LIFE, ANNUITY, AND RETIREMENT SOLUTIONS INDUSTRY

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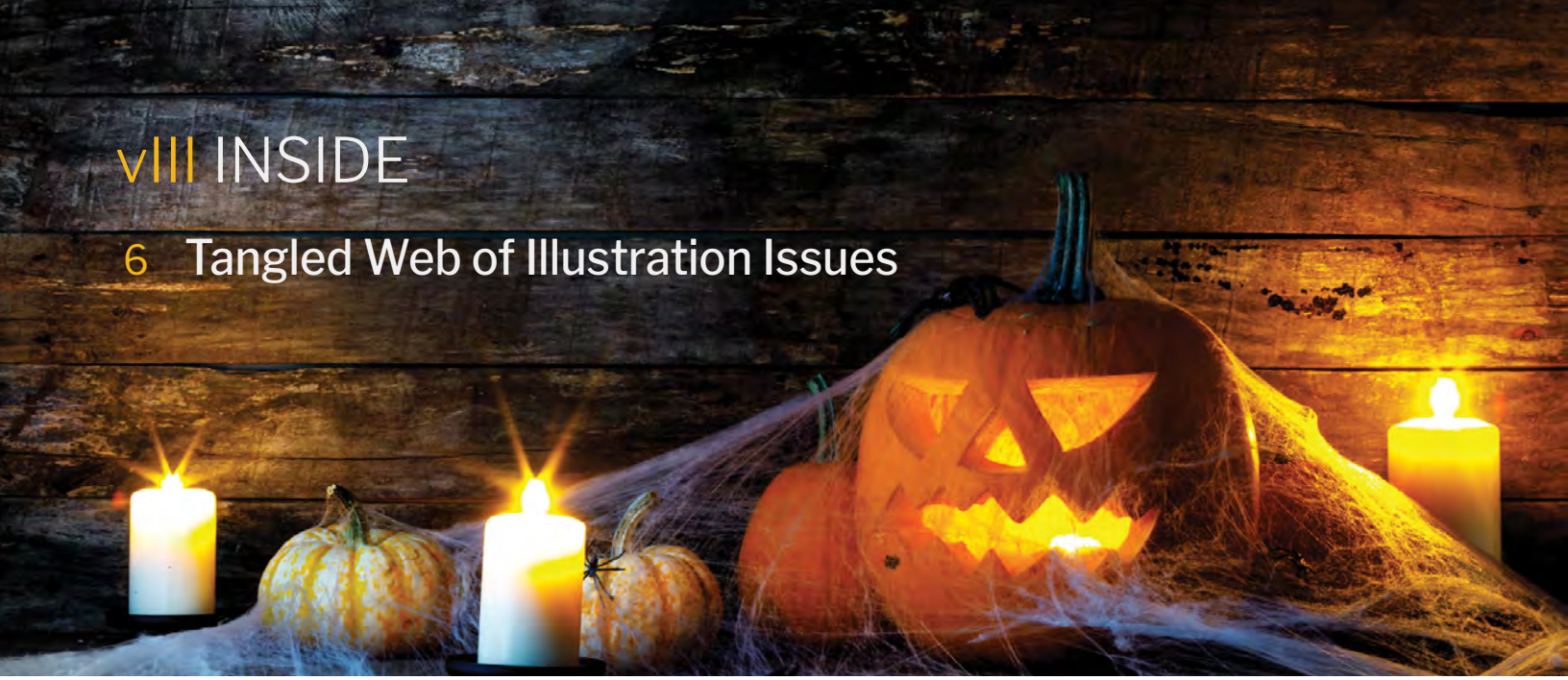
EXPECT FOCUS®

LEGAL ISSUES AND DEVELOPMENTS FROM CARLTON FIELDS

HALLOWEEN EDITION

Tricks and Treats for the Industry

CARLTON FIELDS



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EXPECTFOCUS®

LIFE, ANNUITY, AND RETIREMENT SOLUTIONS OCTOBER 2019

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EXPECTFOCUS® is a quarterly review of developments in the insurance and financial services industry, provided on a complimentary basis to clients and friends of Carlton Fields.

FOIA Competitive Injury Requirement Falls

BY TOM LAUERMAN

The Supreme Court's June decision in *Food Marketing Institute v. Argus Leader Media* has made it easier for federal entities to resist certain Freedom of Information Act requests for confidential business information that the government has obtained from private parties.

Under lower federal court interpretations dating back to the 1970s, one of the exemptions that the government has most frequently relied upon to deny such requests — "Exemption 4" — was under some circumstances available only if disclosure of the information would cause substantial "harm to the competitive position" of the party who provided the information to the government. Therefore, companies that have sought, for example, to prevent the SEC from disclosing their confidential information often have argued that such disclosure would cause the competitive harm, and companies filing FOIA requests for such information have asserted the absence of such harm.

Justice Gorsuch, writing for the Court, concluded that in creating the competitive harm standard, the lower courts had relied inappropriately on what they considered to be the Act's legislative history and had given too little consideration to the Act's actual language. The *Food Marketing Institute* decision is important both to companies seeking to obtain information from governmental entities and to those seeking to prevent the government from disclosing information. The decision changes the arguments that are potentially available to such companies, and in some cases may affect the governmental entity's determination whether the information in question should be disclosed.

Nevertheless, although *Food Marketing Institute* makes it easier for a governmental entity to withhold confidential business information when no competitive harm is shown, neither the Court's opinion nor the FOIA *mandates* that a governmental authority exercise this additional flexibility. Indeed, the SEC, for example, has a strong institutional mandate favoring disclosure of information about registrants that may be material, and it will be interesting to see how, if at all, the SEC now modifies its positions concerning FOIA requests and confidential treatment of information it receives from third parties.

Mostly Tricks Proposed for ASOP 2

Actuaries and Insurers Take Note

BY CLIFTON GRUHN AND STEVEN KASS

The Actuarial Standards Board (ASB) has exposed for comment significant proposed changes to Actuarial Standard of Practice No. 2, "Nonguaranteed Charges or Benefits for Life Insurance Policies and Annuity Contracts" (ASOP 2). The practices insurers use to determine and manage nonguaranteed elements (NGEs) within individual life insurance and annuity products have been the focus of increased attention since ASOP 2 was last updated in 2004. The ASB therefore is updating the ASOP to "reflect current practices and provide additional guidance on the determination of NGEs."

Although ASOP 2 applies only to actuaries, insurers should be alert to its indirect impact on their NGE processes and pricing. Indeed, among other things, the exposed changes mandate expanded and more prescriptive technical requirements for actuaries' NGE determinations, provide specific guidance concerning opinions and disclosures, and require a broader array of disclosures in actuarial reports. *See* "Proposed Revisions to ASOP 2 May Impact Your Product Pricing and Litigation Exposure," *Expect Focus — Life, Annuity, and Retirement Solutions*, Vol. II (June 2019).

The comment period for the proposed changes to ASOP 2 ended on July 15, 2019. The ASB published 16 comments, which came from insurers, individuals, and industry groups (such as the American Academy of Actuaries and the Insured Retirement Institute). While several comments supported revisions to ASOP 2 in light of the current environment surrounding NGEs, many of the comments focused on what they perceived to be:

- Overly prescriptive requirements that traversed into the realm of regulators, were too restrictive on an actuary's discretion, and potentially were at odds with contract language.
- Internal inconsistencies in the proposed changes.
- Potentially ambiguous language and definitions that could lead to overly conservative pricing, which would ultimately harm consumers.
- A general disconnect from the manner in which products are priced.

A common theme among the comments is criticism of, and suggested changes to, sections 3.2 – "Issues and Considerations When Providing Advice on the Actuarial Aspects of the Determination Policy" – and 3.4.2 – "Determination Process for In-Force Products."

The ASB will now review the comments, provide public responses, and determine whether changes should be made to the exposed draft. Given the scope and breadth of the comments, actuaries and insurers should expect that another exposure draft will be required, which would include another comment period. The ASOP 2 task force will then review any comments on the new exposure draft, determine whether additional exposure is required, and, if not, pass the proposed changes to the Life Committee for review, and finally on to the ASB. Based on these requirements, it seems unlikely that the industry will be faced with a new ASOP 2 until the second half of 2020 or the first quarter of 2021, at the earliest. Nevertheless, given the significant implications of the proposed changes, we continue to recommend that actuaries and insurers pay attention now, especially for new products under development and any redeterminations for in-force products that are underway or being considered.

ETFs on the Horizon for Variable Products?

BY CHIP LUNDE AND STEPHEN KRAUS

On May 13, 2019, Sens. Rob Portman (R. Ohio) and Ben Cardin (D. Md.) introduced the Retirement Security and Savings Act of 2019. Among other things, that bill would allow separate accounts supporting variable insurance products to directly hold insurance-dedicated exchange-traded funds as investment options under insurance products and still get tax "look-through" treatment. Importantly, however, the proposed legislation would *not* allow such look-through treatment if separate accounts directly hold regular *retail* ETFs. The bill was referred to the Senate Committee on Finance, where it remains as of this writing.

The Legislation

The proposed legislation would allow separate accounts to invest in insurance-dedicated ETFs by designating certain authorized participants (clearing agencies) and market makers (broker-dealers) as "eligible investors" in insurance-dedicated ETFs, subject to certain limitations. This relief is necessary because, in order to fulfill their functions, which are essential to an ETF, authorized participants and market makers must own shares of the insurance-dedicated ETF — which currently would preclude look-through treatment.

The proposed legislation would limit the activities of an insurance-dedicated ETF's authorized participants and market makers to ensure that retail investors do not have access to insurance-dedicated ETF shares. Specifically, look-through treatment would not be available if: (1) any authorized participant sells the insurance-dedicated ETF's shares to anyone other than market makers or other eligible investors under the Internal Revenue Code Section 817 asset diversification regulations; or (2) any market maker sells the insurance-dedicated ETF's shares to anyone other than authorized participants or other eligible investors under those regulations.

Practical Considerations

Currently, separate accounts purchase and redeem insurance-dedicated mutual fund shares at a set price established by the fund (e.g., as of 4 p.m. each business day) regardless of the size of the separate account's net purchase or redemption orders. However, it is unclear how a separate account would allocate purchases and redemptions of insurance-dedicated ETF shares among contract owners if the separate account were not able to fulfill all of its orders at the same price.

One of the popular features of an ETF is that investors on the exchange can effect transactions at any time during the trading day at market prices that, in theory, generally track closely to net asset value. Thus, funding a variable insurance product with an insurance-dedicated ETF would in theory permit an insurer to offer variable insurance product owners the opportunity to effect purchases, redemptions, transfers, etc., at different unit values throughout the trading day, in each case based on then-current market prices of the insurance-dedicated ETF's shares on an exchange. It could be costly for insurers to develop or modify, and thereafter operate, their systems and relationships with distributors and underlying funds in order to accommodate the additional complexity that this would entail.

Moreover, ETFs must achieve a certain level of assets and trading volume to be viable. Insurers would need to consider the pros, cons, and feasibility of using proprietary versus third-party insurance-dedicated ETFs as variable insurance product investment options.

Finally, insurers would have to consider any additional costs, such as those mentioned above, against any possible advantages of using insurance-dedicated ETFs as investment options. For example, insurers might consider: (1) how many variable insurance product purchasers are interested in intraday trading, given the long-term nature of such products; and (2) whether some variable insurance product purchasers would be deterred from choosing insurance-dedicated ETFs by the risk that the arbitrage market may at times be illiquid and that, for that or other reasons, share prices on an exchange may at times deviate substantially from the net asset value.

Tangled Web of Illustration Issues

BY ANN BLACK, JAMIE BIGAYER, AND STEPHEN CHOI

The NAIC Annuity Disclosure (A) Working Group (Disclosure WG) and the NAIC IUL Illustration (A) Subgroup (IUL SG) continue to untangle the web of issues applicable to fixed index annuity and index universal life (IUL) illustrations. These issues have arisen as a result of different "references" and "multipliers" being spun into the determination of the index interest credited under these products.

Disclosure WG Toiling Over Five Issues

1. *Length of Time an "Index" Must Be in Existence*: While consumer representative Birny Birnbaum bellowed that a minimum of 20 years is necessary for required 10-year scenarios to be meaningful, the Disclosure WG cast their votes to stretch the required time frame from the current 10-year period to a 15-year period.

2. *Changes to an Index's Algorithm*: Many new indexes are determined based on the value of various assets, asset classes, or other "references," and their index values are determined according to an algorithm or "rulebook." The Disclosure WG has been vexed as to whether the index and its algorithm must be fixed. Industry representatives asserted that the algorithm may change if an asset or reference is no longer available, such as the London Interbank Offered Rate. Regulators noted that if an algorithm needs to be changed, a new index could be created and used to determine index interest. Thus, the Disclosure WG decided to prohibit any changes to the rulebook.

3. *Back-Casted Data vs. Actual Data*: The Disclosure WG unanimously agreed that information based on back-casted data of an index should be visually distinguished in an illustration from information based on actual historical performance of the index.

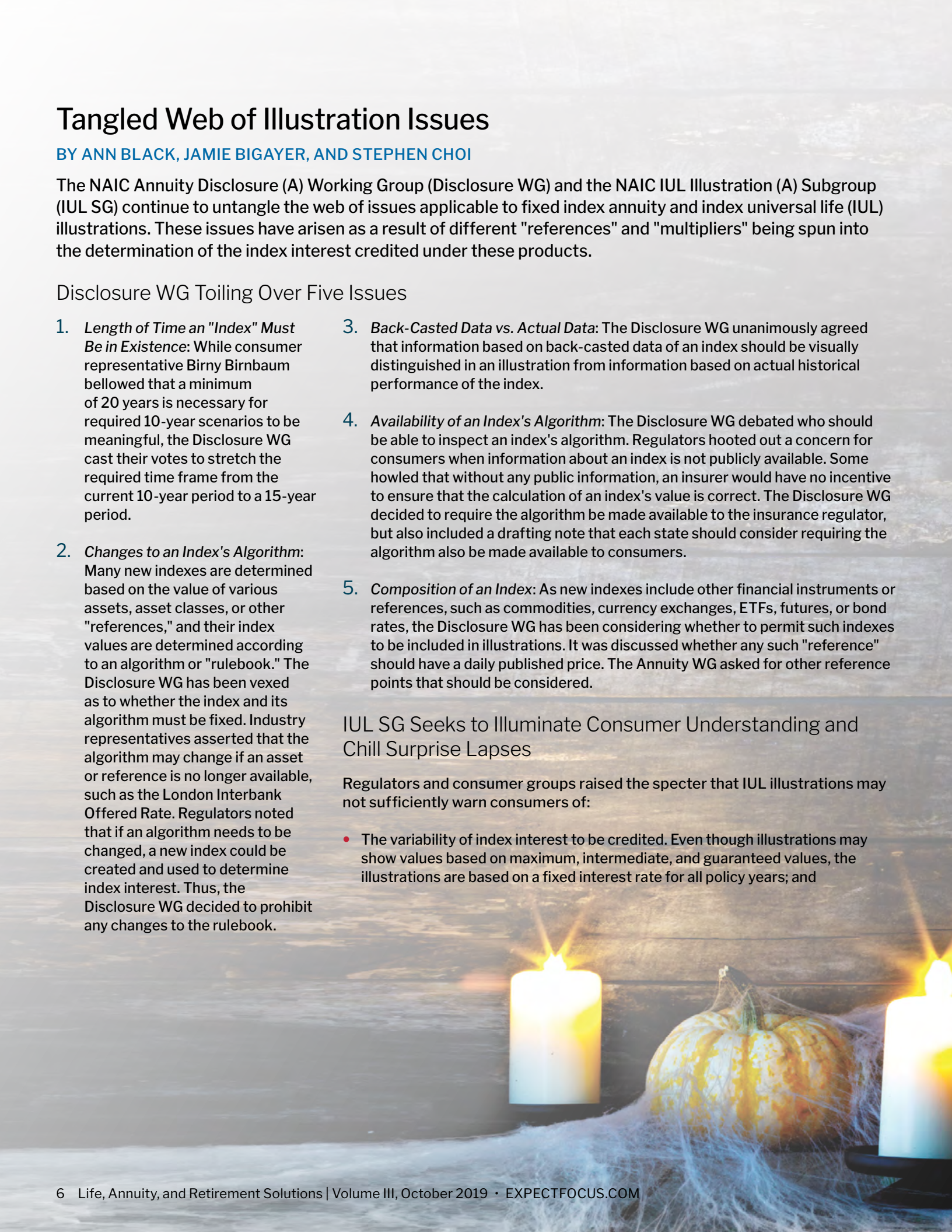
4. *Availability of an Index's Algorithm*: The Disclosure WG debated who should be able to inspect an index's algorithm. Regulators hooted out a concern for consumers when information about an index is not publicly available. Some howled that without any public information, an insurer would have no incentive to ensure that the calculation of an index's value is correct. The Disclosure WG decided to require the algorithm be made available to the insurance regulator, but also included a drafting note that each state should consider requiring the algorithm also be made available to consumers.

5. *Composition of an Index*: As new indexes include other financial instruments or references, such as commodities, currency exchanges, ETFs, futures, or bond rates, the Disclosure WG has been considering whether to permit such indexes to be included in illustrations. It was discussed whether any such "reference" should have a daily published price. The Annuity WG asked for other reference points that should be considered.

IUL SG Seeks to Illuminate Consumer Understanding and Chill Surprise Lapses

Regulators and consumer groups raised the specter that IUL illustrations may not sufficiently warn consumers of:

- The variability of index interest to be credited. Even though illustrations may show values based on maximum, intermediate, and guaranteed values, the illustrations are based on a fixed interest rate for all policy years; and



- The potential for policy lapse if the index interest credited is less than the interest rate assumed in an IUL illustration.

These concerns are heightened for IULs with multipliers because of the interest rate assumed in these IULs' illustrations, and the charges for these IULs are higher than for IULs without multipliers. The IUL SG posited that the higher interest rates being used in IULs with multipliers are a result of how the disciplined current scale is being applied and the number of assets allowed to accumulate at the excess 45 percent disciplined scale rate.

To address these concerns, the IUL SG sought comments on the following questions:

- Should a product with a multiplier feature illustrate a higher scale than a product without multiplier features?
- To what extent should the 145 percent disciplined current scale factor apply to charges supporting bonuses and multipliers?

The IUL SG chair sought votes on five options distinguishing the extent that multipliers should be reflected in IUL illustrations, under which the illustrated rate:

1. Is not adjusted to offset the multiplier charges
2. Is adjusted up to exactly offset the multiplier charges
3. Is adjusted up slightly, up to 1 percent above the multiplier charges on an annual basis
4. Is adjusted up between 1 and 2 percent above the multiplier charges on an annual basis
5. Is adjusted up by more than 2 percent above the multiplier charges on an annual basis

Some of these options would likely limit illustration of the multiplier benefits and thus drive certain multiplier features out of the marketplace. This is similar to AG 49's current approach of limiting the maximum interest rate that can be illustrated by applying a 145 percent limit on the assumed earnings rate. Such solution, however, fails to address the variability of index interest and, depending on the pattern of such variability, may not warn consumers of the potential for policy lapse.

SEC Expands Manager-of-Managers Relief to Affiliated Sub-Advisers

BY CHIP LUNDE

Carillon Order

On May 29, 2019, the SEC granted an exemptive order to Carillon Series Trust and Carillon Tower Advisers Inc. (a Raymond James affiliate) to hire and replace *affiliated* and unaffiliated sub-advisers without shareholder approval. The Carillon order also granted relief from certain disclosure requirements (such as the specific advisory fees paid to a sub-adviser).

The Carillon order is notable because the SEC has been issuing similar so-called manager-of-managers (MoM) orders since 1995, but previously the SEC allowed managers to hire and replace only wholly owned sub-advisers and *unaffiliated* sub-advisers without shareholder approval.

In the SEC's notice of the Carillon application, the SEC noted that it had not previously issued MoM orders with respect to non-wholly owned affiliated sub-advisers due to "concerns relating to conflicts of interest" with respect to hiring and terminating such affiliated sub-advisers. The SEC stated that it was "persuaded" to extend relief to affiliated sub-advisers based in part on the conditions of the relief, including "enhanced oversight" by the fund board. Among other things, under the Carillon order, the fund board is required to find that the sub-adviser change or continuation is in the "best interests" of the fund and does not involve a conflict of interest from which certain affiliates derive "an inappropriate advantage."

The SEC's new willingness to allow managers to hire and replace affiliated sub-advisers without shareholder approval may be particularly helpful, including for MoM funds that support variable insurance products, in view of:

- The rising costs of shareholder proxies.
- The consolidation of investment management firms (which may result in more managers with multiple affiliated entities).
- The increased use of multi-manager funds.

Managers Seeking Similar Relief

Fund managers seeking relief similar to the Carillon order will need to decide whether to (1) obtain their own exemptive order or (2) obtain or rely on no-action relief.

SEC Orders: Generally, firms seeking relief similar to the Carillon order would need to obtain their own order. Obtaining a unique order may be appropriate if an adviser has additional or different facts or seeks relief different from that provided to Carillon.

No-Action Relief: On July 9, 2019, the SEC staff issued no-action relief to BNY Mellon Family of Funds and others to allow BNY Mellon to rely on the Carillon order. Accordingly, fund managers with similar facts may consider whether they can rely on the BNY Mellon no-action letter, or perhaps seek their own no-action relief to rely on the Carillon order.

No shareholder approval required

Innovation Whack-a-Mole

BY ANN BLACK AND JAMIE BIGAYER

Like a game of whack-a-mole, new or existing NAIC groups are being tasked to consider the various regulatory issues that are popping up from insurance innovation. The NAIC's activities over the summer relevant to life insurers are outlined below.

Big Data, Artificial Intelligence, and Underwriting

- The Big Data (EX) Working Group reviewed the use of data to identify potentially fraudulent claims and raised concern that some data points, such as where a consumer lives, may be suspect and potentially biased.
- The Casualty Actuarial and Statistical (C) Task Force continues to work on its "Best Practices for Regulatory Review of Predictive Analytics" white paper, which hammers out 16 best practices for the regulatory review of predictive models. Those applicable to life insurance products include the need for regulators to determine:
  - That the individual input characteristics to a predictive model are related to the expected loss or differences in risk. Each input characteristic should have an intuitive or demonstrable actual relationship to expected loss or risk.
  - That the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values, and outliers are handled.
  - For refreshing a predictive model, whether sufficient validation is performed to ensure the model is still a good fit.
- The new Artificial Intelligence (EX) Working Group sprang up to "study the development of artificial intelligence, its use in the insurance sector, and its impact on consumer protection and privacy, marketplace dynamics, and the state-based insurance regulatory framework." This working group has an initial goal of developing guiding principles for regulators and making other recommendations to the Innovation and Technology (EX) Task Force (Innovation TF).
- The new Accelerated Underwriting (A) Working Group jumped up to "[c]onsider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue and, if appropriate, drafting guidance for the states."

Big Data and Privacy

The Market Regulation and Consumer Affairs (D) Committee is reviewing state insurance privacy protections regarding the collection, use, and disclosure of information and considering whether the NAIC Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Model Regulation (#672) need to be hit with revisions.

Chatbots

The Producer Licensing (D) Task Force is investigating the use of chatbots giving automated investment advice to consumers and intends to bang out a white paper on the topic. Potential issues include data input, algorithms, output of recommendations, choice architecture, and how the display of information may affect consumer choice.

Sandboxes

With Arizona, Kentucky, Utah, Vermont, and Wyoming having enacted regulatory sandboxes; Michigan making an innovation hotline available; and New York, North Carolina, and South Carolina introducing legislation to enact regulatory sandboxes, the Innovation TF continues to consider the role of sandboxes in fostering insurance innovation. For the benefit of the recurring discussions, the Innovation TF will better define the sandbox concept.

New SEC Regulation Defines 'Best Interest' Flexibly

Each Broker-Dealer Can Help Shape Concept Appropriately to Its Business

BY GARY COHEN

The SEC's new Regulation Best Interest (Reg BI) requires broker-dealers to:

- Disclose business practices in dealing with retail customers; and
- Adopt policies and procedures to comply with Reg BI requirements.

Reg BI gives broker-dealers a good bit of flexibility in tailoring their disclosures and business practices. In doing so, each broker-dealer, in effect, will be defining what acting in the customers' "best interest" means for that broker-dealer. Each broker-dealer will be subjecting itself to legal exposure for failure to comply with its disclosures and policies and procedures.

Some quarters harshly criticized the SEC for not defining "best interest." For example, SEC Commissioner Robert J. Jackson Jr. voted against the Commission's adoption of Reg BI. He complained that "[t]he rule does not 'defin[e] ... the term "Best Interest," and in fact goes out of its way to say that it doesn't 'require broker-dealers to recommend [one] "best" product.'"

Commissioner Jackson admonished the Commission that "the core standard of conduct set forth in Regulation Best Interest remains far too ambiguous about a question on which there should be no confusion." He concluded that "the rule relies on a weak mix of measures that are unlikely to make much difference in improving the advice ordinary Americans receive from brokers."

The Commission, however, adopted a requirement that it hadn't included in its original proposal and that arguably has the potential of answering at least some portion of the complaints of Commissioner Jackson and others.

The new requirement is for a broker-dealer to "establish, maintain, and enforce written policies and procedures reasonably designed to achieve compliance with Regulation Best Interest as a whole." The Commission declared that this requirement "creates an affirmative obligation under the Exchange Act with respect to the rule *as a whole*. ..." (emphasis added).

In adopting the expanded requirement for policies and procedures that are coextensive with the *entirety* of Reg BI, the Commission can be said to require each broker-dealer to define the concept of "best interest" in the context of that individual broker-dealer. To do so, each broker-dealer will have to think through what "best interest" means in light of that broker-dealer's unique business model and articulate the implementation of that standard in terms of specific actions that the broker-dealer must implement and follow.

But at the same time, the Commission has pointed out its authority to second-guess a broker-dealer's policies and procedures (as well as disclosure) in order to assure compliance with the provisions and objectives of Reg BI as a whole. The Commission has warned that it intends to review broker-dealer policies and procedures "early on, reducing the chance of retail customer harm." The Commission has said that it will "identify and address potential compliance deficiencies or failures (such as inadequate or inaccurate policies and procedures. ...)."

This regulatory process means that the Commission will measure the adequacy and accuracy of a broker-dealer's policies and procedures (as well as disclosure) against what the Commission deems to be adequate and accurate. This is a process of comparing what is with what should be in light of each broker-dealer's particular business model. In determining what should be for a given broker-dealer, the Commission arguably will be establishing the functional equivalent of a "best interest" standard that the Commission stopped short of defining with specificity.

Multiple Plaintiffs Take Shot at SEC Regulation Best Interest

BY TODD FULLER AND STEPHANIE FICHERA

The Securities and Exchange Commission's Regulation Best Interest faces a bumpy road in the wake of recent lawsuits challenging the appropriateness and effectiveness of the rule.

On September 9, 2019, seven states and the District of Columbia filed suit against the SEC in the U.S. District Court for the Southern District of New York seeking to invalidate Regulation Best Interest, or Reg BI, claiming that the rule is too weak. The plaintiffs — including New York, California, Connecticut, Delaware, Maine, New Mexico, and Oregon — alleged that the final rule is arbitrary and capricious and that the SEC exceeded its authority in violation of the Administrative Procedure Act in issuing it. The states claimed that Reg BI undermines critical consumer protections for retail investors, increases investor confusion about the standards of conduct that apply when investors receive recommendations from brokers or investment advisers, and makes it easier for brokers to market themselves as trusted advisers while still being able to provide conflicted advice.

The states also contended that the adoption of Reg BI contradicts Congress' express direction under the Dodd-Frank Act to implement uniform standards of conduct between brokers and investment advisers. Brokers currently adhere to a suitability standard of care with their clients, while investment advisers are fiduciaries who must act in their clients' best interests. The states alleged that section 913(g)(1) of the Dodd-Frank Act authorizes the SEC to harmonize the standards of conduct for brokers and investment advisers and promulgate rules to ensure that brokers are subject to the same standard of conduct applicable to investment advisers under the Investment Advisers Act of 1940. The states also alleged that section 913(g)(2) directs that any SEC rules establishing a best interest obligation for brokers must provide that the standard of conduct "shall be to act in the best interest of the customer without regard to the financial or other interest of the broker, dealer, or investment adviser providing the advice." The states alleged that, taken together, these provisions make clear that any rules promulgated by the SEC regarding the standard of conduct for brokers must be the same as the standard of conduct applicable to investment advisers. While the SEC contends that Reg BI elevates the standard of care for brokers, the states argued that the rule falls short of the uniform standard of conduct contemplated by the Dodd-Frank Act and fails to even meaningfully elevate existing suitability obligations.

On September 10, 2019, XY Planning Network, a coalition of fee-only financial planners, also filed suit against the SEC in the U.S. District Court for the Southern District of New York. The organization claimed that Reg BI puts investment advisers at a competitive disadvantage to broker-dealers and makes it more difficult to differentiate an investment adviser's fiduciary standard of conduct from the lower standard of conduct applicable to broker-dealers. The suit largely mirrored the lawsuit by the states and contended that the SEC ignored section 913(g) of the Dodd-Frank Act, which states that regulations for broker-dealers should be no less stringent than those for investment advisers when it comes to providing financial advice. XY Planning Network also argued that Reg BI is inconsistent with the Investment Advisers Act, which exempts broker-dealers from the fiduciary standard imposed on investment advisers only if the broker-dealers give advice that is "solely incidental to" the conduct of their business as brokers or dealers. XY Planning Network contends that Reg BI's focus on the episodic nature of the advice provided by broker-dealers ignores whether the advice is "solely incidental" to the provision of brokerage services as set forth in the Investment Advisers Act.

On the same days that these cases were filed in the district court, the states and XY Planning Network simultaneously filed petitions for review of Reg BI in the U.S. Court of Appeals for the Second Circuit.

The Southern District of New York consolidated the two district court cases on September 12, 2019, noting that "the complaints describe the same or substantially similar underlying events arising out of the same or substantially similar operative facts, and assert the same or substantially similar claims against the same defendants." On September 27, 2019, the district court entered a sua sponte order examining its jurisdiction, concluding that it lacked subject-matter jurisdiction because jurisdiction to review the agency decision was statutorily granted to the court of appeals. The district court, thus, dismissed the consolidated action "in favor of further litigation pursuant to the petitions for review filed in the Second Circuit."

It remains to be seen whether the states and XY Planning Network will pursue allegations comparable to those discussed above before the Second Circuit or take other action following the district court's dismissal. Carlton Fields will continue to monitor and report on further developments in these challenges to Reg BI.

Time to Flush Certain Restrictions on Rebates?

BY ANN BLACK AND JAMIE BIGAYER

The NAIC and states are reviewing whether to flush those provisions of state anti-rebating laws that inhibit innovation in the insurance industry. The NAIC Unfair Trade Practices Act (#880) prohibits offering any premium rebate, special favor, valuable consideration, or anything of value not specified in the policy or annuity. The discussion circles around allowing insurers and producers to provide benefits in the form of products, services, or programs that prevent or mitigate risk while at the same time protecting consumers and the financial solvency of insurers. The NAIC and states' activities are summarized below.

North Dakota

North Dakota drafted the following proposed four-part test, with each part answered in the affirmative, in order for an insurer or producer to offer risk prevention, mitigation benefits, or value-added services for free, at a discount, or at market value:

1. Does the provision of the value-added service, taken as a whole, protect the solvency of the applicable insurers and protect consumers?
2. Does the provision of the value-added service, taken as a whole, protect consumers against unfair discrimination?
3. Is the value-added service, taken as a whole, related to the insurance coverage being provided?
4. Does the service mitigate loss or provide loss control that aligns with the risks of the policy, or assess risk, identify sources of risk, or develop strategies for eliminating or reducing those risks?

North Dakota's draft guidance requires that a description of the value-added services be filed within 30 days after its first use for review by the commissioner. "The description must briefly describe what the service is; who the service is offered to; when the service will be offered; and how the service will reduce risk." It also clarifies that no other form or rate filing would be needed.

The Innovation and Technology Task Force circulated North Dakota's proposed guidance as a starting point for a draft NAIC guideline or for revising the Unfair Trade Practices Act language to eliminate the current rebating restrictions.

Ohio

Similar to the North Dakota draft guidance, under Bulletin 2019-04, Ohio does not consider a value-added service provided for "rate reduction, loss control, and/or loss mitigation" an improper rebate when the product or service is not specified in the insurance policy if the product or service is:

1. Directly related to the type of insurance offered or purchased;
2. Intended to mitigate risks or reduce rates or claims to the benefit of policyholders; and
3. Offered or provided in a fair and nondiscriminatory manner to like policyholders.

Alabama

While Alabama enumerated more requirements, Regulation 482-1-163 adopts similar criteria for an insurer or producer to provide a value-added service or product as follows:

a. The service or product is intended to
   i. mitigate loss or provide loss control; or
   ii. assess risk, identify sources of risk, or develop strategies for eliminating or reducing those risks; or
   iii. has a nexus to or enhances the value of the insurance product.
b. The service or product may be offered or provided to a policy/contract owner or insured/annuitant for free or at a discounted price.
c. The service or product is incidental to the sale or servicing of an insurance policy or annuity contract.
d. The service or product is offered or made available in a fair and nondiscriminatory manner.
e. Providing the service or product will not violate any statute, regulation, or order beyond those mentioned in this chapter [of the regulations].
f. If the insurer has directly contracted with the policy/contract owner or insured/annuitant for the service or product, the policy/contract owner or insured/annuitant may discontinue the value-added service or product at any time.

Proposed Legislation

Several states have proposed legislation that would wash the existing rebating restrictions down the drain, including:

- ### Arizona

  Arizona Senate Bill 1008 proposes to allow "an insurer [to offer or provide] products or services that are ancillary or related to any insurance coverage and that are intended to minimize or prevent claims or claims-related expenses or harm to the public, including fire or smoke detectors, risk audits or assessments and products or services to deter property theft or damage."

- ### Massachusetts

  Massachusetts Senate Bill 1031 proposes to exclude from improper rebates "any advice or services provided ... related to risk assessment, risk management tools, claims assistance, claims reduction, administrative services, or advice or services designed to reduce risk, claims or claims expenses."

- ### New Hampshire

  New Hampshire House Bill 338 proposes to allow:

  > A value added service, activity, or product offered or provided without a fee, or at a reduced fee, if the provision of such value added service, activity, or product does not violate any other applicable statute or rule, and is:
  >
  > a. Available to all insureds on an objective and fair basis; and
  >
  > b. Directly related to the firm's servicing of the insurance policy, annuity contract, or brokerage agreement, or offered or undertaken to provide risk control for the benefit of the client.

- ### New York

  New York Senate Bill 3524 and Assembly Bill 6684 would allow services that are offered "in a non-discriminatory manner to all similarly situated insureds or potential insureds, whether or not such services are specified in such policy or contract, ... unless the superintendent determines, after a notice and hearing, that the offer and sale of such services constituted the sole reason for the purchase of ... insurance ... and that, but for ... such service, the purchase of [insurance] would not have taken place."

As more states and the NAIC allow providing value-added products or services for loss control, loss mitigation, and rate reduction, it appears the existing restrictions are circling the drain.

SEC Now May Consider a Simultaneous Settlement Offer and Waiver Request

BY NATALIE NAPIERALA AND ERIN HOYLE

Certain "bad actors" who settle with the SEC may be subject to automatic disqualifications or collateral consequences under federal securities laws and regulations. The Commission, however, may grant a settling party's request for a waiver, which is often preceded by a lengthy process wherein one or more of the SEC's divisions recommend a full or conditional grant, or a denial, of the waiver.

The Commission generally has considered offers of settlement distinct from waiver requests, subject to separate Commission votes at different times. This bifurcated process left a settling party in an uncertain position because the Commission could accept a settlement, which triggered a disqualification, in advance of its decision on the requested waiver. Then, if the Commission denied the waiver, the settling party could be subject to crippling consequences (e.g., a bar, an injunction, or the retention of an independent compliance consultant), with little to no recourse.

Previously, the SEC had appeared to take a harder line in granting these waivers. For example, the commissioners had been giving more attention to waiver requests (rather than allowing staff members to make the decisions), including imposing additional conditions on some waivers. *See* "Can 'Bad Actors' Wave Goodbye to SEC Waivers?" *Expect Focus — Life Insurance*, Vol. II (Spring 2015). In July 2019, however, SEC Chairman Jay Clayton announced that a settling party may now request that the Commission consider an offer of settlement that includes a simultaneous waiver (negotiated with the relevant divisions) in a single recommendation from the enforcement staff. So, where appropriate, the Commission now jointly considers offers of settlement with waiver requests in a single vote.

Chairman Clayton's statement may speed up the settlement process and provide settling parties with more certainty regarding the waiver process. Although the Commission is not obligated to approve either the offer of settlement or the waiver, settling parties will now have the opportunity to consider how — or whether — to proceed with a settlement if their waiver request is denied.

Ninth Circuit Steps In-Line on Arbitrability of ERISA Claims

BY IRMA SOLARES

The Ninth Circuit, in back-to-back opinion and memorandum decisions in *Dorman v. Charles Schwab Corp.*, overruled long-standing precedent that ERISA claims are not arbitrable. The plaintiff, a former Schwab employee, filed a class action suit alleging that the defendants violated ERISA and breached their fiduciary duties by including and retaining several poorly performing Schwab-affiliated investment funds in a defined-contribution retirement plan to generate fees for Schwab and its affiliates.

The district court denied the defendants' motion to compel individual arbitration pursuant to an arbitration agreement in the 401(k) retirement plan. On interlocutory appeal, the Ninth Circuit addressed the threshold question whether ERISA claims can be subject to mandatory arbitration. In an opinion decision, the court concluded that its 1984 decision in *Amaro v. Continental Can Co.*, which held that ERISA claims were not arbitrable, was "clearly irreconcilable" with intervening Supreme Court precedent, including *American Express Co. v. Italian Colors Restaurant* in 2013, and was no longer binding precedent.

In a companion memorandum decision, the Ninth Circuit addressed the enforceability of an arbitration provision that was added to the Schwab defined-contribution plan in December 2014 that provided for individual arbitration only and precluded arbitration on a class, collective, or representative basis. The court rejected the district court's finding that the arbitration clause was invalid, finding that the plaintiff's claims arose out of and related to the plan and that ERISA claims may be subject to mandatory arbitration. Because the arbitration provision was valid and enforceable in accordance with the Supreme Court's recent decision in *Lamps Plus Inc. v. Varela*, the Ninth Circuit reversed and remanded the case with instructions for the district court to order arbitration of the plaintiff's individual claims.

These decisions bring the Ninth Circuit in line with recent Supreme Court precedent upholding the arbitrability of ERISA claims and enforcing class waivers in arbitration provisions.

Intentional Killing a Grave Mistake Under Slayer Statutes

BY MICHAEL WOLGIN AND ELISE HAVERMAN

Recent decisions provide worthwhile guidance for insurers handling slayer claims.

According to traditional inheritance law, a "slayer" is one who intentionally kills, or conspires to kill, feloniously or unjustifiably, someone from whom the slayer would inherit or acquire an interest in assets or property. States prohibit a slayer from acquiring this interest to prevent unjust enrichment and to discourage schemes to kill by those who stand to benefit financially. A life insurer typically encounters slayer laws in addressing a potential slayer's entitlement to death benefit proceeds. In the event the beneficiary is deemed a slayer, the proceeds are typically payable to the secondary or contingent beneficiaries. Insurers faced with competing claims may interplead the funds with the court and obtain a discharge of liability.

One recent ruling argues in favor of taking a patient approach in handling slayer issues and considering interpleader, even if the beneficiary appears likely eligible. In *Banner Life Insurance Co. v. Shelton*, the Northern District of Illinois permitted the insurer to interplead death benefits following the killing of the insured, notwithstanding that the husband, the primary beneficiary, had not been charged with any crime or identified as a person of interest in the police investigation. After the funds were interpleaded, the court continued to deny summary judgment to the husband, finding that the funds could not yet be paid while the police investigation remained open and the husband had not explicitly been ruled out.

Other recent cases illustrate that state slayer doctrines may vary and that an insurer faced with a slayer claim should analyze the applicable jurisdiction's case and statutory law. For example, two recent decisions highlight different interpretations of "intentional" killing within the meaning of slayer statutes. In *In re Estate of Ivy*, an Illinois appellate court reversed the trial court's determination that a criminal court's ruling that a charge of first-degree murder had been established disqualified the killer in civil proceedings as a slayer who "intentionally and unjustifiably" caused the death of the victim. The court explained that the criminal proceedings did not specifically find that the killer *intentionally* killed the decedent. Rather, the first-degree murder charge "could have resulted where only great bodily harm was intended or was the known result" of the killer's actions. Consequently, there was no prior determination that the putative slayer "intentionally and unjustifiably" killed the decedent that could "be resolved as a matter law."

In contrast, in *Prudential Insurance Co. of America v. Grohman*, a Florida district court held that the intent to inflict injury, and not specifically the intent to kill, could be deemed an "intentional" killing within the meaning of the applicable slayer statute. There, the infant child of two married service members was covered under a group life insurance policy issued by the insurer, with the father as the primary beneficiary. The father was convicted of aggravated child abuse in connection with the child's death, but the father still made a claim for the insurance proceeds. After the insurer interpleaded the funds to the court, the court disqualified the father from receiving the death benefit, holding that the father's intentional abuse that resulted in death was sufficient to establish intent within the meaning of the applicable slayer statute.

Two other recent decisions show that the burden of proof applicable to slayer determinations may vary among different states. In *In re Estate of Barnett*, a Georgia appellate court relied on the "clear and convincing evidence" standard to affirm the trial court's entry of summary judgment in favor of the alleged slayer. In contrast, a recent case in Iowa cited only a "preponderance of the evidence" test as applicable to the slayer determination. In *Prudential Insurance Co. of America v. Williams*, the Northern District of Iowa permitted the insurer to interplead insurance proceeds and noted that "the putative beneficiary under the slayer statute need only prove that the named beneficiary caused the death at issue by a preponderance of the evidence." Although an insurer typically interpleads funds prior to a court ruling on whether a party has met its burden of proof, the different burdens may still be relevant to an insurer's assessment of competing claims, and the state-specific law ought to be considered.

Autoerotic Asphyxiation Ruling Brews Circuit Split on Coverage

BY IRMA SOLARES

In *Tran v. Minnesota Life Insurance Co.*, the U.S. Court of Appeals for the Seventh Circuit ruled that an insured's death from autoerotic asphyxiation fell under the policy exclusion for deaths resulting from "intentionally self-inflicted injury" within the meaning of accidental death and dismemberment (AD&D) riders to two life insurance policies issued to the insured.

Minnesota Life paid the insured's widow the life insurance coverage but denied her claim for AD&D coverage because it concluded that the insured's death did not result from an accidental bodily injury. Although the insured's death was initially reported as a suicide, the medical examiner subsequently concluded from sexual paraphernalia on the insured's body that the insured died while performing autoerotic asphyxiation. The district court concluded that reasonable minds could disagree about whether the insured's intentional act to restrict blood flow to the brain to induce a feeling of euphoria was a self-inflicted injury within the meaning of the AD&D rider language. Construing the ambiguity in favor of coverage, the district court entered judgment in favor of the insured's widow.

On appeal, the Seventh Circuit first found that autoerotic asphyxiation is an injury. The court then applied a subjective-objective test to determine whether the autoerotic asphyxiation was accidental or intentional; that is, whether the injured individual had a *subjective* expectation of injuring himself, or whether an expectation of injury was *objectively* reasonable. The Seventh Circuit reversed the district court, concluding that the decedent's subjective intent was clear because "[s]trangling oneself to cut off oxygen to one's brain is an injury, full stop," and "[w]hen that injury kills, it is 'an intentionally self-inflicted injury which resulted in death,' regardless of whether it was done recreationally or with an intent to survive." The court concluded that under the plain and ordinary meaning of the AD&D riders, the insured's death was excluded from coverage, but cautioned that the opinion "does not purport to establish a *per se* rule on insurance coverage for autoerotic asphyxiation" because policy language and factual circumstances involved in death can vary.

CLASS ACTION ROUNDUP

BY ANDRES CHAGUI AND BROOKE PATTERSON

Class actions against life insurers come in all shapes and sizes. The following decisions illustrate some of the issues life insurers are currently facing:

McClendon v. North Carolina Mutual Life Insurance Co. (M.D. Tenn. 2019)

In *McClendon*, the plaintiff's mother purchased a whole life insurance policy to insure the plaintiff's brother, and subsequently took out a loan on the policy. When the brother died, the plaintiff assigned the policy proceeds to a funeral home. The plaintiff was not satisfied with the policy benefit calculation and filed a class action complaint, claiming that similar problems affected thousands of policyholders.

The plaintiff alleged that the insurer breached the contract in three ways: (1) by charging premiums for riders past their term; (2) by applying an incorrect amount of interest to policy loans; and (3) by failing to properly credit payments to the loan balance.

The insurer did not dispute that it applied an incorrect interest rate to the loan amount. Indeed, the insurer admitted that it attempted to correct the mistake by sending the plaintiff a check, which he did not cash. Because the insurer did not contest that it breached the contract with respect to the calculation of interest on the loan, the court granted summary judgment in the plaintiff's favor as to interest calculations made within the six-year statute of limitations.

The court otherwise denied summary judgment to the plaintiff on his breach of contract claims. With respect to the plaintiff's claim that the insurer continued to charge the plaintiff for waiver of premium and accidental death riders after their terms ended, the court held that the continuing payment and acceptance of premiums extended the benefits under the riders beyond their original terms. If the plaintiff had suffered a qualifying event, the court reasoned, his beneficiary would have been entitled to payment pursuant to the rider. That kind of "mutual extension" did not constitute a breach of contract under Alabama law. In addition, because the parties disputed whether the insurer properly credited loan payments to the policy loan's balance, the plaintiff failed to establish that there was no dispute of material fact to warrant entry of summary judgment.

The insurer also moved to dismiss the plaintiff's Alabama and North Carolina deceptive trade practices claims. The court dismissed the North Carolina claim because Alabama had the most significant relationship to the policy. The court also dismissed the Alabama claim because life insurance loans were subject to the Alabama Insurance Code and exempt from Alabama's deceptive trade practices statute. Finally, the court dismissed the plaintiff's unjust enrichment claim because the existence of a valid contract forecloses such a claim, and neither party contested the existence or validity of the insurance policy or loan agreement.

Goostree v. Liberty National Life Insurance Co. (N.D. Ala. 2019)

In *Goostree*, the plaintiffs filed a putative class action alleging that the insurer operated a scheme to sell low face-value life insurance policies to low-income consumers. According to the plaintiffs, the insurer targeted undereducated consumers and charged premiums that far exceeded the policies' face value, thereby generating profits for the insurer and its agents but providing no economic benefit to the plaintiffs.

In particular, the plaintiffs claimed that their agent induced them to purchase multiple insurance policies — for which the collective premium exceeded $14,000 a year — even though one plaintiff earned less than $16,000 a year and the other was retired and receiving Social Security benefits. When the plaintiffs sought to cash out a policy because they could no longer afford the premiums, the agent allegedly explained that a cash out was not permitted and suggested they instead convert their policies to a "reduced paid-up policy," which would no longer obligate the plaintiffs to pay premiums but would reduce their death benefit from $134,000 to $45,000. The plaintiffs alleged that, by this time, they had paid $188,000 in premiums.

The plaintiffs asserted various individual and class action claims against the insurer, including breach of contract; breach of implied covenant of good faith and fair dealing; conversion; rescission; unjust enrichment; declaratory and injunctive relief; negligence, willfulness and/or wantonness in the recommendation and sale of life insurance policies; and negligent and/or wanton training and supervision. The plaintiffs also asserted claims for breach of contract; breach of implied covenant of good faith and fair dealing; declaratory and injunctive relief; and negligence, willfulness, and/or wantonness in the recommendation and sale of life insurance policies against the agent.

The insurer removed the case to federal court, arguing that the plaintiffs had fraudulently joined their agent. The court concluded that the complaint did not allege a special relationship between the plaintiffs and their agent; thus, the plaintiffs failed to plead that the agent owed them any duty. And no contract existed between the plaintiffs and the agent. Because the plaintiffs failed to state any claim against the agent, the court held that the plaintiffs had fraudulently joined their agent. The court dismissed the agent from the action, which allowed the court to hold that it had diversity jurisdiction. The court also concluded that it had jurisdiction under the Class Action Fairness Act (CAFA) because the alleged amount in controversy exceeded CAFA's $5 million minimum and because the plaintiffs failed to demonstrate that CAFA's local controversy exception applied.

Defendants Fend Off Challenge to FIA's Proprietary Index

The End or the Beginning for Suits Over Disappointed Index Interest Expectations?

BY TODD FULLER

Security Benefit Life Insurance Co. and Guggenheim Partners recently secured an important victory in a class action challenging a fixed index annuity's proprietary index with a volatility overlay. Various proprietary indexes are being used by the index crediting options of numerous fixed index annuities. A proprietary index provides an alternative to the S&P 500® index by incorporating different asset classes and volatility control mechanisms. The volatility control mechanism shifts between the different assets or asset classes depending on a target level of volatility of the assets or asset classes.

In *Ogles v. Security Benefit Life Insurance Co.*, the plaintiff brought a putative class action against Security Benefit and Guggenheim alleging federal racketeering violations, and a state law claim for unjust enrichment, relating to his purchase of Security Benefit's "Total Value Annuity" (TVA). The TVA contained several interest crediting options based on a traditional index, like an S&P 500® index, as well as a nontraditional index based on commodities and currencies futures coupled with a volatility overlay, known as the Annuity Linked Trader Vic Index (ALTVI). This particular index is generally thought to perform inversely to equities-based indexes, like the S&P 500®. Accordingly, if the S&P 500® decreased, the ALTVI was intended to increase and vice versa, thus providing the opportunity for interest credits in times when index crediting options linked to stocks or bonds might not.

In July 2012, the plaintiff purchased the TVA and allocated 100 percent of his premium to the ALTVI-based interest crediting option, which promised interest credits based on the amount of change in the ALTVI at the end of a five-year period. When the plaintiff did not receive any interest credit, he sued, asserting violations of the Racketeer Influenced and Corrupt Organizations Act and alleging misrepresentations to the putative class about Security Benefit's true financial condition and the true nature, development, and potential of the TVA and the performance of the ALTVI.

Under the first of two theories of RICO violations, the plaintiff alleged that certain financial transactions involving Guggenheim, Security Benefit, and other related entities misled him about Security Benefit's true financial strength and that he would not have purchased the annuity had he known that Security Benefit's financial picture was more tenuous than it appeared. The court, however, determined that this theory was reverse-preempted under the McCarran-Ferguson Act. As the court explained, McCarran-Ferguson bars application of a federal statute if:

1. The federal statute does not specifically relate to the business of insurance;

2. A state statute exists that regulates the business of insurance; and

3. Application of the federal statute would invalidate, impair, or supersede the state statute.

Because the parties agreed that RICO does not specifically relate to the business of insurance and that the relevant states have enacted laws to regulate insurance, the only question was whether the application of RICO would impair those state insurance laws in this context. The court noted that plaintiff's claims regarding Security Benefit's strength, financial transactions, and solvency are matters squarely within the regulatory oversight of state insurance departments. Thus, asking the court to decide the plaintiff's RICO claim based on these financial transactions, which had not been questioned by state regulators, would mean asking the same questions as the state insurance regulators, effectively "double-checking" their work. The court explained that this would improperly interfere with the states' administrative regimes.

The plaintiff's second RICO theory challenged "simulated historical" illustrations of the ALTVI-based crediting option that the plaintiff had received, as well as the ALTVI's design. The plaintiff alleged that the illustrations fraudulently misrepresented the annuity's potential upside and bore no resemblance to actual real world performance. The plaintiff also alleged that the ALTVI itself was designed to underperform and that the volatility overlay was falsely represented to provide more upside potential when in reality it:

1. Was designed to minimize interest credits;

2. Was faulty by design; or

3. Was being improperly managed.

The court, however, held that the plaintiff's attempt to establish predicate RICO acts based on fraud was not supported by any well-pleaded factual allegations. Indeed, the court noted that there was no allegation that the ALTVI-based crediting option's historical simulations were themselves inherently fraudulent — only that the product did not perform as well in the real world. The court also explained that there could be no misrepresentation under the circumstances, because the historical simulations themselves disclosed that "simulated past performance" of the ALTVI "does not reflect what will happen in the future." Similarly, the court held that there were no plausible factual allegations demonstrating that the development of the ALTVI, including the volatility overlay, was somehow fraudulent, let alone that it was designed to underperform. The court concluded that it was hard-pressed to find any misrepresentations, let alone any particularized allegations that would satisfy the heightened pleading requirements, necessary to support a plausible RICO claim.

After dismissing the plaintiff's federal RICO claims for failure to state a claim, the court declined to exercise supplemental jurisdiction over the state law unjust enrichment claim.

The plaintiff recently appealed the dismissal order to the U.S. Court of Appeals for the Tenth Circuit. We will be following this issue closely and will provide continued updates as they become available.

Court Sheds Light on ERISA's Fiduciary Exception to Attorney-Client Privilege

BY TODD FULLER AND DIMITRIJE CANIC

A federal district court in Ohio recently attempted to shed some light on when internal communications between an ERISA plan administrator and its in-house counsel are discoverable and when they are protected by the attorney-client privilege.

In *Duncan v. Minnesota Life Insurance Co.*, an ERISA plan beneficiary sought the production of certain communications between Minnesota Life (the plan administrator) and its in-house counsel relating to Minnesota Life's denial of the beneficiary's claim for accidental death benefits. Minnesota Life had previously withheld the documents arguing that such communications between it and its in-house counsel were protected by the attorney-client privilege. The beneficiary, however, argued that Minnesota Life was required to produce such documents based on ERISA's fiduciary exception. Under the fiduciary exception, a plan fiduciary generally must make available to the beneficiary, upon request, any communications with an attorney that are intended to assist in the administration of the plan. This is because when an attorney advises a plan administrator or other fiduciary concerning plan administration, the attorney's clients are the plan beneficiaries for whom the fiduciary acts, not the plan administrator. Minnesota Life countered that none of the communications with its in-house counsel related to administration of the plan, such as deciding whether to grant or deny the beneficiary's claim, but rather were made in preparation for anticipated litigation.

The court explained that when the interests of the ERISA plan fiduciary and the plan beneficiaries have diverged sufficiently such that the fiduciary seeking legal advice is no longer acting directly in the interests of the beneficiaries, but in its own interests to defend against plan beneficiaries, then the attorney-client privilege remains intact. The court noted, however, that the mere prospect of potential litigation over a claim decision is insufficient to defeat the fiduciary exception because denying benefits to a beneficiary — and any related pre-decisional legal advice — is as much a part of the administration of a plan as conferring benefits to a beneficiary.

Following an in camera review of the subject communications, the court compelled the production of certain communications between Minnesota Life and in-house counsel occurring before and after the claim denial because the parties' relationship had not become adversarial yet and simply involved ordinary matters of ERISA claim administration. The court, however, noted that "[t]hings changed somewhat dramatically" when the beneficiary's counsel notified Minnesota Life that they were appealing the initial denial of benefits. The court held that "[o]nce Minnesota Life received counsel's strongly worded, evidence-based letter along with [a doctor's] opinion letter, Minnesota Life faced more than a mere possibility of future litigation if it continued to deny benefits." The court noted that, at this point, the relationship was clearly adversarial and litigation was almost a certainty. Accordingly, the court determined that the fiduciary exception did not apply to communications after this point as such communications were protected by the attorney-client privilege.

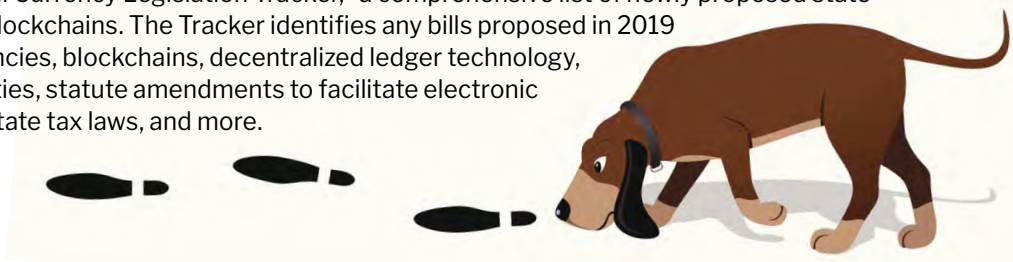
Carlton Fields Rolls Out Blockchain, Crypto, and Virtual Currency State Legislation Tracker

BY EDMUND ZAHAREWICZ AND MATTHEW KOHEN

Since 2010, bitcoin and other decentralized systems have challenged the status quo of financial transactions and their regulation. As the insurance industry, among others, explores their uses for enhancing product innovation, customer service, and back-office efficiency, all levels of government have begun to grapple with the implications of these technologies.

While the federal government has focused primarily on regulating these technologies to prevent fraud and criminal activity, states have focused on enabling their use. State legislatures have, for example, introduced laws to facilitate research and technology, provide clarity as to the legal status of various crypto assets, create new business entities, experiment with new regulations governing the issuance of novel types of investment products, and support new businesses providing products and services using blockchain technology.

Carlton Fields' Blockchain and Digital Currency Practice has been monitoring these developments and is pleased to offer its "2019 State Blockchain, Crypto and Virtual Currency Legislation Tracker," a comprehensive list of newly proposed state legislation relating to cryptocurrencies and blockchains. The Tracker identifies any bills proposed in 2019 that touch on cryptocurrencies, virtual currencies, blockchains, decentralized ledger technology, digital assets used for the issuance of securities, statute amendments to facilitate electronic transactions recorded on blockchains, new state tax laws, and more.



The Tracker is updated weekly on the firm's website: https://bit.ly/2mJ14x8.

NEWS & NOTES

The ALI Life Insurance Company Products Conference will occur on November 6-8 in Washington, D.C. **Richard Choi**, shareholder and conference co-chair, will lead an introductory workshop for legal and compliance staff. Shareholder **Ann Black** will speak on the topic of "Fixed and Fixed Indexed Annuities and Life Insurance Products." **Gary Cohen** will participate in a panel on "Mutual Funds and Advisers: Key Regulatory and Litigation Developments." Shareholder **Chip Lunde** will speak on a panel titled "Compliance with New SEC Regulation Best Interest, Form CRS, and Investment Adviser Fiduciary Duty and 'Solely Incidental' Interpretations."

The IRI VISION19 Conference occurred on September 9-11 in Charleston, South Carolina. Shareholder **Richard Choi** spoke at a Reg BI power workshop for broker-dealers that explored interpretational questions, operational and technological challenges, and the impact on advisor-client relationships.

The firm was an executive partner of the ACLI's Compliance & Legal Sections Annual Meeting on July 15-17 in Fort Lauderdale, Florida. Shareholder **Irma Solares** spoke on the panel "Litigation Update," providing an overview on recent litigation developments.

Carlton Fields is "the best of the best" law firm in class action defense and complex commercial litigation, according to *BTI Litigation Outlook 2020: Changes, Trends, and Opportunities for Law Firms*. The report is based solely on in-depth telephone interviews with leading legal decision-makers.

The firm was recognized among the most diverse law firms in the country, ranking in the top 10 nationally among firms of its size in *Law360*'s 2019 Diversity Snapshot for "The Best Law Firms for Minority Attorneys" and "The Best Law Firms for Female Partners." The ranked firms are "examples of what a more diverse and more inclusive workforce can look like."

Carlton Fields continues to rank as one of the top law firms in the country for diversity according to *Vault*'s 2020 Best Law Firms for Diversity. The firm also ranked in the top 10 for diversity for racial minorities, individuals with disabilities, LGBTQ individuals, and women. Additionally, the firm placed in the top 25 for "Best Law Firm for Technology and Innovation."

Carlton Fields welcomes the following two attorneys, who are joining the Life, Annuity, and Retirement Solutions Industry Group, to the firm's Washington, D.C., office: Of Counsel **Scott Abeles**, and associate **Elise** Haverman.

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