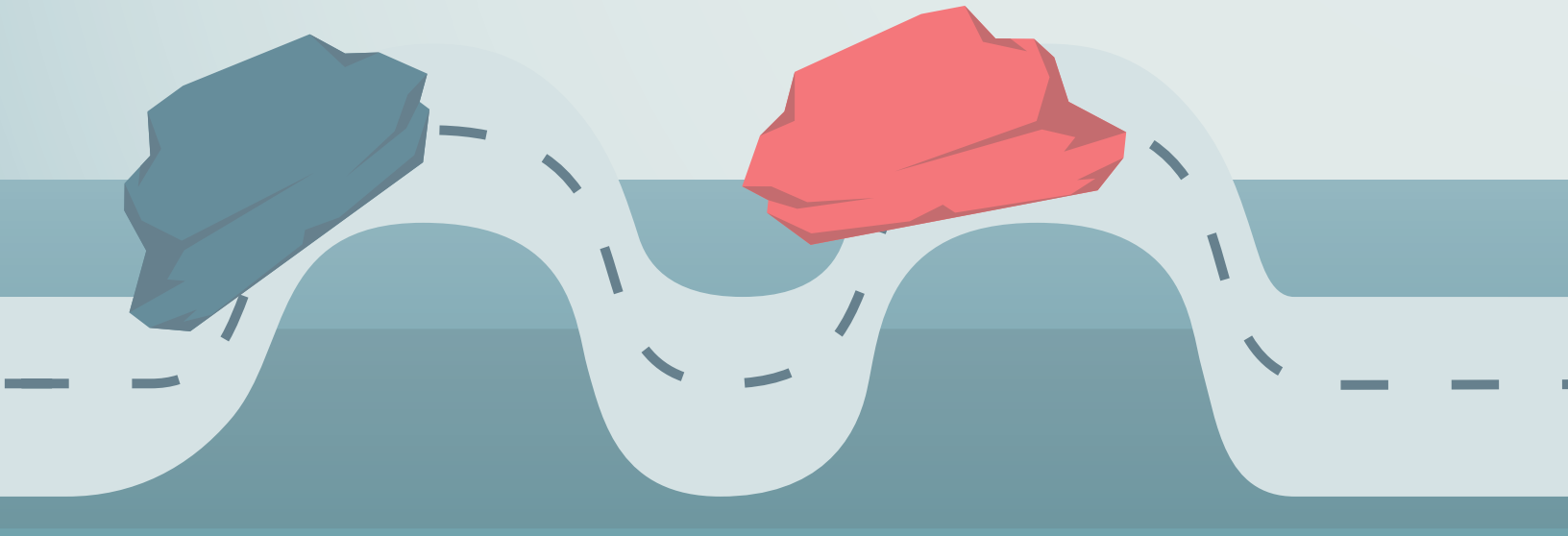
1. Connecticut will hold insurers using big data in their operations responsible and accountable even if the big data is provided by third-party vendors.
2. Connecticut "has the authority to require that insurance carriers and third-party data vendors, model developers, and bureaus provide [it] with access to data used to build models or algorithms included in all rate, form, and underwriting filings."
3. Connecticut is concerned about how big data:
   - Is "utilized as a precursor to or as a part of algorithms, predictive models, and analytic processes";
   - Is governed, "emphasiz[ing] the importance of data accuracy, context, completeness, consistency, timeliness, [and] relevancy"; and
   - Algorithms are "inventoried, risk assessed/ranked, risk managed, validated for technical quality, and governed throughout their life cycle."

The commissioner attached to the notice an extensive list "of the types of information that may be requested during the course of an examination specific to the usage of data brokers," including with respect to:

1. The examinee and who oversees data-related questions.
2. Data sources, including all vendors and aggregators, and whether the data sources are checked for reliability, accuracy, consistency, and completeness.
3. Data storage, including the privacy protections in place and the action plan and insurance coverage in the case of a breach.
4. Data curation, including how the data is prepared for use and the methods of data validation, accuracy determination, and data correction used.
5. Data documentation, including how the data transformation process is documented, by whom it is reviewed, and what corrective action is taken to prevent future errors.

Insurer's Big Data Process and Procedures

Insurers need to consider how they will develop policies and procedures designed to comply with the Connecticut notice. How will an insurer check all data sources, including those from third parties, for reliability, accuracy, consistency, and completeness? Will the data and algorithms be housed internally or on a third-party vendor's system? This has implications for the appropriate level of privacy protections and breach response processes that must in place. Additionally, insurers need to thoroughly document their policies and procedures so they may be reviewed upon examination.



Authority to Require Access to Data

The Connecticut notice's assertion of authority to require "insurance carriers and third-party data vendors, model developers, and bureaus" to provide Connecticut access to all data and algorithms being used raises significant questions. It is unclear, for example, whether a state's regulatory authority extends to third-party vendors. In fact, consumer representative Birny Birnbaum often gets shin splints over the fact that third-party vendors are not regulated or licensed.

Perhaps Connecticut believes that, even if it has no direct authority over third-party vendors, it could require insurers to provide the information. That, however, may conflict with the agreements between the insurer and third-party vendor. These agreements often limit or prevent the insurer from disclosing the data or algorithm provided by the third party beyond the insurer's own use. While the issue of confidentiality of third-party data and algorithms has been discussed at the NAIC, the Connecticut notice makes no mention or accommodation for this issue. Accordingly, insurers may want their vendor agreements to require third parties to cooperate in responding to such regulatory requests.

Conclusion

These sprints by Colorado and Connecticut are a sign to the insurance industry of the rocky road ahead, as there will be more entrants to this race. For example, the NAIC's Accelerated Underwriting Working Group is developing a report that will include a discussion of the consumer data used in algorithms and models. And the states continue to introduce proposals limiting the data that can be used by insurers, including restrictions on the use of claims history, credit scores, education, occupation, zip code, genetic information, and status as a victim of domestic abuse. There will doubtless be more heights to scale as more states begin their own excursions by introducing further restrictions on various types of data, which insurers will need to carefully monitor.

SEC Veteran William J. Kotapish Joins Carlton Fields

Carlton Fields is pleased to announce that prominent regulatory attorney **William J. Kotapish** has joined the firm in its Washington, D.C., office after a distinguished career at the Securities and Exchange Commission.

Kotapish enhances Carlton Fields' Financial Services Regulatory Practice with more than three decades of experience in financial products. He advises investment companies, investment advisers, and life insurance companies on securities compliance and regulatory matters. Kotapish previously served as assistant director in the SEC's Division of Investment Management, overseeing the Office of Insurance Products.

In his 20-year career with the SEC, Kotapish oversaw the review of variable product and underlying mutual fund registration statements, consideration and disposition of exemptive applications, and requests for no-action relief and interpretive guidance. Kotapish was deeply involved in establishing and updating standards for disclosure for a variety of financial products, including variable annuities, variable life insurance, and fixed indexed annuities.

He also advised SEC staff on legal and regulatory issues affecting SEC-registered insurance products and underlying mutual funds, rulemaking, and other initiatives. Before joining the SEC, Kotapish represented investment companies and investment advisers in private practice for more than a decade.

Life Insurer Has No Duty to Investigate Forged Policy Change Form

BY ELISE HAVERMAN

The Georgia Court of Appeals affirmed summary judgment for the insurer where it paid a death benefit to the person whose name appeared on a change form, notwithstanding suggestions of fraud.

Upon the insured's death, the insurer paid death benefits to his wife per the insured's policy. The insured's granddaughter was initially the designated beneficiary, until the insured's wife submitted a policy owner and beneficiary change form a month before the insured's death. A year later, the insured's granddaughter sued the company, disputing entitlement and alleging that her signature on the form was forged, although she never responded to the insurer's notification that her signature was required on the change form.

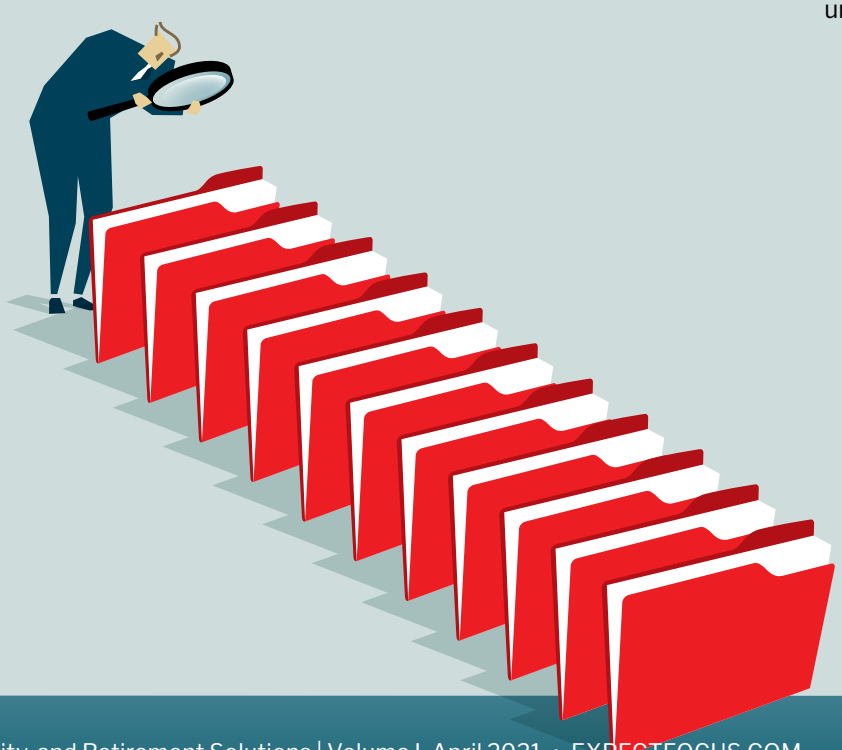
The trial court granted summary judgment in favor of the insurer and the granddaughter appealed.

The core of this case involved a Georgia statute requiring a life insurer to pay life insurance or annuity proceeds to the person "then designated" in the policy or contract. The statute fully discharges the insurer from all claims under the policy or contract unless, before payment is made, the insurer receives written notice by or on behalf of some other person entitled to payment under the policy.

The granddaughter argued that this statute did not preclude her claims because the benefit was not paid to the person "then designated" in the policy, as the alleged forged change of policy form was void. She never disputed that the form was executed before the insured's death.

The Georgia Court of Appeals relied on an Alabama Supreme Court decision as sound, persuasive, and in accord with the interpretation of a nearly identical statute. That case concluded that under their similar statute, whenever an event triggers the insurer's duty to pay and payment is made to the person whose name appears on the face of the policy or any change to the policy in regular form as the proper beneficiary, payment has been made per the terms of the policy. The purpose of that statute is to protect an insurer that pays a benefit to one then designated as the beneficiary against a subsequent claim by one actually possessing a superior right to the benefits.

The Georgia Court of Appeals affirmed the lower court's ruling. The court reasoned that the granddaughter did not provide the required statutory notice to the insurer that she had a competing claim before payment. Likewise, because Georgia law does not impose a duty on the insurer to investigate and determine if a person fraudulently completes and submits a change form, it paid the person appearing on the face of the change of policy form — the insured's wife — and was therefore discharged from liability under the statute.



More Aggressive Enforcement Sprouts at SEC

BY ERIN HOYLE

The SEC has restored the authority of senior Division of Enforcement officials to initiate investigations without requiring approval by the SEC. This authority was originally established in 2009, but later revoked in 2017. On February 9, then-acting SEC Chair Allison Herren Lee reestablished senior enforcement staff's ability to issue subpoenas and take sworn testimony sua sponte. This approach will likely decentralize and accelerate the approval process for investigations and enhance the Enforcement Division's investigative autonomy.

Days later, the SEC also reversed course as to its procedure for waiving automatic disqualifications that the federal securities laws and regulations impose on so-called bad actors. On February 11, Lee announced that a settling party may no longer request joint consideration of enforcement action settlement offers with waiver requests. This reinstitutes a bifurcated process to consider offers of settlement separately from waiver requests. The announcement is a reversal of a procedure that then-SEC Chair Jay Clayton announced in July 2019. *See* "SEC Now May Consider a Simultaneous Settlement Offer and Waiver Request," *Expect Focus – Life, Annuity, and Retirement Solutions* (October 2019). As a consequence of the change, parties that offer to settle enforcement actions can expect a lengthier process and renewed uncertainty about the overall consequences of resolving SEC enforcement matters.

The waiver policy shift, however, stirred up controversy within the SEC. On February 12, SEC Commissioners Hester Peirce and Elad Roisman issued a statement criticizing this policy change. They rejected the notion that certain structural conflicts or pressures justify a bifurcated process and reaffirmed their support for considering and accepting simultaneous settlement offers and waiver requests.

Nonetheless, Lee's statements and other recent developments seem to mark the start of a more assertive Enforcement Division. Although incoming SEC Chair Gary Gensler, who formally took office on April 17, will ultimately have a large say about the extent of any such policy shifts, he too may favor significant changes to the SEC's enforcement approach.

California Becomes Hotbed for Policy Lapse Notice Claims

BY DIMITRIJE CANIC

In our April 2020 issue, we discussed how policy lapse notice cases were on the rise in California after the state amended its insurance code, requiring policies to provide a 60-day grace period and notice before any policy lapsed for nonpayment. Among other things, we noted that the California Supreme Court had accepted review of the decision in *McHugh v. Protective Life Insurance Co.* that the amended regulations apply only to new contracts issued after January 1, 2013.

Since then, an avalanche of cases have been filed in federal courts, mostly by the same law firms, bringing the total number of such actions up to 18 at one point in California. Plaintiffs in these cases allege various claims for breach of contract, breach of the implied covenant of good faith and fair dealing, and unfair competition. However, eight of these cases are stayed pending the outcome of *McHugh* and three others have been dismissed. The California Supreme Court has not yet held oral arguments in *McHugh*.

Nevertheless, an important development has occurred in the Ninth Circuit, as the circuit court will review the decision in *Thomas v. State Farm Life Insurance Co.*, in which the trial court granted summary judgment in favor of the plaintiffs. The court held that although the amendments could not apply retroactively to existing policies, they do apply to existing policies that are renewed after January 1, 2013. It will be interesting to see whether the circuit court adopts the district court's view that the "renewal" of a policy incorporates all statutory requirements enacted since the policy's last renewal — which would appear to present a number of constitutional issues under the contracts clause — or whether it will reject this theory and interpret the contract as written. Oral argument in *Thomas* is currently scheduled for June 8, 2021.

New Hampshire Supreme Court Invalidates Long-Term Care Rate Caps

BY TODD FULLER

The New Hampshire Supreme Court recently determined that regulations limiting premium rate increases for long-term care insurance policies exceeded the state insurance commissioner's rulemaking authority and were therefore invalid.

The decision arose from Genworth's challenge to New Hampshire's amended regulations for long-term care insurance policies, which capped premium rate increases based on an insured's attained age and barred the insurance commissioner from approving any requested increase above the stated caps. Genworth argued that the regulations exceeded the commissioner's statutory authority to "issue reasonable rules to promote premium adequacy and to protect the policyholder in the event of substantial rate increases," and did just the opposite. The trial court ruled in favor of the insurance department and Genworth appealed.

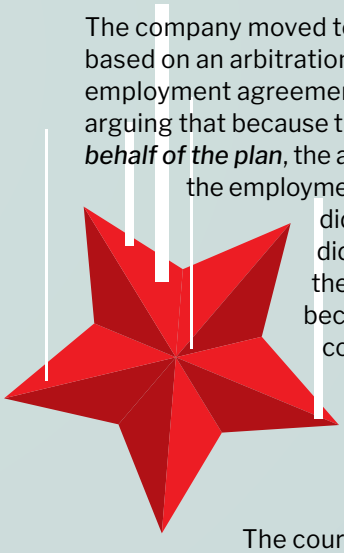
The New Hampshire Supreme Court, however, sided with Genworth. The court explained that "an insurer's ability to cover costs depends, at least in part, on its ability to increase rates when its actuarial assumptions prove flawed." The amended regulations, however, did not afford the commissioner the discretion to approve rate increases that exceeded the caps, nor did they contain any exception to exceed the caps to avoid premium inadequacy. The court also observed that the premium cap rates failed to protect policyholders "in the event of" substantial rate increases because the commissioner could not approve any substantial rate increase in the first place.

The decision is an important victory for insurers issuing long-term care insurance policies in New Hampshire in their efforts to maintain premium adequacy. While it does not prevent the commissioner from promulgating new premium cap regulations that comport with the court's analysis, it may allow the commissioner to consider rate increase regulations that account for the inherent difficulties insurers face in predicting costs for long-term care insurance policies.

ERISA Fiduciary Duty Claim Against Plan Not Subject to Arbitration

BY IRMA REBOSO SOLARES

Although courts routinely enforce arbitration agreements, they will not compel arbitration of claims outside the scope of the parties' agreement. That was the outcome in *Hawkins v. Cintas Corp.*, in which two former employees and participants in the company's defined contribution retirement plan sued the company for breach of fiduciary duty under ERISA for mismanaging the plan.



The company moved to compel arbitration, based on an arbitration provision in the plaintiffs' employment agreements. The plaintiffs opposed, arguing that because the action was filed ***on behalf of the plan***, the arbitration provisions in the employment agreements — which did not include the plan — did not apply. In response, the company argued that because the plan is a defined contribution plan with individual accounts, the participants' claims are inherently individualized.

The court disagreed, holding that when a cause of action is focused on mismanagement of the entire plan, not specific individual accounts, the claim falls "squarely" within ERISA section 409 and the relief sought is to benefit the plan. The court also found that there was no valid arbitration agreement between the *plan and the company*. The arbitration clause in the employment agreement was limited to claims by an employee and did not extend to nonentities, such as the plan. Consequently, the court denied the motion to compel arbitration.

Citing Ninth Circuit authority, the court acknowledged that the outcome might have been different if the *plan documents* had required arbitration of claims, disputes, or breaches arising out of the plan. The court's reasoning seems, however, to foreclose the possibility that an arbitration provision in an employment agreement could extend to claims that other parties (e.g., a plan) could have against the employer. But careful thought should be given to the possibility of including language in employee agreements that covers such claims.

The case provides yet another cautionary tale about the importance of careful drafting of plan documents and arbitration provisions.

The action is on appeal to the Sixth Circuit Court of Appeals.

Mexico Imposes Digital Services Tax on Online Activities

Possible Future Risk for U.S. Financial Services Companies

BY TOM MORANTE AND YANI CONTRERAS

Global digitalization spurred by rapid advances in digital technology is enabling virtual business operations at a frenetic pace, including by insurance and other U.S. financial services companies. Without the need for physical presence or infrastructure in a specific jurisdiction, technological platforms facilitate the delivery of services on a worldwide basis, posing challenges to taxing authorities in collecting tax from online activities such as streaming services like Netflix, and digital intermediation services like Amazon (where the digital intermediation leads to the sale and purchase of goods) or Expedia (where the digital intermediation leads to the sale and purchase of services).

To address the tax revenue shortfall arising in connection with digital services provided to a Mexico-based user, Mexico enacted chapter III-Bis on Title I of the Value-Added Tax Law effective June 2020.

This regulatory scheme imposes a value-added tax (VAT) on widely popular streaming services in Mexico, such as movies, music, and games, and digital intermediation services for Mexico-based users provided by companies located both in and outside Mexico. Historically, Mexican companies were subject to VAT on the services they provided (which implicitly included digital services), but now, Mexican companies providing digital services are specifically subject to VAT under this new chapter.

A person will be considered a Mexico-based user if the person (individual or company) meets any of the following criteria: (a) the user has an address in Mexico; (b) payment for the service is made by a Mexican bank; (c) the company providing the service has an IP address located in Mexico; and/or (d) the user has a phone number with a Mexico area code.

For digital streaming providers, the digital VAT is 16% on the price of the services provided and applies to both foreign technology platforms without a permanent establishment in Mexico (that were not subject to tax before this amendment) and Mexican digital streaming providers. In connection with digital intermediation services, the digital VAT is 8%, if the offeror of the good or service is an individual registered with the Mexican tax authority as a person with entrepreneurial activities, or at a rate of 16%, if the offeror of the good or service is an individual without a Mexican taxpayer identification number.

The VAT on the transaction is charged to the Mexico-based user of the services (i.e., the VAT is added to the cost of the services provided), and typically the digital provider withholds the VAT and remits it to the Mexican tax authority.

Failure to withhold and pay the VAT may result in the Mexican tax authority notifying the local telecommunications operator to temporarily block access to the digital service until the obligations of the digital service provider are satisfied.

U.S. financial services companies operating in a digital cross-border context are not subject to this digital tax yet, but a similar regulatory scheme likely will be considered and perhaps extended in the future to insurtech services.

Let a Thousand Flowers Bloom

Advisory Voices Proliferate at SEC

BY GARY COHEN

The hot topic of environmental, social, and governance (ESG) disclosure has called attention to a growing number of voices advising the SEC commissioners.

The SEC's Asset Management Advisory Committee, Investor Advisory Committee, and Investor Advocate have made ESG recommendations. Then-acting Chair Allison Herren Lee recently appointed a senior adviser for ESG and, together with Commissioner Caroline Crenshaw, called for an ESG Advisory Committee and a staff task force on ESG. This totals four existing and two proposed streams of ESG advice to the commissioners from sources within or created by the SEC.

The SEC formed the **Asset Management Advisory Committee** in late 2019 to provide the commission with "diverse perspectives on asset management and related advice and recommendations" regarding:

- Trends and developments affecting investors and market participants.
- The effects of globalization, including as it relates to operations, risks and regulation.
- Changes in the role of technology and service providers.

Congress formed the **Investor Advisory Committee** in the 2010 Dodd-Frank Wall Street Reform and Consumer Protection Act to "advise and consult" with the SEC on:

- Regulatory priorities of the SEC.
- Issues relating to the regulation of securities products, trading strategies, fee structures, and the effectiveness of disclosure.
- Initiatives to protect investor interests.
- Initiatives to promote investor confidence and the integrity of the securities marketplace.

Congress established the **Office of the Investor Advocate** within the SEC in the Dodd-Frank Act to report directly to the SEC's chairman and provide the following "functions":

- Assist retail investors in resolving significant problems they may have with the SEC or with self-regulatory organizations.
- Identify areas in which investors would benefit from changes in the SEC's regulations or the rules of self-regulatory organizations.
- Identify problems that investors have with financial service providers and investment products.
- Analyze the potential impact on investors of proposed regulations of the SEC and self-regulatory organizations.
- Propose to the SEC changes in the commission's regulations or orders, and propose to Congress any legislative, administrative, or personnel changes that may be appropriate to mitigate problems identified and to promote the interests of investors.

The recommendations of these existing entities, plus any entity created as proposed, together with regular staff input and public comments, will give the commissioners a lot to digest.

Cast Into the Deep: Questions for Charting New Privacy Waters

BY ANN BLACK AND PATRICIA CARREIRO

As insurers consider new data from new sources and new means for consumer outreach, working through the privacy requirements is like navigating choppy waters. The various privacy regimes include:

- Gramm-Leach-Bliley Act (GLBA) and state equivalents that govern financial institutions' use, collection, and sharing of consumer information and require certain notices and consents based on the type of information collected, its use, and with whom it is shared.
- Fair Credit Reporting Act (FCRA) regarding the use of credit reports (broadly defined) and imposing requirements for notices, authorizations, and permitted uses.
- Health Insurance Portability and Accountability Act (HIPAA) governing the use of health information by covered entities and their business associates and requiring certain notices, authorizations, and cybersecurity precautions.
- Federal marketing laws, such as the Telephone Consumer Protection Act (TCPA), the Telemarketing Sales Rule (TSR), and the Controlling the Assault of Non-Solicited Pornography and Marketing Act (CAN-SPAM), that require certain notices, authorizations, and consents for certain consumer outreach.
- Driver Privacy Protection Act (DPPA) and state equivalents that govern the use and disclosure of information gathered by state departments of motor vehicles.
- State insurance laws requiring certain notices and authorizations and cybersecurity policies and procedures. State insurance laws vary widely but can require the provision of rights of access, modification, and deletion, and prohibit certain uses of information and business practices.
- State privacy laws requiring particular notices and consents, contractual provisions in partner relationships, reasonable cybersecurity measures, and additional rights (such as the right to know, correct, or delete certain information), and prohibiting certain practices. This is an area of especially rapid growth and, for insurers, often involves a close analysis of state laws' GLBA exemptions.
- Contractual obligations to third parties from whom you collect data.

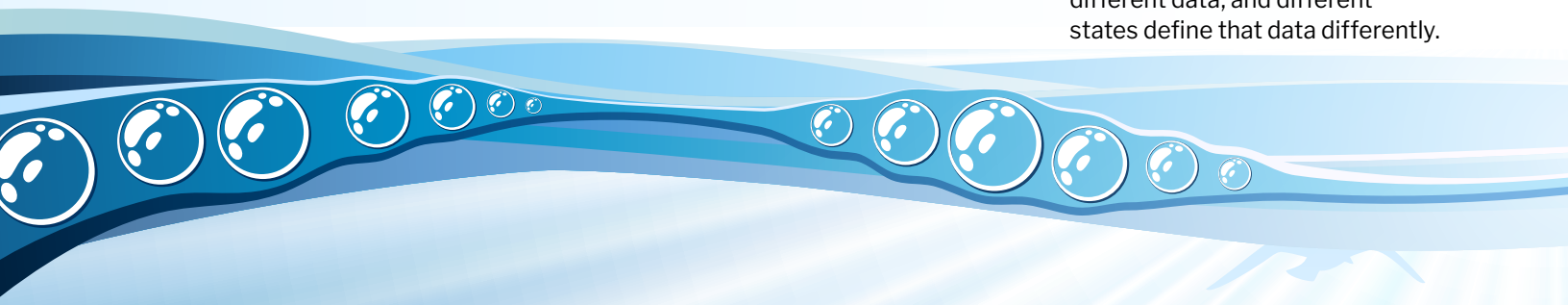
These regimes include many different and overlapping requirements as to the notices you provide to, and the acknowledgments or authorizations you seek from, consumers. And their proper application requires careful consideration and analysis of their requirements and exceptions.

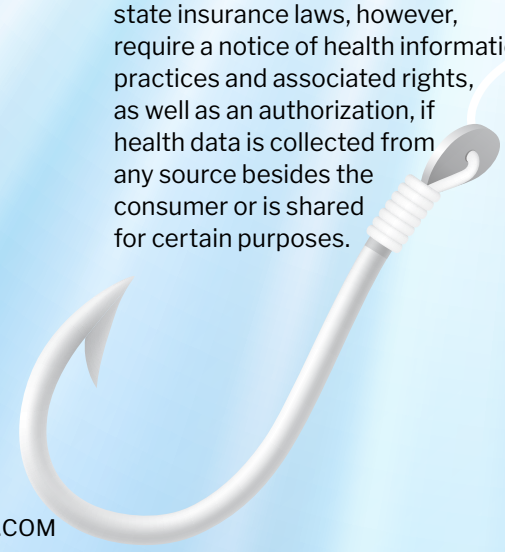
Here are seven questions for smooth sailing through the seven seas of privacy:

1. What data will be collected and from whom?

   Different privacy laws apply to different data, and different states define that data differently. So the first step is to make sure everyone on board understands key terms the same way. Next, take stock of the data that will be collected throughout the process, so you can evaluate potential laws implicated. Will you collect health data? Pull credit reports? Use DMV information?

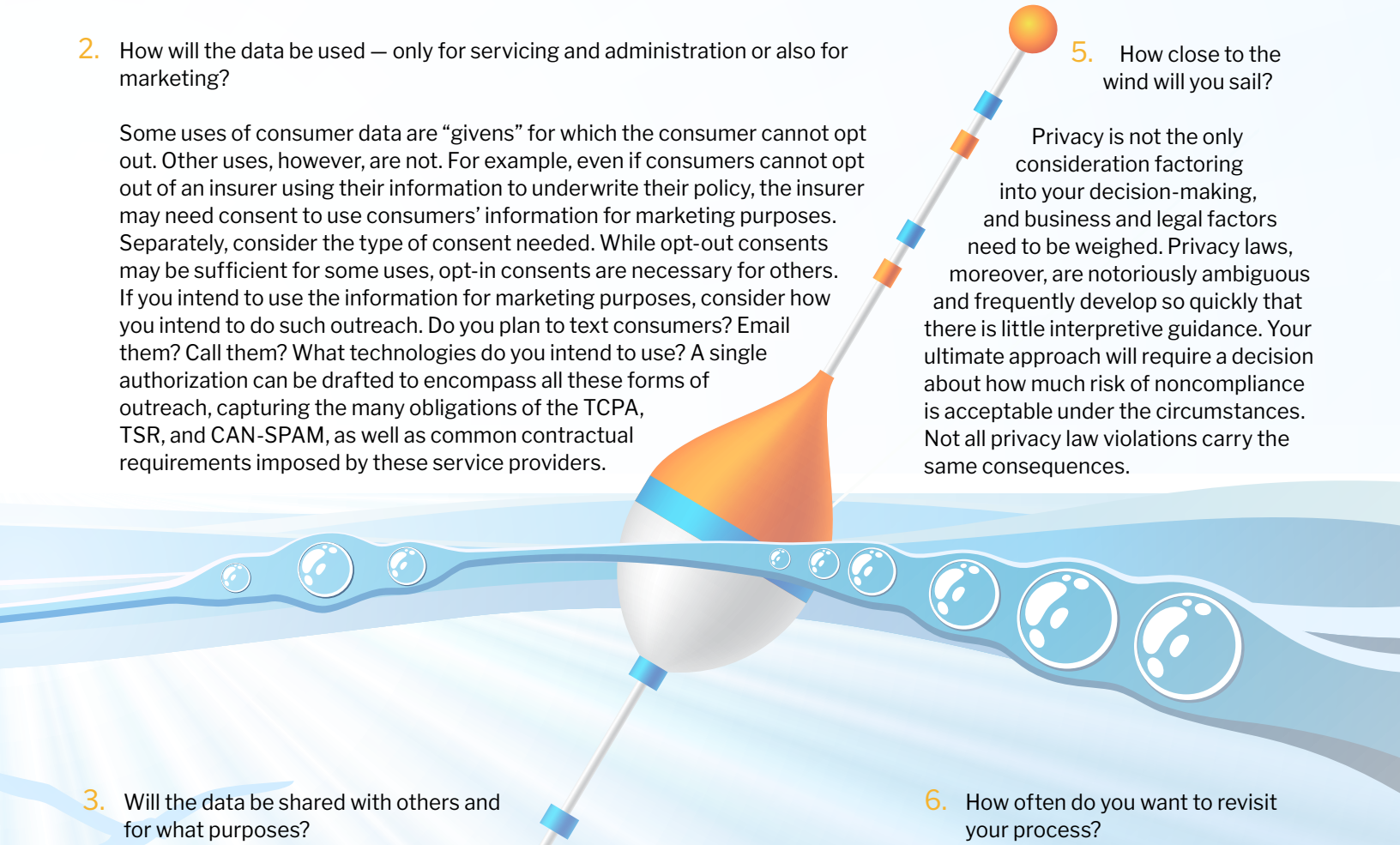
   The same data may trigger different obligations depending on whose data is being collected. For example, a life insurer collecting health information from a consumer need not be concerned with HIPAA. Some state insurance laws, however, require a notice of health information practices and associated rights, as well as an authorization, if health data is collected from any source besides the consumer or is shared for certain purposes.





2. How will the data be used — only for servicing and administration or also for marketing?

Some uses of consumer data are "givens" for which the consumer cannot opt out. Other uses, however, are not. For example, even if consumers cannot opt out of an insurer using their information to underwrite their policy, the insurer may need consent to use consumers' information for marketing purposes. Separately, consider the type of consent needed. While opt-out consents may be sufficient for some uses, opt-in consents are necessary for others. If you intend to use the information for marketing purposes, consider how you intend to do such outreach. Do you plan to text consumers? Email them? Call them? What technologies do you intend to use? A single authorization can be drafted to encompass all these forms of outreach, capturing the many obligations of the TCPA, TSR, and CAN-SPAM, as well as common contractual requirements imposed by these service providers.



3. Will the data be shared with others and for what purposes?

How you will use or share the data you collect has a significant impact on what notices and consents you need. Your use of the data and with whom you share it is particularly important for determining your GLBA obligations, as many uses are exempt from the GLBA's requirements to provide notice and an opportunity to opt out. Also, sharing with affiliates versus nonaffiliates can have very different consequences. For example, depending on when you intend to share data with a nonaffiliate and for what purpose, you may not need to provide a consumer with your GLBA notice until the consumer becomes your customer.

When designing your procedures, remember to consider not only your own statutory privacy obligations but also those you contractually inherit based on statutes that apply to your partners. For example, if you are contracting with a HIPAA-covered entity or business associate, you will likely inherit some HIPAA obligations.

If you are sharing consumer information with any parties, remember to include the necessary restrictions and certifications in your contracts to prevent that sharing from being considered a "sale."

4. How will you document your compliance?

Function under the maxim, "If you can't prove it, it didn't happen." Make sure your process creates a record of your compliance. Be aware of the evidence you are creating.

5. How close to the wind will you sail?

Privacy is not the only consideration factoring into your decision-making, and business and legal factors need to be weighed. Privacy laws, moreover, are notoriously ambiguous and frequently develop so quickly that there is little interpretive guidance. Your ultimate approach will require a decision about how much risk of noncompliance is acceptable under the circumstances. Not all privacy law violations carry the same consequences.

6. How often do you want to revisit your process?

Given the speed at which new privacy legislation is being passed, some insurers base their plans not only on currently enacted legislation but also on expected privacy trends and developments. This can help avoid being in a constant state of catch-up.

7. How will you protect the data you collect?

Batten down the hatches. All data collection and retention brings with it a risk of a breach and its fallout. Prepare now to minimize your risk. Contract and insure appropriately.

Fair winds and following seas!

NEWS & NOTES

Carlton Fields is the top law firm for insurance thought leadership for the fourth consecutive year, according to *JD Supra*'s Readers' Choice Awards. Only one law firm is eligible to earn the "top law firm" classification in each of the 28 categories covered by the awards.

Carlton Fields is recognized as a top law firm in the 20th Annual BTI Client Service A-Team report, a designation limited to law firms that deliver unparalleled client service. This is the only legal ranking that identifies leading law firms for client service through a national survey of corporate counsel. The firm has been included in this report for more than a decade.

Carlton Fields is a sponsor of the IRI 20 in 21 Conference on April 14, 21, and 28, and May 5. The conference is a series of virtual sessions in which key leaders cover legislation and regulation; diversity, equity, and inclusion; economic policy; fintech; and more.

The firm is hosting a webinar with the ACLI on June 23 on the topic of implications of the confluence of fiduciary and best interest rules for annuity recommendations. Shareholder **Richard Choi** will moderate the webinar.

Carlton Fields is sponsoring the Global Insurance Symposium on June 28-30 in Des Moines, Iowa, and virtually. The symposium is said to be the preeminent event for insurance professionals from around the world, with dynamic panel discussions and interactive demonstrations of cutting-edge technologies.

The firm earned a perfect score of 100% on the 2021 Human Rights Campaign Foundation's *Corporate Equality Index*, designating the firm as a "Best Place to Work for LGBTQ Equality" for the 12th year in a row. The rating recognizes Carlton Fields' LGBTQ-friendly policies and practices and its devotion to workplace equality.

Carlton Fields welcomes the following attorneys to the firm: Of Counsel **Vanessa Singh Johannes** (white collar crime and government investigations, Miami) and **Dara Lindquist** (construction, Orlando); and Associates **Alex Bein** (property and casualty insurance, New York) and **Kurtley Taylor** (white collar crime and government investigations, Tampa).

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