LIFE, ANNUITY, AND RETIREMENT SOLUTIONS INDUSTRY Volume II, September 2020

EXPECTFOCUS®

LEGAL ISSUES AND DEVELOPMENTS FROM CARLTON FIELDS

A VIRTUALLY HOT SUMMER

FIRMS AND REGULATORS SPEED AHEAD

CARLTON FIELDS

Carlton Fields Class Action Survey

We are pleased to announce the release of the ninth annual *Carlton Fields Class Action Survey: Best Practices in Reducing Cost and Managing Risk in Class Action Litigation*. The survey tracks trends identified by in-house counsel and best practices in class action management and cost reduction.

The survey draws on interviews of general and senior in-house counsel at more than 400 companies with median annual revenues of $6.7 billion across a wide range of industries. The data collected presents a snapshot of the ways in which leading corporate legal departments identify, measure, and manage class action risk.

vII INSIDE

EXPECTFOCUS®

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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.

AI Challenges for Securities Firms

Key Summer Reading From FINRA

BY EDMUND ZAHAREWICZ

In June, the Financial Services Regulatory Authority issued a report on the use of artificial intelligence (AI) in the securities industry, which is characterized by such technologies as machine learning, natural language processing, and computer vision. The report comes as financial and investment firms of all stripes are allocating significant resources to exploring, developing, and deploying AI-based applications to offer innovative products, increase revenues, cut costs, and improve customer service.

The report highlights purposes for which firms are evaluating or using AI, including:

- Enhancing customer experience
- Targeting customer outreach, providing individual brokers with better insights into customer preferences
- Improving investment management and trading performance
- Enhancing compliance and risk management functions
- Automating administrative functions

The report also highlights a number of regulatory and other key factors that firms may want to consider as they develop and adopt AI-based tools, including:

- AI model risk management
- Data governance
- Customer privacy
- Supervisory control
- Cybersecurity
- Outsourcing/vendor management
- Books and records
- Workforce structure

For example, with regard to machine learning models, which employ sophisticated algorithms to make predictions and find patterns that may suggest courses of action, the report notes that firms may benefit from reviewing and updating their model risk management frameworks to address the new and unique challenges such models may pose. This includes challenges related to model explainability, data integrity, and customer privacy.

The report requested comments by interested persons, including about areas in which guidance or changes to FINRA rules may be desirable to support the adoption of AI applications consistent with investor protection and market integrity.

NAIC Virtual Block Party

BY ANN BLACK, JAMIE BIGAYER, AND STEPHEN CHOI

The NAIC and the Interstate Insurance Product Regulation Commission ("Compact") are cooking up various initiatives that will impact life and annuity issuers. Below is the spread of the different issues.

Revised Recipe for the Standard Nonforfeiture Floor

The NAIC's Life Actuarial Task Force (LATF) is set to revise the recipe for the Standard Nonforfeiture Law for Individual Deferred Annuities (Model 805), as the NAIC's Executive (EX) Committee, at its August 13 meeting, agreed to LATF's request to amend the model. In making that request, during the August 3 LATF meeting, regulators acknowledged that if the current 1% floor is not reduced, annuity product availability may be limited because of the historically low interest rate environment.

Also at that August 3 meeting, LATF members discussed whether the floor should be reduced to 0%. New York expressed its concern that a guaranteed floor of 0% would result in consumers receiving no interest while still being subject to "substantial" surrender charges. The American Council of Life Insurers pointed out, however, that due to competitive pressures, insurers would usually declare rates higher than 0% even if the minimum guaranteed rate is 0%.

The Compact has informed LATF that because the Compact standards refer to Model 805, once the NAIC changes the floor, insurers will immediately be able to file products including the new floor rate with the Compact.

New Centerpiece for the Privacy Protections Working Group

The Privacy Protections Working Group decided to change the centerpiece for its review of the state insurance privacy protection laws from the NAIC Insurance Information and Privacy Protection Model Act (Model 670) to the Privacy of Consumer Financial and Health Information Regulation (Model 672). The change was made in recognition of the fact that Model 672 is more widely adopted by states and reflects more current thinking of the NAIC.

Checking the Ingredients for Compact Standards

As a result of the Colorado Supreme Court's decision in *Amica v. Wertz*, the Compact is creating a shopping list of states' statutory policy requirements and comparing them to the Compact standard requirements to see if the Compact is missing any ingredients. In addition, the Compact is seeking guidance on resolving any differences between state statutory requirements and Compact standards.

Gag Orders

Stifling Effect on SEC Critics

BY BRIAN ROSNER AND NATALIE NAPIERALA

Any consent judgment with the SEC includes what is often called a "gag clause." These clauses prohibit the defendant from challenging the truth of any allegation in the SEC's complaint or making any statement that might be construed as saying that the complaint lacked a factual basis. This prevents defendants and their counsel from informing the public — including the press and Congress — about what they perceive to be unfair SEC tactics or factual assertions in the proceeding.

The lawfulness of the SEC's power to shield itself from review and criticism in this way is currently under judicial review by the Second Circuit Court of Appeals in *SEC v. Romeril*.

In 2003, the SEC filed a civil enforcement action against Barry Romeril and certain other parties. Without admitting or denying the allegations, the parties, including Romeril, settled the litigation and entered into the consent judgment that included the gag clause.

Many years later, Romeril asked the federal district court to remove the gag clause to allow him to make "truthful public statements" about the SEC's case against him. Following the district judge's denial of his request, Romeril is arguing on appeal that the gag clause is void ab initio as an unconstitutional prior restraint on truthful speech. The SEC argues that the gag clause in the settlement agreement with Romeril was a freely negotiated condition of a contract and that Romeril was represented by competent counsel.

Although the law is clear that First Amendment rights may be waived, the law is equally clear that First Amendment waivers are to be scrutinized when the government is a party. It is not just the individual's rights — Romeril's in this instance — that are involved; it is society's need to hear criticism of the government in order to address and reform government, where appropriate.

The SEC argues that deterrence — its ability to deter violations of the securities laws — will be diminished if settling defendants like Romeril are allowed to question the factual basis of the SEC's action. However, like most parties who enter into SEC consent orders, Romeril was also subjected to other sanctions that seem significant enough to deter securities violations of the sort alleged in the complaint.

Or, the SEC argues, allowing individuals in Romeril's position to speak will raise public doubts about the propriety of the SEC's conduct, thus reducing respect for the SEC and diminishing its effectiveness. However, there is no bar on defendants complaining about Department of Justice actions that convicted them, and yet the DOJ survives and remains effective.

The Second Circuit's review of the SEC's gag power is particularly timely. Among the case law in support of invalidating such gags is a recent Fourth Circuit Court of Appeals holding that released an individual from his agreement with a police department not to publicly discuss a beating that he alleged the police had inflicted on him.

Carlton Fields is counsel for amicus curiae Americans for Prosperity Foundation in its brief in support of Romeril's challenge to the SEC's gag order.

FINRA Corporate Financing Rule Amendments Bring Clarity for Insurance Products

BY ANN FURMAN

The SEC has approved amendments to FINRA's corporate financing rule. The purpose of the rule is to allow FINRA to determine that public offering terms and conditions are not unfair, unreasonable, or inconsistent with FINRA rules. The rule requires FINRA members that participate in a public offering covered by the rule to file information with FINRA about the underwriting terms and arrangements.

Portions of the amended rule that are significant to public offerings of insurance products become effective September 16, 2020.

Prior to the amendments, the rule exempted variable contracts, market value adjusted (MVA) insurance contracts, and exempt securities, including group annuity contracts sold to qualified plans, but not other types of insurance products such as registered index-linked annuities (RILAs) and contingent deferred annuities (CDAs). Accordingly, it was not clear whether FINRA required principal underwriters of nonexempt insurance products to either comply with the rule or obtain an exemption or other relief from the rule.

As amended, FINRA Rule 5110(h)(2) expands the list of offerings that are exempt from both the filing requirements and substantive rule compliance. In addition to open-end funds and closed-end investment companies under certain conditions, the amended rule exempts the following insurance product offerings from rule filing and compliance requirements:

- Variable contracts;
- Certain modified guaranteed annuity contracts and modified guaranteed life insurance policies with an MVA feature; and
- "Insurance contracts not otherwise included" in the above two categories.

The amended catchall phrase "insurance contracts not otherwise included" is welcome news for principal underwriters of RILAs, CDAs, and yet-to-be-developed insurance products not designed as variable or MVA contracts.

SEC Proposes Big Changes to Fund Disclosure

BY GARY COHEN

The SEC has proposed "comprehensive modifications to the mutual fund … disclosure framework," as highlighted below. More detailed analysis of the proposal is also available in our legal alert. *See* "SEC Proposes Changes to Fund Shareholder Reports, Prospectuses, SAIs, and Ads."

Shareholder reports would become the "central source of fund disclosure for existing shareholders." Funds would no longer send annual updated prospectuses to shareholders.

Funds would have drastically shortened shareholder reports — three or so pages — delivered electronically. Financial statements, schedules of investments, financial highlights, and information on directors, officers, and investment advisory agreement approval would be removed but available to shareholders in paper at no charge on request.

The annual reports would be required to include a narrative setting out changes that a fund had made in its disclosure documents during the year, even if the fund had previously provided the disclosure to shareholders by prospectus sticker. The narrative would also set out disclosure changes that the fund planned to make in its annually updated prospectus.

Prospectus disclosure would be modified:

- Fee tables and terms would be simplified, and disclosure of certain acquired fund fees and expenses would be deemphasized;
- Principal risks would be disclosed in order of importance, rather than alphabetically or otherwise; and
- Performance would be compared to the overall applicable market, in addition to any narrow index against which a fund chooses to compare itself.

Any ads showing fee and expense figures would be required to include maximum sales loads, nonrecurring fees, and total annual expenses. Funds advertising "zero expenses" would be required to consider disclosing intermediary fees like wrap fees, securities lending fees, and adviser fees that the adviser is waiving.

For variable insurance products offered through SEC-registered separate accounts:

- The proposal's changes to the required contents of fund disclosure documents generally would apply for underlying funds the same way as for retail funds selling directly to the public.
- The proposal, however, generally would not otherwise modify or supersede the SEC's recently adopted disclosure reforms — including summary prospectus delivery — in connection with variable insurance products.

As of the date of publication, the comment period expiration date has not been set.

No Summer Break for the Rebating Drafting Group

BY ANN BLACK AND JAMIE BIGAYER*

The rebating drafting group of the NAIC's Innovation and Technology (EX) Task Force ("Innovation TF") has been busy all summer working on proposed changes to section 4(H) of the NAIC's Unfair Trade Practices Act (UTPA). On June 23, the Innovation TF released for comment proposed revisions to the UTPA's rebating section. These comments were discussed during the July 23 meeting of the Innovation TF. During the Innovation TF's August 7 meeting, Commissioner Dwyer reviewed the changes made to the draft rebating section in response to the 21 comment letters received.

In general, if certain conditions are met, the draft rebating section allows insurers, producers, and their representatives to offer:

- Products and services related to the insurance coverage that are primarily intended to help the recipient when such products or services are not provided in the insurance contract.
- Promotional items, within specified limits.

The more notable changes and discussions from the August 7 meeting are below.

1. Recipients of the Products and Services or Promotional Items

The August 7 version of the rebating provision includes a new defined term "client," which includes "policyholders, potential policyholders, certificate holders, potential certificate holders, insureds, potential insureds or applicants." This change was made in recognition of the range of persons who may receive products, services, or promotional items.

2. Nature of Products and Services

In response to the various comments seeking to clarify or broaden the scope of the products and services permitted under the revised rebating provision, the August 7 version added loss mitigation and assistance with compliance with a state or federal law or regulatory requirement as permissible products and services.

Some of the more notable suggested products or services the rebating drafting group declined to add as permissible include those that:

- Incent consumer referrals of insurance products that they already obtained and for which they are current insureds.
- Enhance the value of the insurance benefits to the policyholder.

Commissioner Dwyer explained that the Innovation TF also declined suggestions to:

- Limit the available products and services to particular lines of business due to states' differing definitions for various lines of business and the possibility that the limitations might be too restrictive.
- Include products and services that would be available in connection with the administration of group insurance out of a concern that this would allow for products and services to be offered in connection with force-placed insurance and title insurance, areas in which regulators had previous concerns over rebating practices.

The revisions to the rebating language also allow for a pilot program or testing of products and services where the insurer does not yet have evidence that the products or services meet the conditions of permissible products or services. To test, the insurer must have:

- A good faith belief that the product or service relates to the insurance coverage and primarily satisfies one of the eight enumerated types of products and services listed in the revised rebating language.
- Commissioner approval for the test.

3. Availability of the Product and Services

The revisions to the rebating language require that the products or services be offered to all clients unless the limited availability is based on fair, written objective criteria that are not unfairly discriminatory. In response to comments, the drafting group acknowledged that the objective criteria may include risk characteristics of a client.

4. Required Disclosure

To make clear that an insurer remains responsible when offering products or services, especially when there is no relationship between a third party providing the product or service and the insurer, a new section (e)(2) was added to the August 7 version requiring disclosure to the consumer that the product or service "is not part of the insurance policy" and what "assistance, if any, … the insurer will provide should the consumer have an issue with the product or service."

5. Prohibition on "Free Insurance" and Use of "Free" in Any Offer

Apparently in response to the New York Department of Financial Services' (NYDFS) comment, the August 7 version also added a new section (g) explicitly prohibiting "free" insurance and the use of the word "free." The NYDFS asserted that someone is paying for the product or service even if it is not the consumer. The NYDFS' comments referenced OGC Opinion No. 08-05-15, in which a proposed insurance coverage to consumers "free-of-charge" with the purchase of an extended service contract was found to violate New York insurance law and regulations.

The Innovation TF continued to accept comments on the revised draft rebating section until August 28.

**With assistance from Facundo Scialpi, a student at the University of Miami School of Law.*

Back to School for Annuity and Life Disclosures and Illustrations

BY ANN BLACK AND STEPHEN CHOI

The NAIC Virtual Summer National Meeting marked that it is time to get back to school for a number of annuity and life disclosure and illustration initiatives. Both regulators and insurers will need to sharpen their pencils to complete their assignments.

1. Extension to Finish Revisions to the Annuity Disclosure Model Regulation

   The NAIC Annuity Disclosure (A) Working Group ("Disclosure WG") was given an extension until the Fall National Meeting to finish its project to revise the Annuity Disclosure Model Regulation's (Model 245) requirements for fixed index annuity illustrations. The current version of the revisions requires:

   - Each component of an index to be in existence for at least 15 years before the index could be illustrated.
   - The illustrations to differentiate between those indexes that have been in existence for at least 15 years versus those whose components have been in existence for at least 15 years.
   - Additional disclosures on the computation of indexes based upon components.

   The Disclosure WG asked for the extension to modify the proposed required disclosure provisions of Model 245. During the extension, the Disclosure WG will also consider whether to volunteer for the assignment to develop product oversight standards for fixed index annuities and address the relationship between an index provider and the hedging provider.

2. Continued Revisions to Policy Overview Documents and Changes to the Life Insurance Disclosure Model Regulation

   The Life Insurance Illustration Issues (A) Working Group continues its work on a consumer-oriented term policy overview document. This group also continues to debate whether insurers (a) could elect to deliver the policy overview document at the time of application or at the time of policy delivery or (b) must deliver the policy overview document at the time of application.

3. Proposed New Assignment to Revisit the Annuity and Life Illustration Requirements

   Life Insurance and Annuities (A) Committee Chair Jillian Froment raised the possibility of handing out a new assignment. Froment noted that it is time to pause and review the current regulatory framework for life and annuity illustrations to determine what, if any, changes may be needed. Froment gave members the homework of thinking about the issue for a later discussion.

4. Hitting the Books on AG 49-A

   With the NAIC Executive Committee and Plenary's adoption of Actuarial Guideline 49-A (AG 49-A), insurers may need to hit the books and modify their indexed universal life (IUL) illustrations for policies that will be sold after November 25. In particular, insurers issuing IULs with index interest rate enhancements, such as multipliers or cap buyouts, should review their IUL illustrations and may need to reduce certain illustrated index interest rates to comply with new governors contained in AG 49-A. In addition, if policy loans are illustrated, changes to the IUL illustrations may be needed so that the indexed interest rate credited on the amount loaned does not exceed the loan interest rate by more than 50 basis points.

IRS Continues Hot Streak

Issues Additional Favorable Fee-Based Annuity Rulings

BY STEPHEN KRAUS

In June, the IRS issued two private letter rulings (PLRs) dealing with fee-based annuities. The facts of these two PLRs are generally identical to the facts of 17 PLRs issued by the IRS last November, with one important difference.

Although the 17 prior PLRs included a representation that the fees covered by the PLRs would not exceed an annual rate of 1.5% of the annuity's cash value, the two June PLRs had no such limitation. Interestingly, the IRS may have foreshadowed this development in that an additional PLR issued last November also had no limitation on the amount of fees.

The tax treatment of advisory fees paid directly from an annuity contract has a 30-year history. Originally, the IRS took the position that the tax treatment depended on the context. In the tax-qualified context, such as IRA annuities, 403(b) annuities, or annuities issued in connection with a 401(k) plan, the IRS took the position that the payment of an adviser's fee was not a taxable distribution from the annuity or plan. With regard to nonqualified annuities, the IRS took the exact opposite position, treating the payment of the adviser's fee as a taxable distribution from the annuity, subject to current income tax and possibly the 10% premature distribution tax penalty.

The recently issued PLRs, like the PLRs last November, contained several representations, including:

- The annuity owner will authorize payment of the investment advisory fees from the annuity's cash value.
- The fees will compensate the adviser only for investment advice with respect to the annuity and not for any other services.
- The annuity will be solely liable for paying the entire fee, which will be paid directly to the adviser and not to the annuity owner.
- The adviser will not receive a commission for the sale of the annuity.

Despite this favorable development, the PLRs can be relied on only by the taxpayers who received them. Therefore, taxpayers should assess the risks before treating advisory fees paid from annuities as nontaxable distributions without obtaining their own PLR.

DOL Warms Up to Private Equity in 401(k) Plans

BY LOWELL WALTERS

On June 3, 2020, the Department of Labor provided valuable insights via an information letter addressing private equity investment (PEI) within defined contribution retirement plans (such as 401(k) plans). The letter addressed a scenario in which PEI would be a part of a larger, diversified asset allocation fund (such as a balanced fund or target-date fund).

The DOL did not consider the use of PEI as a separate direct investment option, noting that "direct investments in private equity investments present distinct legal and operational issues for fiduciaries of ERISA-covered individual account plans." Such fiduciary concerns were raised by the SEC in a risk alert issued on June 23, 2020, and discussed in more detail in "OCIE Turns up Heat on Private Fund Adviser Compliance" on page 16.

Based on the letter and other guidance addressing issues not covered by the letter, the following is a checklist of considerations that are relevant when deciding whether to allow PEI in participant-directed 401(k) plans. Because of the complexity and breadth of issues, many plan sponsors and retirement plan committees will need expert professional assistance to answer all the questions in this checklist.

Effect of PEI on General Plan Operations

- Will the fund option with PEI have sufficient liquidity to handle cash outflows (including hardship distributions, loans, and required minimum distributions)?
- Will that fund option be able to accommodate investments of relatively small amounts over time via payroll deduction?
- In the event of a divorce or a death, will the PEI subject itself to the retirement plan's QDRO and beneficiary procedures (which might require the investment to be split with, respectively, a divorcing spouse or beneficiaries)?

Determination that the PEI is a Proper Plan Investment Option

- Are the PEI's goals consistent with the interests of the fund option that holds the PEI, the plan, and its participants and beneficiaries, considering such aspects as the likelihood of appropriate return with reasonable risk within a reasonable time horizon?
- Are the PEI fees and expenses reasonable?
- Do participants have a level of sophistication that makes it likely they will use the fund option containing PEI appropriately?
- Will the PEI provide information that will adequately inform participants of how it works, how it differs from other investments, the fees and risks involved, and what restrictions apply?
- Will the PEI add to the investment diversification already available to plan participants?

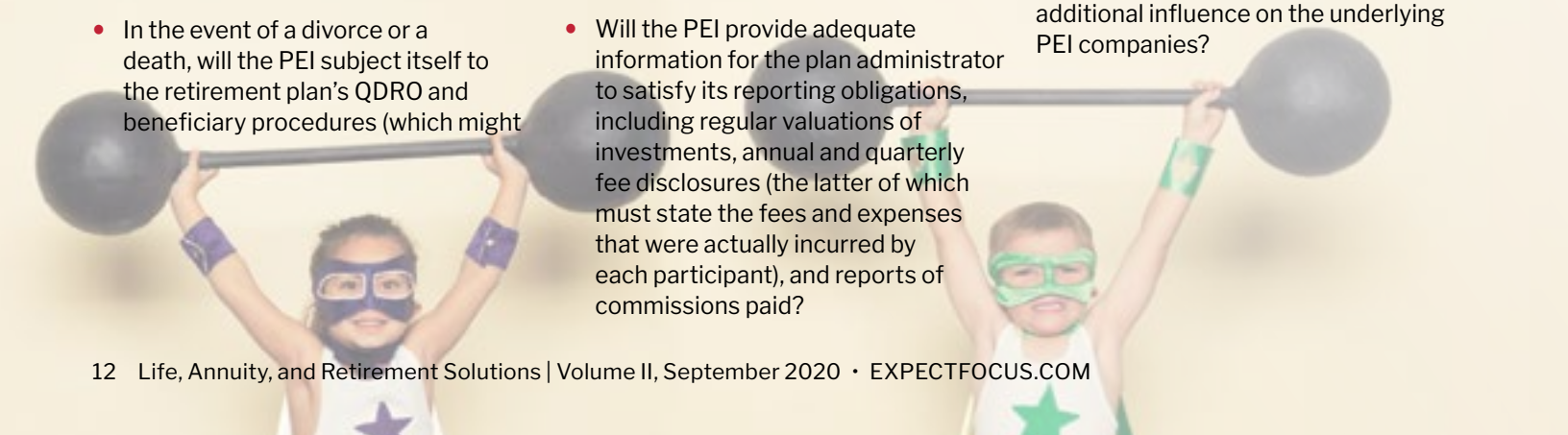
Impact of PEI on DOL Form 5500 Reporting Obligations

- Is the PEI being valued reasonably, and will the valuation be acceptable for annual audit purposes?
- Will the PEI provide adequate information for the plan administrator to satisfy its reporting obligations, including regular valuations of investments, annual and quarterly fee disclosures (the latter of which must state the fees and expenses that were actually incurred by each participant), and reports of commissions paid?
- Will the PEI affect the plan's annual audit process, the time or cost of conducting an audit, or audit waiver qualifications?

Evaluation of Potential Increase in the Risk of Conflicts of Interest or Self-dealing

- Do any fiduciaries stand to gain (financially or otherwise) by a plan option's investment in a particular PEI?
- Do any decision-makers or "influencers" have personal funds invested in the PEI or stand to earn a commission from the plan option's investment?

While all prohibited transactions must be avoided, the use of PEIs will probably increase the risk of certain types of "self-dealing" that might violate a plan sponsor's fiduciary obligations even if it does not constitute a prohibited transaction. For example, assume a CEO has personal funds invested in a PEI. To the CEO, it makes sense to allow 401(k) participants to invest in that PEI, too, since the CEO already vetted the PEI and determined it is a prudent investment. However, might the additional 401(k) investments reduce the risk of loss to the CEO's personal investment? Might the CEO be able to aggregate the personal investment with the plan's investment to exert additional influence on the underlying PEI companies?



SEC Still Cool With Virtual Fund Board Meetings

BY GARY COHEN

Mutual fund boards of directors need not meet in person to approve investment advisory contracts, Rule 12b-1 plans, or independent public accountants through December 31.

This SEC relief is conditioned on:

- A need due to circumstances related to COVID-19;
- Directors casting votes at a meeting using means of communication by which directors can hear each other simultaneously; and
- Ratification, at the board's next in-person meeting, of the action taken.

The SEC originally ordered this relief on March 25 and extended it on June 19. However, the SEC did not extend certain other relief it had granted on March 25.

In extending the relief, the SEC said that "[t]he health and safety of all participants in the securities markets is of paramount importance, and the Commission recognizes that boards of directors of registered management investment companies ... continue to face challenges traveling in order to meet the in-person voting requirements."

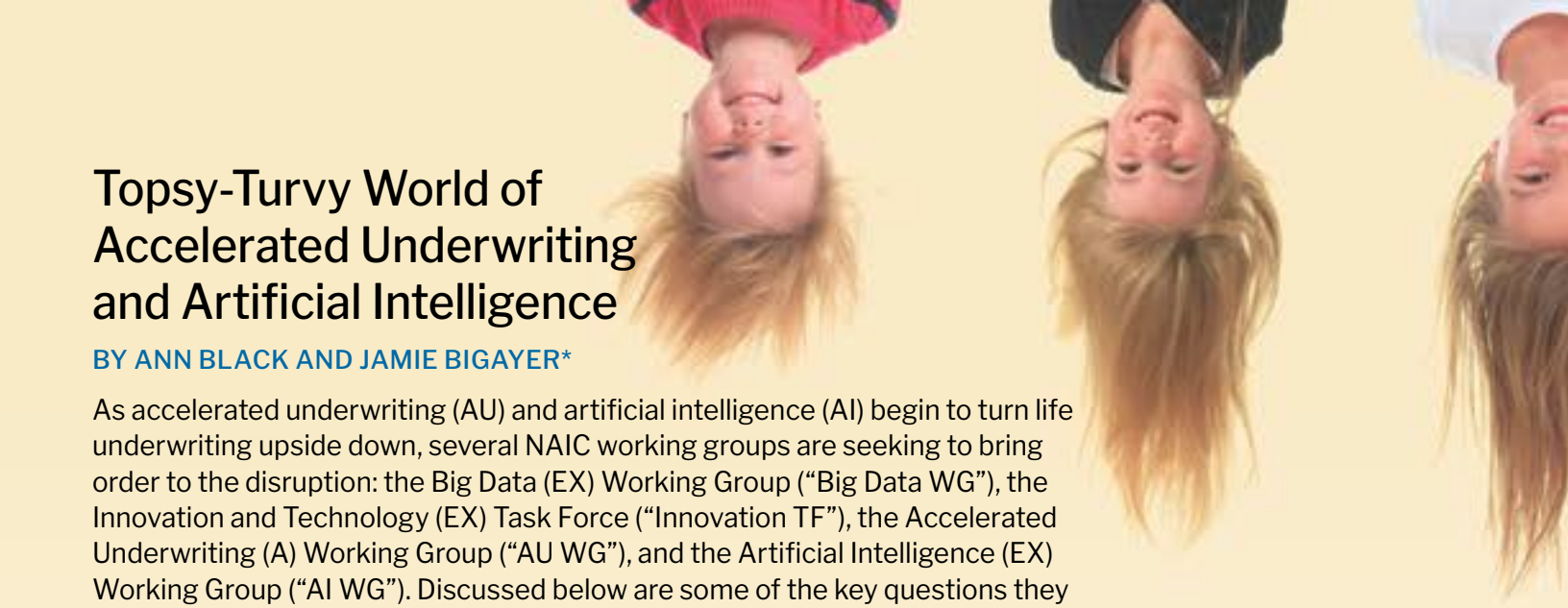
The SEC also said that it "intends to continue to monitor the current situation" and, "if necessary," further extend the "time period for the relief."

Visit the Carlton Fields COVID-19 Resource Page

COVID-19 continues to give rise to numerous issues affecting many aspects of virtually all types of businesses — including the issuance, distribution, and administration of life insurance, securities, and other retirement products and services.

Our lawyers have been focusing on COVID-19 issues arising in their areas of practice, and we are continually posting useful information about these issues on a dedicated resource page that is available at https://www.carltonfields.com/coronavirus.

The materials on the resource page are conveniently organized according to the types of business activity in connection with which the issues arise.



Topsy-Turvy World of Accelerated Underwriting and Artificial Intelligence

BY ANN BLACK AND JAMIE BIGAYER*

As accelerated underwriting (AU) and artificial intelligence (AI) begin to turn life underwriting upside down, several NAIC working groups are seeking to bring order to the disruption: the Big Data (EX) Working Group ("Big Data WG"), the Innovation and Technology (EX) Task Force ("Innovation TF"), the Accelerated Underwriting (A) Working Group ("AU WG"), and the Artificial Intelligence (EX) Working Group ("AI WG"). Discussed below are some of the key questions they have been considering that potentially have major implications for consumers and the insurance industry.

Who Is Subject to Regulation?

With the flood of newly available consumer data, third-party vendors have entered the fray of life insurance underwriting. By rearranging the data and developing new models, these vendors offer to reduce the time taken to underwrite a policy. Consumer groups frenetically complain that unregulated third-party vendors are not accountable if they provide an insurer with data points or models that contain inaccurate information or prohibited factors that lead to unfair discrimination. At the August 13 NAIC special session on race, Birny Birnbaum of the Center for Economic Justice urged regulators to establish oversight for unregulated vendors of data and models.

Acknowledging these concerns, the AI WG incorporated into its AI Principles a definition of "AI actors" that includes "third parties such as rating, data providers and advisory organizations" who play an active role in the AI system life cycle. By so doing, regulators have made clear their expectation that third-party vendors "promote, consider, monitor and uphold" fair, ethical, accountable, compliant, transparent, secure, safe, and robust AI principles even if they are outside the regulatory reach of the state insurance departments. The AI Principles were adopted at the August 14 Joint Meeting of the NAIC's Executive Committee and Plenary.

What Data Should Be Used?

- Is the Data Accurate?

  Because the new sources of non-traditional data are often not consumer reporting agencies and are therefore not subject to the Fair Credit Reporting Act, at the August 7 Innovation TF meeting, regulators and consumer groups questioned the accuracy of the disjointed array of data that is used in AU. To assure the accuracy of non-traditional data, at its July 31 meeting, the AU WG considered:

  - Reinforcing to insurers that they retain the sole responsibility for the collection, scrutiny, and analysis of data to ensure it is reliable, even if it is provided by a third-party vendor.
  - Banning the use of non-FCRA data or requiring FCRA-type protections on non-FCRA data, including consumer rights to access and correct such data.

- Do the Data Points Used Reflect Causation or Merely Correlation?

  To the extent that behavioral data points, such as a person's gym membership, shopping habits, wearable device data, magazine subscriptions, voting history, and web browsing history, are used within AU models, regulators and consumer groups have expressed concerns that such data points:

  - Not be unhinged, but have a rational and understandable relation to risk.
  - Reflect the consumer's reality. For example, the fact that a lower-income individual cannot afford a monthly gym membership does not automatically mean that person lives an unhealthy lifestyle warranting a higher risk class.
  - Not be littered with unrelated information, but are only that of the individual. For example, a person could purchase unhealthy products at a grocery store for someone else's consumption.

  Presenters at the August 4 Big Data WG meeting urged regulators to "dig deeper" into what an insurer's model is trying to achieve, why each variable is important, and "what aspect of the real world makes the correlation come about."

- Should Credit Scores Be Allowed?

  Credit scores are an increasingly messy factor in underwriting "as the distributions of credit scores vary significantly among ethnic groups." At the NAIC special session on race, regulators discussed the historical bias imbedded in credit scores and the potential discriminatory impact of factors linked to economics. During its July 31 meeting, the AU WG warned that credit scores should not be used in isolation; instead, checks and balances must be employed to protect against discrimination.

Are Consumers Adequately Protected?

- What Do Consumers Know and Did They Consent?

  Regulators fear consumers are unaware or confused about the amount and extent of their data being collected or how it is being used. Regulators and consumer representatives are considering requiring insurers to:

  - Obtain consumers' consent.
  - Disclose the information used in underwriting.
  - Test input data for accuracy and inherent bias.

  Additionally, the AU WG's work product will seek to address whether:

  - Consumers understand what information can be collected on them and how it can be used.
  - The results are transparent to consumers.

- Do the Data Points or Models Used Discriminate?

  To confront the issue of whether data points or models result in discrimination:

  - After its June 30 meeting, the AI WG included within its AI Principles "avoiding proxy discrimination" due to regulatory concern that some data points such as credit score, education, occupation, and criminal history used in a model may result in unfair discrimination.
  - During its July 31 meeting, the AU WG discussed the need for insurers to test their models and ensure the results are not skewed but are reliable and unbiased. This testing should occur during development, periodically, and on all future generations of an AU program. The AU WG also posited that insurers should document their AU program testing and monitoring and warned that AU programs will be challenged in upcoming market conduct exams.
  - Also at its July 31 meeting, the AU WG stressed the importance of multiple departments, including IT, internal audit, actuarial, and legal, being able to explain the data points used and how the model works, not just those that run the model.

Do Regulators Have the Tools to Review the Models?

Regulators acknowledge that their review of complex models becomes more difficult if:

- There is a lack of transparency, particularly if the models are a "black box" because it is not clearly explainable how a given rating or score resulted from the data used by the model. This issue is exacerbated if the models evolve over time through machine learning.
- There is a lack of regulatory expertise and resources to review complex models properly. Regulators have discussed the development of an NAIC resource to assist their review of complex models, particularly for property and casualty rate review.
- Companies rely on third-party vendors, who are not subject to regulation, to provide data or develop models and such vendors restrict insurers from sharing information.

At the August 8 Big Data WG meeting, presenters from the Casualty Actuarial and Statistical Task Force discussed that the regulatory review of complex models should:

- Ensure compliance with rating laws; rates that are not excessive, inadequate, or unfairly discriminatory.
- Review all aspects of the model: data, assumptions, adjustments, variables, input, and resulting output.
- Evaluate how the model interacts with and improves the rating plan.
- Enable competition and innovation.

Additionally, presenters at the August 7 Innovation TF meeting suggested that regulatory review of models should take place before the models are in place, especially if the models come from a third-party vendor.

**With assistance from Facundo Scialpi, a student at the University of Miami School of Law.*

OCIE Turns Up Heat on Private Fund Adviser Compliance

BY STEPHEN CHOI

On June 23, the SEC's Office of Compliance Inspections and Examinations issued a risk alert providing an overview of certain compliance deficiencies observed in examinations of registered investment advisers managing private equity funds or hedge funds ("private funds"). The risk alert is relevant not only to private fund advisers but also to investors in, and distributors of, private funds and private placement variable products that offer private funds as investment options.

Further, many of the same issues flagged by the risk alert will also be relevant to decisions whether to take advantage of new flexibility just announced by the Department of Labor, as discussed in "DOL Warms Up to Private Equity in 401(k) Plans" on page 12.

Conflicts of Interest

The deficiencies noted in the risk alert that relate to conflicts include nonexistent or inadequate disclosure about:

- Conflicts related to allocations of investments among clients.
- Multiple clients investing in the same portfolio company at different levels of a capital structure.
- Financial relationships between investors or clients and the private fund adviser.
- Preferential liquidity rights included in private fund advisers' side letters with select investors.
- Private fund advisers' interests in recommended investments.
- Conflicts related to co-investments or failure to follow the disclosed co-investment allocation process.
- Private fund advisers' relationship with service providers.
- Conflicts related to private fund restructurings.
- Conflicts related to purchases and sales between clients (i.e., "cross-transactions").

Fees and Expenses Borne (Directly or Indirectly) by Private Fund Investors

The risk alert notes deficiencies such as:

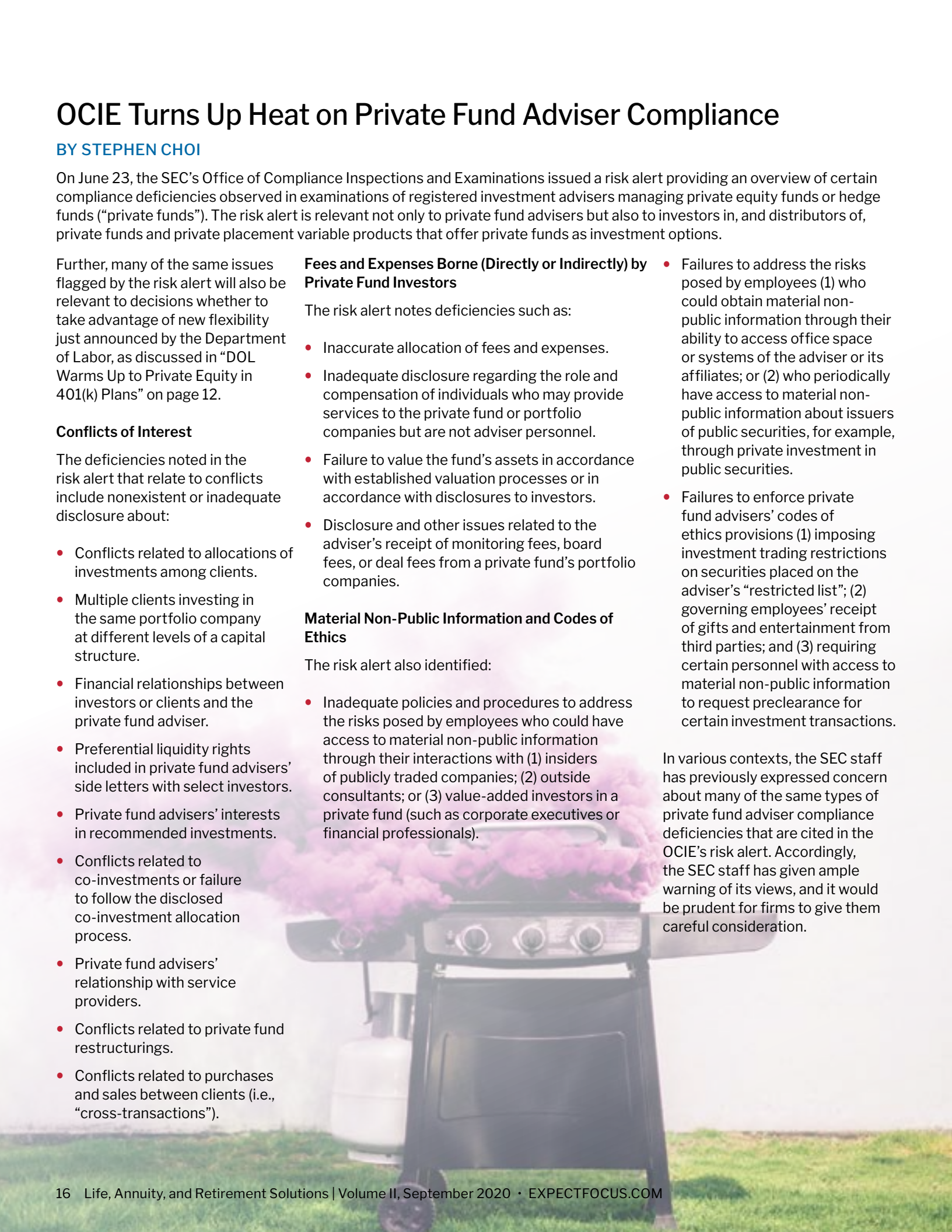
- Inaccurate allocation of fees and expenses.
- Inadequate disclosure regarding the role and compensation of individuals who may provide services to the private fund or portfolio companies but are not adviser personnel.
- Failure to value the fund's assets in accordance with established valuation processes or in accordance with disclosures to investors.
- Disclosure and other issues related to the adviser's receipt of monitoring fees, board fees, or deal fees from a private fund's portfolio companies.

Material Non-Public Information and Codes of Ethics

The risk alert also identified:

- Inadequate policies and procedures to address the risks posed by employees who could have access to material non-public information through their interactions with (1) insiders of publicly traded companies; (2) outside consultants; or (3) value-added investors in a private fund (such as corporate executives or financial professionals).
- Failures to address the risks posed by employees (1) who could obtain material non-public information through their ability to access office space or systems of the adviser or its affiliates; or (2) who periodically have access to material non-public information about issuers of public securities, for example, through private investment in public securities.
- Failures to enforce private fund advisers' codes of ethics provisions (1) imposing investment trading restrictions on securities placed on the adviser's "restricted list"; (2) governing employees' receipt of gifts and entertainment from third parties; and (3) requiring certain personnel with access to material non-public information to request preclearance for certain investment transactions.

In various contexts, the SEC staff has previously expressed concern about many of the same types of private fund adviser compliance deficiencies that are cited in the OCIE's risk alert. Accordingly, the SEC staff has given ample warning of its views, and it would be prudent for firms to give them careful consideration.



Not Quite Across the Suitability Finish Line

BY ANN BLACK*

While everyone may be growing weary, the work to revise the state insurance standard of care for annuity transaction recommendations is not quite finished. There are still a number of miles left on this marathon run, as follows:

- State adoption of revisions to their suitability requirements to conform to the 2020 revisions to the NAIC Suitability in Annuity Transactions Model Regulation #275.
- Drafting NAIC frequently asked questions guidance to states and industry.
- Drafting revisions to the NAIC Market Regulation Handbook.

Except for Iowa and Arizona, the remaining states have yet to make revisions to their suitability requirements to conform to the 2020 NAIC Suitability in Annuity Transactions Model Regulation #275. During the Annuity Suitability Working Group's ("Suitability WG") July 29 call:

- Idaho reported that updates to its suitability requirements have been submitted to the legislature to be discussed during the January 2021 session.
- Kentucky advised that it is required by state law to review its suitability regulation this year and plans to update its suitability language in August.
- Ohio noted that it expects to start the legislative process in August or September with a target date of January 1, 2021.
- Rhode Island noted that it is in the preliminary phases of preparing suitability regulation for review.

On August 17, Michigan introduced House Bills 6112, 6113, 6114, and 6115 to update its state suitability requirements. Other states are believed to be in the process of updating their suitability requirements.

As part of its charge to promote greater uniformity across NAIC-member jurisdictions, the Suitability WG is preparing an FAQ. A draft has been exposed for comment, and the Suitability WG anticipates discussing comments during a September meeting. To cheer the states across the finish line, the draft NAIC FAQ reminds the states that they need to work toward adopting the 2020 revisions for section 989J of the Dodd-Frank Wall Street Reform and Consumer Protection Act (commonly called the "Harkin amendment") that apply to the sale of certain non-SEC registered insurance products.

As the 2020 revisions are being adopted by the states, the NAIC will need to update its Market Regulation Handbook to revise the standards for conducting a suitability examination. Work has not yet started on this effort.

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

Court Throws Cold Water on SEC Disgorgement Remedy

BY GARY COHEN

The SEC may continue to seek disgorgement of a wrongdoer's profits, but the amount must be:

- Awarded to the wrongdoer's victims; and
- Net of the wrongdoer's legitimate expenses.

The U.S. Supreme Court recently determined that court-ordered disgorgement is an available remedy to the SEC in an enforcement action. This is so even though Congress did not expressly authorize disgorgement and disgorgement, at least by that name, is not a traditional equitable remedy.

The Supreme Court's chief determination balanced two countervailing principles. First, an equitable remedy — whether called restitution, an accounting, or disgorgement — should be available to deprive wrongdoers of their profits from unlawful activity. Second, wrongdoers should not be punished by paying more than fair compensation to the persons wronged.

However, a number of questions remain. The Supreme Court remanded the case for the Ninth Circuit to determine whether, consistent with the following equitable principles:

- An SEC order directing any disgorgement proceeds to the U.S. Treasury, rather than directly to the victims, would be for the benefit of investors;
- Wrongdoers can be found liable for profits as partners in wrongdoing or whether individual liability of wrongdoers is required; and
- Any legitimate expenses that wrongdoers have incurred should be deducted from wrongdoers' profits.

The SEC has typically sought disgorgement of the full amount that wrongdoers raised from victims. The Supreme Court's decision means that victims stand to receive less than they invested.

The wrongdoers in this case solicited foreign nationals to invest in the construction of a cancer treatment center but misappropriated much of the funds in violation of the terms of a private offering memorandum.

The case is *Liu v. SEC,* decided 8–1. Justice Thomas dissented on the ground that the statute authorizes the SEC to seek only "equitable relief that may be appropriate or necessary for the benefit of investors" and that disgorgement is not a traditional equitable remedy.

ASB Airs Summer Rerun

Seeks Round 2 of ASOP 2 Comments

BY CLIFTON GRUHN

When last we left the Actuarial Standards Board (ASB), the board was considering comments on the first exposure draft of proposed changes to Actuarial Standard of Practice No. 2 (ASOP 2), now titled "Nonguaranteed Elements for Life Insurance and Annuity Products." *See* "Proposed Revisions to ASOP 2 May Impact Your Product Pricing and Litigation Exposure," *Expect Focus – Life, Annuity, and Retirement Solutions* (June 2019); "Mostly Tricks Proposed for ASOP 2," *Expect Focus – Life, Annuity, and Retirement Solutions* (October 2019). The ASB is now back with a second ASOP 2 exposure draft that seeks to address many of the issues raised in the 16 comments received from various insurers, individuals, and industry groups.

Given the recent attention to nonguaranteed elements (NGEs) from both litigants and regulators (see N.Y. Reg. 210), the ASB is seeking to modernize ASOP 2 to "reflect current practices and provide additional guidance on the determination of NGEs." Many comments received on the ASB's first go-around at revising ASOP 2 focused on sections 3.2 and 3.4 — "Issues and Considerations When Providing Advice on the Actuarial Aspects of the Determination Policy" and "Determination Process for NGE Scales," respectively. Several of the comments argued that the proposed revisions amounted to overly prescriptive restrictions on actuaries' discretion.

The ASB appears to have taken the issues to heart, as the new exposure draft makes several changes to those sections. The proposed changes to sections 3.2 and 3.4 appear aimed at providing more discretion to actuaries in their NGE determinations, including expanding factors actuaries can consider. To that end, the ASB added a new section 3.4.2.5 "to allow the actuary to take into account anticipated experience factors that were not part of the previous determination of NGE scale." That new section reads:

> Additional Considerations — When recommending or determining a revision to **NGE scales**, the actuary may consider using additional **anticipated experience factors** that were not part of the previous determination of **NGE scales**.

The ASB also added language to several sections, including sections 3.2.1 and 3.3.1, "to allow the actuary to consider other relevant items or additional factors" and made other changes in language to expand the discretion that commenters argued was lacking in the previous draft. At the same time, the ASB appears to have expanded actuaries' documentation obligations in several places, including in sections 3.2, 3.4, and 4.1, which address development and modification of determination policies, development of NGE scales, and disclosures in actuarial reports.

November 13, 2020, is the deadline for comments on the ASB's new ASOP 2 exposure draft. If past is prologue, there will be numerous comments for the ASB to consider. Thus, it is unlikely that a new ASOP 2 will be in place before the second quarter of 2021, and likely later than that.

Life Industry Class Action Trends in the First Half of 2020

BY STEPHANIE FICHERA

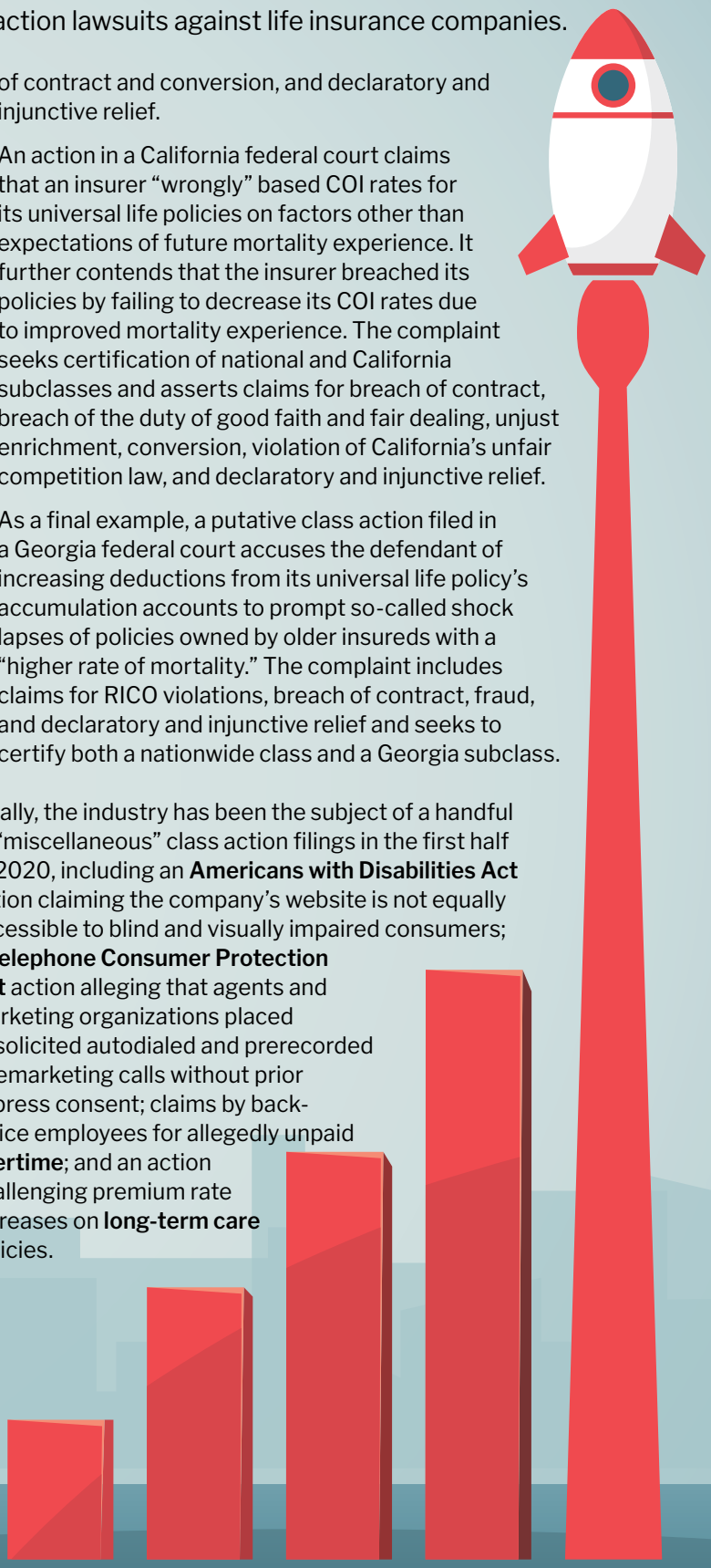
The first half of 2020 saw an uptick in the filing of class action lawsuits against life insurance companies.

Life insurance companies have continued to be the target of putative class actions in California challenging the **lapse or termination of policies for nonpayment of premium**. Since we last reported on the subject in April, several more actions have been filed in California federal courts. *See* "Policy Lapse Notice Claims on the Rise in California," *Expect Focus — Life, Annuity, and Retirement Solutions* (April 2020). The actions accuse various companies of failing to comply with provisions of the California Insurance Code, which require that life insurance policies include a 60-day grace period before any lapse for nonpayment and that insurers give at least 30 days' notice of lapse or termination to the policies' owners and their designees. The actions all seek to certify classes of "past, present, and future owners or beneficiaries" of policies in force after implementation of the California lapse laws, which have or will experience lapse, termination, and/or reinstatement without the required notice and/or grace period. The plaintiffs seek declaratory and injunctive relief; damages for breach of contract, unfair competition, and violation of the implied covenant of good faith and fair dealing; and, in some cases, damages for a financial elder abuse subclass.

Class action litigation challenging the amounts charged for **cost of insurance** (COI) also endures. *See* "2019 Year-End Class Action Roundup," *Expect Focus — Life, Annuity, and Retirement Solutions* (December 2019). Numerous actions were filed across the country against life insurers during the first half of 2020:

- Putative class actions were filed, for example, in Minnesota and Arizona federal courts claiming an insurer breached the plaintiffs' policies by using "unauthorized" factors when determining monthly COI rates, which caused the COI charges deducted from the policies' account values to be "inflated." Plaintiffs contend that, by "loading" COI rates with "unauthorized" expenses, the insurer deducted expenses from their account values that exceeded what was allowed by the policies. These actions seek certification of statewide classes, damages for breach of contract and conversion, and declaratory and injunctive relief.
- An action in a California federal court claims that an insurer "wrongly" based COI rates for its universal life policies on factors other than expectations of future mortality experience. It further contends that the insurer breached its policies by failing to decrease its COI rates due to improved mortality experience. The complaint seeks certification of national and California subclasses and asserts claims for breach of contract, breach of the duty of good faith and fair dealing, unjust enrichment, conversion, violation of California's unfair competition law, and declaratory and injunctive relief.
- As a final example, a putative class action filed in a Georgia federal court accuses the defendant of increasing deductions from its universal life policy's accumulation accounts to prompt so-called shock lapses of policies owned by older insureds with a "higher rate of mortality." The complaint includes claims for RICO violations, breach of contract, fraud, and declaratory and injunctive relief and seeks to certify both a nationwide class and a Georgia subclass.

Finally, the industry has been the subject of a handful of "miscellaneous" class action filings in the first half of 2020, including an **Americans with Disabilities Act** action claiming the company's website is not equally accessible to blind and visually impaired consumers; a **Telephone Consumer Protection Act** action alleging that agents and marketing organizations placed unsolicited autodialed and prerecorded telemarketing calls without prior express consent; claims by back-office employees for allegedly unpaid **overtime**; and an action challenging premium rate increases on **long-term care** policies.



Third and Eleventh Circuits Show No "Lapse" in Judgment

BY MICHAEL WOLGIN

In the first half of 2020, two decisions were issued by federal appellate courts related to the lapse of life insurance policies. Both decisions affirmed the insurer's position and rejected challenges to the determination of lapse.

In *Power v. Erie Family Life Insurance Co.*, the Third Circuit Court of Appeals affirmed that Pennsylvania's implied duty of good faith and fair dealing did not require Erie Family Life Insurance Co. to notify the assignee of a life insurance policy of the policy's impending lapse. Erie had sent notices of nonpayment and lapse to the address on file, but the assignee did not receive them because he had failed to provide Erie with his address. The assignee argued that once the company undertook to provide notices to him, "the law implies a duty" to "do so in good faith." The assignee further argued that before the lapse, he had spoken with a representative of Erie who assured him that "nothing would happen to the policy without [him] being notified." The court rejected these arguments because the "policy [did] not require Erie to remind [him] when premiums [were] due or otherwise notify him before the policy lapses." The court further determined that even if the duty of good faith applied, it was the assignee's "lack of diligence — not Erie's — that rendered these notices undeliverable."

Additionally, in *Brannen v. Jackson National Life Insurance Co.*, the Eleventh Circuit Court of Appeals affirmed the district court's ruling that Jackson National did not waive the right to lapse by retaining a late premium payment for 12 days. Eight months after the insured had allowed his life insurance policy to lapse and subsequently died, his beneficiaries hired a lawyer to pursue the death benefit. The lawyer sent Jackson National a demand and a check for the past-due premium. Twelve days then elapsed, during which the company processed the lawyer's documents, deposited the check, determined that the premium could not be accepted, and issued a refund. The Eleventh Circuit held that, under applicable Georgia law, "the insurance company did not improperly 'retain' the [beneficiaries'] belated payment so as to waive the policy lapse." The court reasoned that 12 days was "not unreasonably long." The court distinguished other cases finding a waiver of lapse that involved longer retentions of late premium payments or other facts supporting waiver. The court found that there was no "pattern evidence in this case" and no basis for the argument that Jackson National purportedly created a new contract by cashing the check "with full knowledge of its purpose."

These decisions should be useful support for life insurance companies in disputes over policy lapse, which are frequently litigated.

Supreme Court Shuts Door on Defined-Benefit Plan Participants' ERISA Suits

BY BROOKE PATTERSON

In a recent 5–4 decision, the U.S. Supreme Court shut the door on defined-benefit plan participants' standing to sue under the Employee Retirement Income Security Act of 1974 (ERISA). The court held in *Thole v. U.S. Bank N.A.* that participants in a defined-benefit pension plan who have been paid all their pension benefits lack Article III standing to sue for breach of fiduciary duty under ERISA, regardless of any alleged injuries to the plan itself.

The plaintiffs were retired participants in U.S. Bank's defined-benefit retirement plan. The plan guaranteed a fixed payment each month, not dependent on the plan's value or the investment decisions of the plan's fiduciaries. Although the plaintiffs received all their monthly pension benefits, they filed a putative class action against U.S. Bank and plan fiduciaries. The plaintiffs alleged that the plan was underfunded and that the defendants had violated ERISA's duties of loyalty and prudence by poorly investing the plan's assets, investing plan funds in the investment managers' mutual funds, and paying excessive management fees. The plaintiffs requested repayment of $750 million to the plan, as well as injunctive relief, including replacement of the plan's fiduciaries. After the suit was filed, the defendants contributed enough funds to "overfund" the plan.

The Supreme Court limited its consideration to the question of standing. The majority, led by Justice Kavanaugh, held that the plaintiffs lacked standing. Because the plaintiffs had received — and continued to receive — all their monthly benefit payments, the majority reasoned that the outcome of the suit would not affect their ability to receive future benefit payments. As such, neither plaintiff had a concrete stake in the lawsuit and lacked Article III standing.

While *Thole* shuts the door on plan participants' ability to bring fiduciary breach lawsuits if their benefits have not been reduced or otherwise altered, the court left open the possibility that artful pleading by participants of egregious mismanagement, which would render the plan unable to pay future benefits, could survive dismissal.

Supreme Court to Settle Circuit Split on TCPA Autodialer Prohibitions

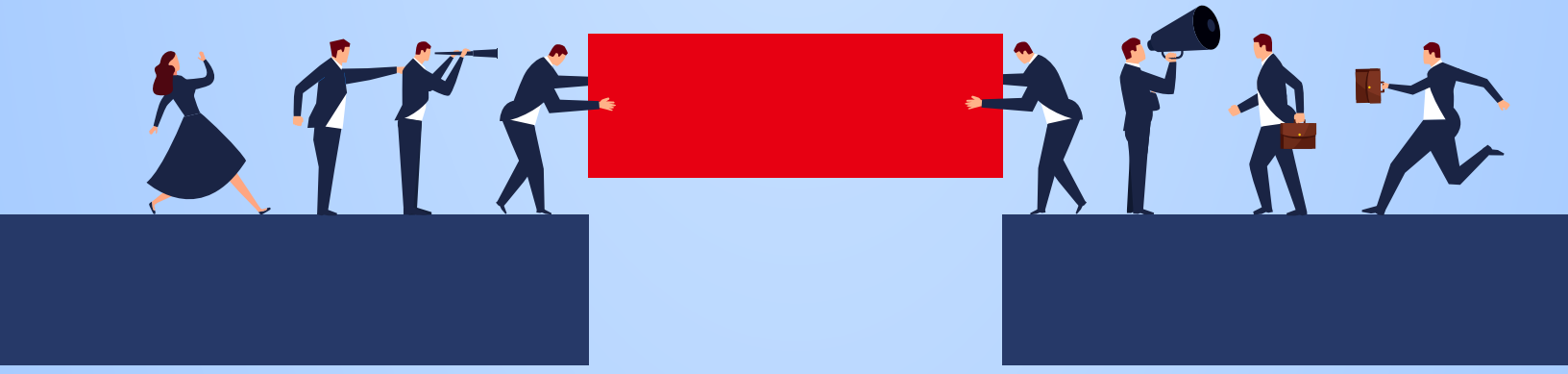
BY DIMITRIJE CANIC

In our April issue, we covered the beginnings of a circuit split over the extent to which the Telephone Consumer Protection Act (TCPA) prohibits advertisers and other advertising campaigns from using automated dialing systems. *See* "Did Your Text Message or Phone Call Campaign Use an Illegal 'Autodialer'?," *Expect Focus – Life, Annuity, and Retirement Solutions* (April 2020). The TCPA defines autodialers as equipment that "store[s] or produce[s] telephone numbers to be called, using a random or sequential number generator." The "broad approach," initially adopted by the Ninth Circuit, considers equipment that can dial any stored number automatically to satisfy the TCPA definition. The "narrow approach," adopted by the Third, Seventh, and Eleventh Circuits, refuses to extend the TCPA definition to automated dialers beyond randomly or sequentially generated numbers.

Since April, the Second and Sixth Circuits joined the Ninth Circuit and adopted the "broad approach," splitting the circuits evenly at 3–3. In *Duran v. La Boom Disco Inc.*, the Second Circuit explained that the phrase "using a random or sequential number generator" modified only the term "produce" and did not apply to the term "store" in the key phrase of the TCPA. Thus, according to the "broad approach," any automated call is a prohibited autodialer if it calls numbers that (1) were generated by humans or computers and stored; or (2) randomly or sequentially produced by a computer.

The Sixth Circuit in *Allan v. Pennsylvania Higher Education Assistance Agency* followed the Ninth Circuit's approach, concluding that the autodialer phrase is ambiguous and looking to the rest of the statute for guidance. It found that the TCPA, as a whole, was meant to cover "equipment that made automatic calls from lists of recipients," regardless of whether the numbers were randomly or sequentially generated. The court explained that "[i]f stored-number systems are not covered, companies could avoid the autodialer ban altogether by transferring numbers from the number generator to a separate storage device and then dialing from that separate storage device."

In early July, the U.S. Supreme Court granted certiorari in *Duguid v. Facebook Inc.*, a putative class action against Facebook over its alleged practice of sending text messages to non-users even when the person elects to stop receiving notifications. *Duguid* will provide an opportunity for the Supreme Court to consider whether the TCPA's definition of automated dialing systems encompasses any device that can "store" and "automatically dial" telephone numbers, even if the device does not "us[e] a random or sequential number generator," and may resolve the circuit split.



ERISA Disability Plan Insurers Score Important Circuit Court Victories

BY IRMA SOLARES, ELISE HAVERMAN, AND BROOKE PATTERSON

In recent months, circuit courts across the country have supported insurers' discretion to deny long-term disability benefits (LTD) under ERISA. Since the beginning of the year, disability plan insurers have prevailed in the majority of disability claim disputes to reach the First, Third, Seventh, Ninth, Tenth, and Eleventh Circuit Courts of Appeals. Below is an overview of some of the appellate wins for disability insurers so far this year.

Even if one doctor finds a participant disabled, an insurer can reasonably credit other doctors who examine the participant and disagree with that finding. The **Third Circuit** so held when it upheld a company's decision to discontinue LTD benefits to a plan participant under a policy provision that disability benefits would end after two years unless the participant's disability prevented her from doing any job for which she was reasonably fitted by training, education, or experience.

Upon review of the participant's file, four health care professionals concluded that the participant could perform work in her field. During an administrative appeal, the insurer's in-house reviewer found that the participant's headaches, arthritis, Crohn's disease, and fibromyalgia did not prevent her from doing light or sedentary work, a view shared by some of the participant's own doctors. Only one of the participant's doctors found that she had limited functional capabilities that prevented her from working. Based on the totality of the medical records, the participant was denied continuing LTD benefits. Both the district court and the court of appeals concluded that the insurer's decision was reasonable, and not arbitrary and capricious.

In another case, the Third Circuit also affirmed judgment for the insurer, finding that the insurer did not abuse its discretion in denying a claim for LTD benefits submitted by a participant based on complaints of migraine headaches.

In a **Seventh Circuit** decision, the participant was denied continuing LTD benefits because she did not satisfy the "any occupation" definition of disability that would have allowed her benefits to continue after two years. During the two-year review, her primary physician reported that some of the participant's endometriosis symptoms that had resulted in the commencement of LTD had subsided, but her Lyme disease specialist noted that the participant was still experiencing fatigue and other symptoms. The specialist ultimately informed the insurer that the participant could not work at all, for fear of stress exacerbating her symptoms. The participant herself told the insurer that she was improving and had engaged in certain activities. Two consulting physicians concluded that her reported activities were disproportionate to her complaints, and there was no evidence that she could not perform the duties of her regular occupation. The insurer subsequently terminated her LTD benefits. Then, during an administrative appeal, additional physicians were consulted, but the participant declined to submit to an independent medical examination, and her appeal was denied.

Notably, neither party addressed whether the participant satisfied the definition of "any occupation" disability in the district court. Because the plan did not give the insurer discretion, the district court appropriately reviewed the administrative record de novo and ruled in the insurer's favor. Given the participant's burden to prove entitlement to benefits, her failure to prove that she met "any occupation" definition was fatal to her claim, and the Seventh Circuit affirmed.

The **Fourth Circuit** found that an insurer did not abuse its discretion in denying a participant continued LTD benefits. The court reiterated its long-held view that it will not disturb a plan administrator's decision provided that it is reasonable, even if the court would have come to a contrary conclusion independently.

The **Ninth Circuit** reviewed the denial of "any occupation" disability benefits under a de novo standard of review, finding that neither of the participant's treating physicians certified his disability during the "any occupation" period, and contemporaneous medical records suggested that his complaints were opportunistic.

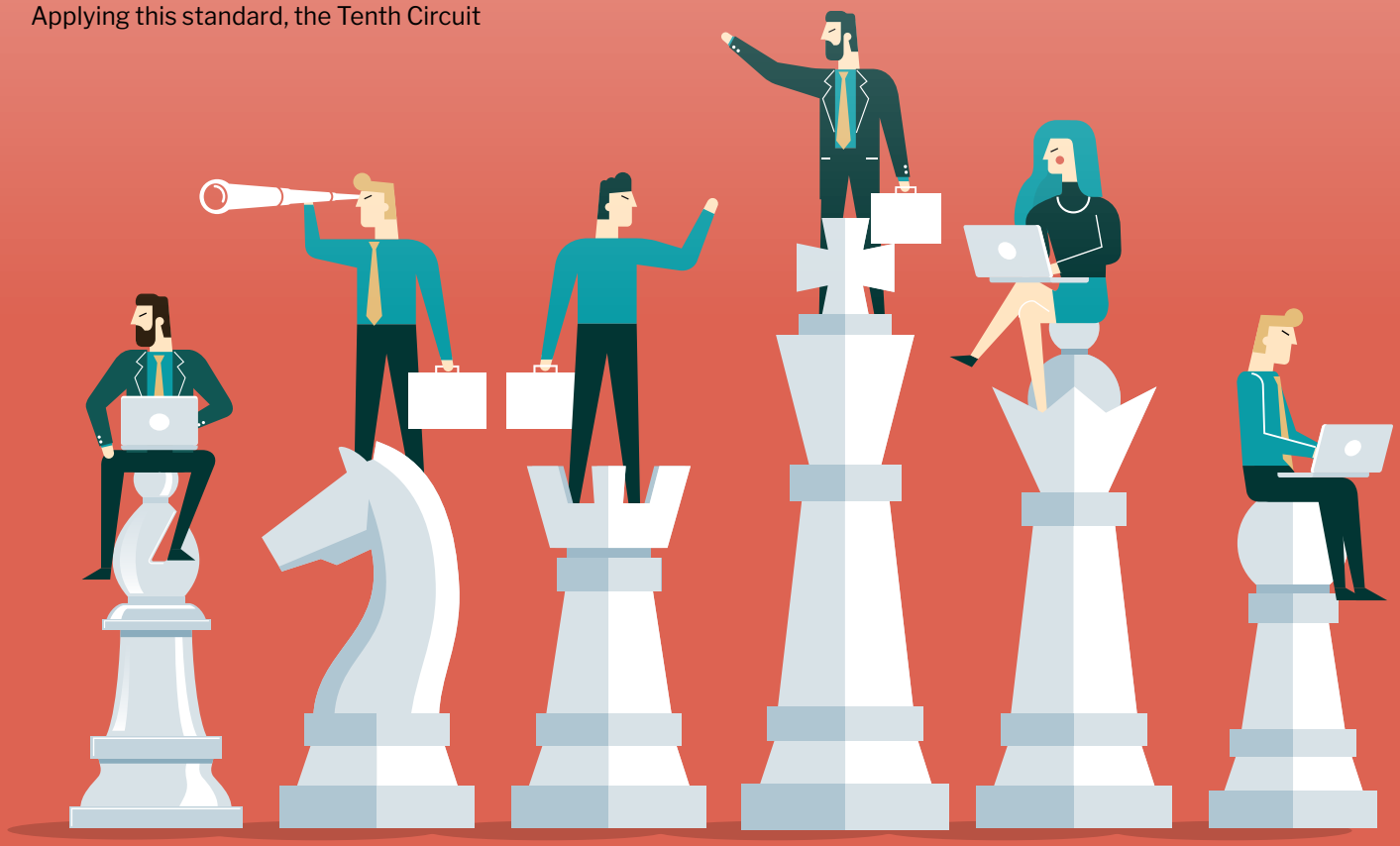
In a **Tenth Circuit** decision, the court grappled with choice-of-law issues, which impacted whether the denial of benefits was subject to abuse of discretion or de novo review. The participant worked in Colorado, but the policy was governed by Pennsylvania law, where the insured employer was incorporated and had its principal place of business. The court concluded that Pennsylvania law — and the abuse of discretion standard — applied. Applying this standard, the Tenth Circuit reversed the district court and held that the insurer's denial of benefits for alleged neurological impairments must be affirmed. In so holding, the court rejected the participant's claim that the insurer operated under a conflict of interest as both the insurer and claims administrator.

The **Eleventh Circuit** affirmed the denial of an LTD benefits claim because of a preexisting condition related to the participant's substance abuse and drug dependency. During an administrative appeal, the participant asserted that his disability was the result of substance abuse/dependency that had commenced outside the applicable six-month look-back period. An independent physician who reviewed the pertinent records concluded, however, that the participant's disability was a preexisting condition during the look-back period. The Eleventh Circuit found that the insurer reasonably proved that substance abuse/drug dependency was a preexisting condition under the policy and that the insurer's determinations deserved deference.

Disability insurers have not fared as well in the **Sixth Circuit**. That court reversed judgment for the plan administrator and ruled in favor of the participant in at least three separate opinions since the beginning of the year, and found in favor of the insurer only once.

Conclusion

These decisions reflect that, in evaluating claims under ERISA, courts generally continue to follow the deferential constructs for review and will affirm decisions that are based on reliable evidence — even if that evidence may be conflicting — provided the insurer's decisions are reasonable. Courts, however, may still be expected to reject benefits decisions that appear to be based on cherry-picked evidence or the insurer's willful disregard of unfavorable facts.



Carlton Fields Rolls Out Blockchain Consultancy

BY HUHNSIK CHUNG AND BARRY WEISSMAN

Carlton Fields has established a consulting firm — SQrBlock Solutions — to identify and coordinate the development of blockchain-powered applications for every industry sector, including the insurance and investment product industries.

SQrBlock is delivering comprehensive solutions, from concept to implementation, bringing backend-as-a-service providers, consultants, developers, and lawyers under one roof. This one-stop approach includes blockchain platform selection, application design and product development, and a full range of legal, regulatory, and compliance services.

SQrBlock's enterprise blockchain solutions have been successfully deployed in dozens of applications for different industry sectors around the world. Blockchain holds immense potential for improving efficiency, providing real-time information, and reducing costs. A compelling case also exists for blockchain technology as a critical priority to improve trust and coordination with external parties, minimize fraud, unlock new business models, enhance business network accountability and operational efficiency, and future-proof businesses against antiquated business models.

More information about how SQrBlock can help firms innovate is available at www.sqrblock.com.

NEWS & NOTES

For the third consecutive year, Carlton Fields is the **No. 1 law firm for insurance**, according to *JD Supra*'s 2020 Readers Choice Awards. Only one law firm earned the designation in each of the 26 categories covered by the awards. Additionally, Shareholder **Ann Black** was recognized as a top author in insurance based on consistently high readership and engagement for her thought leadership articles in 2019. Fewer than 1% of *JD Supra* authors received this award.

Carlton Fields is one of the "**Midsize Law Firms Punching Way Above Their Weight**," according to a recent BTI Consulting Group report. It identifies top midsize and smaller law firms that are "bringing the same level of confidence and reliability as the big firms." Corporate counsel recognized Carlton Fields for its industry understanding, active and accountable client service, and unfailing commitment to help.

Carlton Fields is a sponsor of the **IRI Supply Chain Summit** on September 9, 16, 23, and 30. The summit is a series of virtual sessions presented through the lens of the entire retirement income space supply chain, and will focus on how to develop and market products in this new environment.

The firm is sponsoring the **ACLI Annual Conference** on October 12–13. The conference brings together senior executives from life and financial services companies to examine today's business and political issues.

Carlton Fields is participating in the **ALI CLE Conference on Life Insurance Company Products** on November 5, 6, and 10. Shareholders **Ann Black** and **Richard** Choi are speakers.

Carlton Fields participated in the **NAFA Annuity Leadership Forum** on July 27–31. Shareholder **Richard Choi** was a panelist on the forum's legal firm program.

Carlton Fields continues to be recognized as one of the top law firms in the country for diversity, ranking in the **top 30** in *The American Lawyer*'**s 2020 Diversity Scorecard** for the fourth consecutive year. The annual scorecard is considered a leading benchmark measuring law firm diversity based on the percentage of minority attorneys — Asian American, African American, Latino or Hispanic, Native American, and self-described multiracial attorneys — at Am Law 200 and *National Law Journal* 250 law firms in the calendar year 2019.

Carlton Fields is pleased to announce its participation in the **Law Firm Antiracism Alliance** (LFAA), a new, nationwide group of now more than 200 law firms dedicated to furthering the pursuit of equal justice in the law. The coalition was created after recent events reaffirmed the need for a more collaborative effort between the private bar and legal services organizations on racial inequality and injustice initiatives.

Carlton Fields welcomes the following attorneys to the firm: Shareholders **Roger Kobert** (business litigation, New York) and **Robert "Bobby" Shannon** (business litigation, Atlanta); Senior Counsels **Thomas F. Morante** (financial services regulatory, Miami) and **Patricia DeLeo** (real estate and commercial finance, Hartford); and Associates **Amanda Brahm** (labor and employment, Hartford) and **Logan Owen Moses** (business litigation, Atlanta).

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