LIFE INSURANCE INDUSTRY

Volume IV, December 2017

EXPECTFOCUS®

LEGAL ISSUES AND DEVELOPMENTS FROM CARLTON FIELDS JORDEN BURT, P.A.

INNOVATORS vs. POLICYMAKERS

REGULATORS RACE TO KEEP UP WITH CHANGING TECHNOLOGY

CARLTON FIELDS
JORDEN BURT

EXPECTFOCUS®
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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 Jorden Burt, P.A.

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Delicate FINRA Balancing Act: To Self-Report or Not?

BY NATALIE NAPIERALA & GABRIELLA PAGLIERI

FINRA Rule 4530(a) requires member firms to promptly report certain enumerated events. Rule 4530(b) is less specific, with supplemental guidance advising that a firm should report when it concludes or reasonably should have concluded that conduct or events will result in "widespread or potential widespread impact to the member, its customers or the markets," or ensue from a "material failure of the firm's systems, policies or practices involving numerous customers, multiple errors or significant dollar amounts."

But which events or conduct should a member firm consider self-reporting under 4530(b)? Little guidance is available to firms, which could expose themselves to a regulatory investigation or an enforcement action by making non-mandatory disclosure. Nevertheless, a firm may benefit from self-reporting certain misconduct, regardless of whether the rule really requires such disclosure.

For starters, self-reporting may yield certain "cooperation credit," which could translate to smaller fines and no or fewer charges or sanctions. Yet, whether and to what extent a firm would be rewarded with cooperation credit is uncertain. For example, in 2008, FINRA issued Regulatory Notice 08-70 acknowledging that "extraordinary cooperation" may directly influence the outcome of an investigation to the member's benefit. Since then, examples of cases citing such "extraordinary cooperation" mainly involve large institutions that preemptively and voluntarily pay millions of dollars in restitution to clients for potential violations. All such cases involved firms that took significant remedial measures in addition to self-reporting, and none involved self-reporting alone. Thus, some smaller member firms that lack the means to proffer large sums in restitution payment may prefer to keep silent.

FINRA should clarify the benefits to firms for self-reporting, which may lead to an increase of members' cooperation with FINRA. In fact, FINRA – recognizing that firms often struggle with whether to self-report certain conduct or events – has announced that regulators soon will seek to clarify the scope of cooperation credit. Members should stay tuned.

COI Litigation Review – Early Dismissals Remain Elusive in Rate Increase Actions

BY SHAUNDA PATTERSON-STRACHAN

Suits challenging insurers' cost of insurance (COI) rate increases continue to generate much activity. In recent months, this activity has included transfers, consolidations, several actions that are inching closer to trial-readiness, and even a plaintiff's jury verdict in an individual action. Although defendants continue to seek disposal or a narrowing of the scope of claims via motions to dismiss, the most recent rulings may foreshadow protracted litigation for the industry in this area.

For example, in September, rulings were issued just days apart in actions then proceeding separately in federal court in Pennsylvania: *In re: Lincoln National COI Litigation*, a consolidated putative class action, and *EFG Bank AG, Cayman Branch v. Lincoln National Life Insurance Company*, an individual investor-initiated suit. The district court granted in part and denied in part Lincoln National's motions to dismiss the respective complaints. While the plaintiffs had asserted 11 causes of action in the consolidated class action complaint filed in *In re: Lincoln National* and the *EFG* plaintiffs asserted only four, the dismissal rulings were similar in various respects, most notably as to the plaintiffs' breach of contract claims, both of which survived Lincoln National's motion.

In both rulings, the court found plausible at this stage the theories of liability underlying the respective plaintiffs' breach of contract (and breach of the implied covenant of good faith and fair dealing) claims. These claims included contentions that: (i) the rate increase was not uniform; (ii) the rate increase was based on impermissible factors (set forth in notice letters and statements to brokers explaining the rate increases); (iii) Lincoln National's assertions regarding mortality expectations lacked credibility in light of improved mortality; and (iv) Lincoln National interpreted "interest" in the contracts to impermissibly include interest credited to the policyholders' accounts (as opposed to only the interest the company earns or expects to earn on its profits from providing insurance). Notably, as to the *EFG* plaintiffs' theory that a breach of contract was evidenced, allegedly, by the fact that the rate increase imposed "excessive costs of insurance rates," Lincoln National noted that that the contracts set forth maximum rates and that the plaintiffs had not alleged that the new rates exceeded the maximums. The court observed that "Lincoln has the better of this argument," but nevertheless ruled it "does not preclude Plaintiffs from having stated, overall, a breach of contract claim." The court, however, dismissed the plaintiffs' claims for declaratory relief in both actions, finding they duplicated the breach of contract claim.

The court's *In re: Lincoln National* decision also addressed several claims absent from the individual action,

including the plaintiffs' claims, on behalf of certain putative subclasses, that Lincoln National violated state consumer protection laws in California, New Jersey, North Carolina, and Texas. The court generally rejected the insurer's contention that the plaintiffs failed to allege sufficient facts to support these claims and that the claims duplicated the breach of contract claim. For example, in sustaining the plaintiffs' claim of violation of the North Carolina Deceptive and Unfair Trade Practices Act, NC Gen. Stat. § 75-1, et seq., the court found that, at this early stage, the claims, in which the plaintiffs contended the insurer defendants "acted with the intent of abusing their discretion," went beyond merely alleging a breach. (In November, subsequent to issuing these rulings, the court consolidated the *EFG* and *In re: Lincoln National* actions.)

And in November, in *Brach Family Foundation, Inc. v. AXA Equitable Life Insurance Co.*, a putative class action suit involving a COI rate increase challenge pending since February 2016, the Southern District of New York denied AXA's partial motion to dismiss the plaintiff's second amended complaint. AXA had sought dismissal of a claim alleging misrepresentation in violation of New York Insurance Law Section 4226. Plaintiff had re-pled the claim after the district court granted the insurer's motion to dismiss it in a December 2016 order. *See Expect Focus* Volume I, March 2017. The court found plaintiff had cured the prior pleading deficiencies. Its findings included that the newly amended allegations, which, *inter alia*, "granularly describe[d] how and when AXA disseminated" the allegedly misleading materials to the plaintiff and "specif[ied] the dates and contents" of the illustrations and interrogatories that allegedly misrepresented the policies' benefits, were "more than enough to distinguish the [second amended complaint] from complaints that this Court and other courts have found wanting under Rule 9(b)."

The court also rejected other bases for dismissal advanced by AXA (*e.g.*, plaintiff cannot pursue the claim as to illustrations it did not view) because they "would not affect the bottom line." Specifically, the court reasoned that, even if true, the Section 4226 claim would survive at least as to the illustrations the plaintiff claims to have reviewed before getting the policy. Accordingly, the court said it would reserve judgment on these arguments.

Stay tuned, however, as AXA has moved for reconsideration of the ruling, arguing that it overlooks controlling precedent regarding illustrations. For example, AXA argues that the court should have reached its previously briefed argument that the plaintiff cannot base a Section 4226 claim on an alleged violation of New York Regulation 74, which sets forth disclosure-related standards regarding the use of illustrations in the sale of life insurance policies.

Third Time Is the Charm: Class Certified in DMF-Related Shareholder Suit

BY DAWN WILLIAMS

In *City of Westland Police & Fire Retirement System v. MetLife*, the plaintiffs allege that the insurer overstated its earnings because it did not hold sufficient reserves for death benefit claims on group life insurance policies that were incurred but not reported. Although MetLife used the Social Security Administration's Death Master File (DMF) to terminate annuity benefits, it did not use the DMF consistently enough to trigger life insurance benefits, according to the plaintiffs. The shareholders claim that it was only after regulators began investigating this activity that the insurers revealed the scope of the regulatory investigations, and that they also took tens of millions of dollars in charges against their reserves. The complaint alleges that stock prices fell after these revelations, causing shareholders economic harm.

While the first two iterations of this lawsuit were largely dismissed by the Southern District of New York, the third amended complaint found a bit more traction with the court. The key difference was that the plaintiffs finally claimed that in 2007 MetLife searched the DMF for individual life policies, uncovered $80 million in unclaimed benefits, and therefore increased its reserves by $25 million; it did not, however, search its group life policies against the DMF until 2010 through 2011. In a November 2016 ruling, the district court found that the fact that its reserves increased after the initial search gave rise to a plausible allegation that MetLife's general statements about its reserving were material misrepresentations or omissions. The new allegation was insufficient, however, to lead to a plausible inference of scienter for plaintiff's Section 10(b) claims.

Thus, the only claims to survive the pleading stage were claims under Sections 11 and 15 of the Securities Act of 1933, for losses allegedly traceable to two public offerings of approximately 230 million shares of common stock, because the court did not require a pleading of scienter, reliance, or loss causation for those claims. Nearly a year later, on September 22, the district judge adopted the magistrate's recommendation that the class be certified. The court determined that common issues predominated, as the plaintiffs alleged that MetLife made uniform misrepresentations through the offering materials, and each class member then purchased the stock. The materiality of the statements, held the judge, would be based on objective criteria. Despite evidence that the lead plaintiff was in a precarious financial situation and that it previously agreed to a consent decree with its regulator years ago, the court also found that it was an adequate and typical representative.

The plaintiffs have since filed a fourth amended complaint in an attempt to cure the scienter deficiencies, and MetLife has already moved to dismiss.

The Continuing Representation Doctrine Does Not Apply to Fraud Allegations

BY ADRIANA PEREZ

In *Messmer v. KDK Fin. Serv. Inc.*, an individual action involving alleged fraud in connection with the sale and surrender of deferred annuities to a senior, the Indiana Court of Appeals refused to extend the doctrine of continuous representation to cases involving fraud and brokers of financial services.

The plaintiff, an elderly purchaser of five annuity products, alleged that defendants – agents and marketing organizations (the issuers were not parties to the action) – were liable for fraud because they did not advise her of the charges she would face when surrendering her annuities. Plaintiff Messmer, who had filed her complaint approximately nine months after the expiration of the six-year statute of limitations applicable to her fraud claims, attempted to refute the defendants' contention that her claims were time-barred by arguing that the statute of limitations was tolled by application of the continuous representation doctrine.

The court disagreed. In its September 14 ruling affirming the trial court's grant of the defendants' summary judgment motion, the appellate court recognized that the continuous representation doctrine provides that the applicable statute of limitations does not commence until the end of a professional's representation of a client in the same matter in which the alleged malpractice occurred. Explaining that the purpose of the rule is to allow representatives an opportunity to remedy their errors, the court also recognized that although the doctrine has been applied to accountants and lawyers, no state has applied it to the financial services industry.

Ultimately, contrasting such claims with those for fraud, the court held that the doctrine is "simply incompatible" with cases alleging fraud because it is not reasonable for a client to continue to maintain confidence in the professional's good faith after a fraud is discovered; rather, the client, upon discovery of the fraud, is required to investigate and access the facts.

The court also affirmed the trial court's grant of summary judgment for the defendants regarding the plaintiff's claim for constructive fraud, predicated on the defendants' alleged breach of fiduciary duty that left her without an "understanding of the effect of the surrender," as to one of the five annuities. As the court recognized, the plaintiff's deposition testimony revealed she could not recall the details necessary to establish the "groundwork for a fraud contention," *e.g.*, "what she was told, by whom, and when." The court also cited evidence that the plaintiff had actual knowledge of the surrender charges.

Based on Principles of Fairness, Court Dismisses Putative Class Action RICO Claims Asserted Years After Initiation of Suit

BY LAURA WALL

In *Robertson v. SunLife Financial*, a federal district court in Louisiana dismissed with prejudice as time-barred an amended putative class action complaint alleging RICO and state racketeering claims related to alleged wrongful conduct by an agent related to annuities issued by SunLife. The initial complaint was filed in 2008 as an individual action against the agent for allegedly forging a $999,999 check to fraudulently withdraw funds from the plaintiff's annuity account. While the insurer had already been added as a defendant by then, earlier this year, nearly nine years after the action was initially brought, the complaint was amended to include putative class action RICO and state racketeering claims against Sun Life, based on alleged acts of racketeering purportedly occurring in 2005 through 2007.

After its removal of the action to federal court, SunLife moved to dismiss the RICO and state racketeering claims — subject to four-year and five-year limitations periods, respectively — as untimely. It was undisputed that the claims would fail as time-barred unless they could relate back to the date of the originally filed complaint. The plaintiff, though, failed to make this showing. As the court explained, pointing to both Fifth Circuit and Louisiana Supreme Court authorities, based on principles of fairness, relation back is permitted only if the original complaint gives the defendant fair notice of the claims brought in the amended complaint. However, it found that the plaintiff's original complaint "did not allege, or even suggest, that Sun Life engaged in racketeering activities," where, as contrasted with the original complaint, the newly amended complaint alleged "criminal rather than negligent conduct," and introduced a "new key actor," among other "fundamental changes in plaintiff's factual allegations." Consequently, Plaintiff's racketeering claims were barred by the statute of limitations and dismissed by the district court with prejudice.

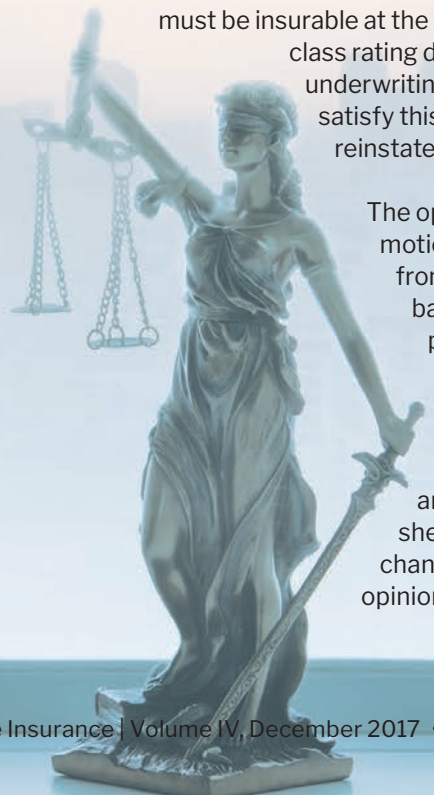
Denial of Reinstatement of Lapsed Life Insurance Policy Affirmed Due to Failure to Satisfy Required Underwriting Standard

BY ROLLIE GOSS

In *European Pensions Management Limited v. Columbus Life Insurance Co.*, a pension benefit plan that had purchased a life insurance policy on the secondary market and then permitted it to lapse for non-payment of premiums sued the insurer Columbus Life, alleging breach of contract and bad faith. The plaintiff in this Southern District of Ohio case originally contended that Columbus Life had wrongfully lapsed the policy, but abandoned that claim and instead decided to pursue only a claim that Columbus Life wrongly refused to reinstate the policy. The policy provided a right to reinstatement within five years of lapse, if the insured was still living, and "subject to evidence of insurability satisfactory to" Columbus Life. The insured answered questions in the reinstatement application about adverse medical conditions in the negative, although he had been diagnosed with Parkinson's disease, dementia, peripheral vascular disease, and chronic kidney disease. Reinstatement was denied based on "overall current medical history."

The plaintiff contended that the "insurability" standard was ambiguous and must be interpreted in its favor. The court disagreed and granted summary judgment to the insurer, finding that the language "evidence of insurability satisfactory to the company" must be included in reinstatement provisions pursuant to Ohio Rev. Code § 3915.05(J), and that such language had been deemed "plain, clear and unambiguous" by the Ohio Court of Appeals and courts in other states. The court held that the common sense meaning of that phrase "requires an indication of the insured's relative good health and must be proven with medical evidence." This standard is to be interpreted "using an objective standard such that the evidence must be satisfactory to a reasonable insurer." This meant that the insured must be insurable at the same standard mortality class rating determined by the initial underwriting. The plaintiff failed to satisfy this standard, and denial of reinstatement was upheld.

The opinion also granted a motion to exclude evidence from plaintiff's expert based on the failure to provide sufficient expert disclosures under FRCP 26, the failure to properly explain the opinions in deposition, and a deposition errata sheet which sought to change one of the expert's opinions.



The NAIC Says Aloha

BY ANN BLACK & JAMIE BIGAYER

The National Association of Insurance Commissioners held its Fall National Meeting December 2-4 in Hawaii, saying aloha to 2017 and aloha to 2018. Key takeaways include:

- Welcoming a discussion of regulatory sandboxes at the Innovation and Technology (EX) Task Force meeting. This included a warm reception for the American Insurance Association's draft legislation for more regulatory flexibility in working with startups and incumbent insurers seeking to bring innovative products and services to market.

- Inviting the Casualty Actuarial and Statistical (C) Task Force to appoint a Predictive Analytics (C) Working Group to address the use of predictive analytics and models by insurers.

- Greeting additional discussion at the Big Data (EX) Working Group of the current regulatory frameworks for the oversight of insurers' use of consumer data, data needs and tools for regulators to monitor the marketplace, and the principles and structure for a mechanism to assist state regulatory review of complex models.

- Saying sayonara to the Promoting Appropriate Sales Practices in Life Insurance and Annuities (A) Working Group as it adopted its final "CONSUMER ALERT! Be Skeptical About 'Free Meal' Seminars; Question Credentials of Insurance and Financial Services Experts."

The Impact of the EU Requirement to 'Unbundle' Research Costs

BY TOM LAUERMAN

A recent European Union (EU) directive prohibits certain investment managers from receiving securities research whose cost is "bundled" together with broker-dealers' costs of effecting securities transactions directed by the investment managers. So, beginning January 3, these investment managers must pay separately for such research with their own assets or with client assets held in "research payment accounts" meeting specified requirements.

Even in cases where the EU directive does not apply, this development will probably result in:

- more broker-dealers "unbundling" (i.e., charging separately for) their execution and research services), and

- more investment managers seeking out such unbundled arrangements, with the investment managers themselves absorbing any research costs.

Any such trends could be important for almost any type of securities investment account, including general or separate investment accounts of insurance companies, mutual funds in which such separate accounts may invest, and other accounts managed by individuals or companies affiliated with insurance companies or market insurance products.

Some broker-dealers have been concerned that their receipt of "unbundled" payments for research, as mandated by the EU directive, would require them to register with the SEC as investment advisers. The SEC staff, however, issued an October 26 letter that, in effect, temporarily suspends any such adviser registration requirement. Among other conditions, this relief applies only to payments made by investment managers that are domiciled in the EU (and therefore are directly subject to the directive) or are indirectly subject to the directive because of certain types of "contractual obligation." This temporary relief expires July 3, 2020. By then, the SEC hopes to have determined whether the relief should be continued, withdrawn, or modified.

Also on October 26, the SEC staff issued two other letters that facilitate "unbundling" by permitting investment managers, subject to conditions, to:

- aggregate securities transaction orders for clients who pay different amounts for research as permitted by the EU directive, if the investment managers are subject to the directive (either directly or pursuant to a contractual obligation), and

- rely on the safe harbor in Section 28(e) of the Securities Exchange Act of 1934 with respect to their use of research payment accounts as provided for under the directive.

Regulators Continue to Scrutinize Initial Coin Offerings

BY EDMUND ZAHAREWICZ & JOSH WIRTH

As reported in the most recent issue of Expect Focus, the SEC issued an investigative report in July cautioning market participants that distributed ledger (blockchain) technology-based offers and sales of digital "tokens" or "coins" in a so-called initial coin offering (ICO) may be subject to federal securities laws, depending on the circumstances. Subsequently, the SEC and other regulators have continued to scrutinize ICO-related activities.

In August, the SEC staff issued several trading suspensions on certain issuers of microcap stock who made claims regarding their investments in ICOs or touted coin/token related news. In a related SEC investor alert, the staff warned investors to "be especially cautious" of warning signs of possible ICO-related fraud. According to the staff, such signs include situations where a company claims that its ICO is "SEC-compliant" without explaining how or purports to raise capital through an ICO described in vague or nonsensical terms or with undefined technical or legal jargon.

In September, the SEC brought its first enforcement action involving an ICO against a purported businessman and two companies. The complaint alleges that the companies' marketing materials contained several misstatements asserting that the ICO would invest the proceeds into real estate and diamonds when, in fact, no real estate or diamonds had been purchased. The SEC alleged that the defendants attempted to "skirt the registration requirements of the federal securities laws." In November, a New York federal judge entered a preliminary injunction freezing the businessman's assets.

September also saw the SEC announce new enforcement initiatives aimed at cyber-related misconduct. The initiatives include a newly-created "Cyber Unit" which will specifically target securities violations "involving distributed ledger technology and initial coin offerings," among other types of cyber-related misconduct. In December, the Cyber Unit made headlines by charging two individuals and a Canadian company with securities fraud and the unlawful offer and sale of unregistered securities called "PlexCoin" in connection with a purported ICO. The unit also obtained an emergency asset freeze to stop the alleged ICO fraud, which had raised up to $15 million from thousands of investors by falsely promising a 13-fold profit in less than a month. According to the chief of the Cyber Unit, this first Cyber Unit case contained "all of the characteristics of a full-fledged cyber scam and is exactly the kind of misconduct the unit will be pursuing."

In October, the Commodity Futures Trading Commission published a "A CFTC Primer on Virtual Currencies" as part of its LabCFTC initiative. Launched in May, LabCFTC is designed to promote responsible FinTech innovation by making the CFTC more accessible to innovators, and to serve as a platform to inform the CFTC's understanding of new technologies. The primer describes the CFTC's jurisdiction as being "implicated when a virtual currency is used in a derivatives contract, or if there is fraud or manipulation involving a virtual currency traded in interstate commerce." While acknowledging the SEC's investigative report findings that digital tokens sold in ICOs may be securities, the primer states "[t]here is no inconsistency between the SEC's analysis and the CFTC's determination that virtual currencies are commodities and that virtual tokens may be commodities or derivatives contracts depending on the particular facts and circumstances."

In November, the SEC staff issued a public statement warning celebrities and others that ICO endorsements may be unlawful if the digital tokens or coins sold are securities and they do not disclose the nature, source, and amount of compensation paid in exchange for the endorsement. The staff's statement also cautioned investors to conduct research before investing in ICOs, noting that investors should understand whether a promoter's endorsement "is truly independent or a paid promotion."

In December, the SEC issued a cease-and-desist order against a company conducting an ICO to raise capital to improve and create an "ecosystem" around an existing phone app. The company represented to investors that the sale of its "utility tokens" did not pose a significant risk of implicating federal securities laws. The SEC disagreed and contacted the company, which promptly terminated the ICO and returned all of the investors' funds. In light of these remedial efforts, the SEC did not seek to impose any civil penalties.

Finally, in a recent speech, SEC Chairman Jay Clayton highlighted concerns over the lack of information about many online platforms that list and trade virtual coins or tokens offered and sold in ICOs. The Chairman followed these remarks with a public statement in December discussing the SEC's commitment to "vigorously" police ICOs and encouraging investors to consider the risks involved with these investments. The Chairman's statement further expressed his own view that the majority of ICO offerings directly implicate federal securities laws.

The DOL Fiduciary Rule: Charting a Course, Avoiding Collisions and Potential Litigation

Q&As on Annuity Sales Practices, 'Investment Advice' and Litigation

BY JAMES F. JORDEN

For the past several months, we have written about potential litigation issues under the "revised temporary" DOL Rule involving the offer and sale of annuities in the IRA market. This article continues that discussion. Recall that while the Rule's revised broad definition of "fiduciary" was adopted effective June 9, 2017, the Rule's exemptions were made available for a temporary transition period, by adherence only to the Rule's Impartial Conduct Standards. As in the past, the answers below are limited to the Rule's impact during this "temporary" period. In particular this Q&A addresses issues raised in the Department's recent release which provides for an 18-month Extension of Transition Period and Delay of Applicability Dates for the Best Interest Contract Exemption; the Class Exemption for Principal Transactions; and PTE 84-24 (Release) (29 CFR Part 2550, 11/29/17) .

In particular, we focus on the issues the Department (and consumer groups) raised regarding the status of "enforcement" procedures during the transition period, with an emphasis on the comments in the Release on potential implications for both regulatory enforcement and litigation during this period and beyond. In last month's Q&As we also suggested some measures to protect against exposure in connection with advising on or effecting a transaction involving advice on IRA purchases or distributions from an ERISA plan to an IRA. We now focus on recent comments from the Department that may be relevant to that analysis. The issues we have been discussing relate primarily to potential litigation involving the sale of annuities to IRAs or advice regarding such a sale. Such litigation, during this transition period can only be brought, if at all, as state law claims (presumably under a state law fiduciary standard) because ERISA does not provide a cause of action for breach of an alleged fiduciary duty unless the advice or sale is to an ERISA qualified plan. However, in this discussion, we will address the IRA only transactions as well as potential litigation in federal court when advice or sales are made to ERISA plans.

Q Has the Department revised or provided additional direction in the Release regarding its "enforcement" position during this temporary transitional period?

A Yes, in several respects; first, early in the Release, the Department notes that the primary reason for the comment letters opposing the proposed delay was that investors would be harmed because "*there would not be any meaningful enforcement mechanism in the PTE's without the contract, warranty, disclosure and other enforcement and accountability conditions*."[i] The same commenters urged that the Department "*at a bare minimum, should add the specific disclosure and representation of fiduciary compliance conditions originally required for transition relief.*"[ii]

Q How did the Department respond to these criticisms of the delay?

A First, the Department referenced the strong and substantial comments from the industry that "*investors are sufficiently protected by the imposition of the Impartial Conduct Standards along with many applicable non-ERISA consumer protections*."[iii] The extensive footnote references in the release which support these comments include a comment that, in addition to the existence of the Impartial Conduct Standards, "*there is an additional existing and overlapping robust infrastructure of regulations that are enforced by the SEC, FINRA, Treasury and the IRS, not to mention the Department*" to provide continuing protection to investors.

Q What was the Department's ultimate rationale for not requiring the disclosures requested by those opposing the delay?

A The Release provides the following reasons for not including these requirements:

1. Many financial institutions are already "using their compliance infrastructures" to meet the requirements of the Impartial Conduct Standards.

2. There are two enforcement mechanisms that remain in place: the imposition of excise taxes, and the existing cause of action under ERISA for improper fiduciary advice to ERISA plan assets, including advice concerning rollovers of plan assets into non plan investments.[iv]

Q Why are these comments relevant to an analysis of litigation risk and the steps necessary to reduce that risk?

A A response to that question involves a three-step evaluation.

1. To the extent the Department has provided guidance on the conduct expected of those parties deemed to be "fiduciaries," the failure to adhere to that conduct would logically result in consequences. For example when the Department

says it "*expects that advisers and financial institutions will adopt prudent supervisory mechanisms to prevent violations of the Impartial Conduct Standards*,"[v] then the decision by financial institutions not to adopt such "supervisory procedures" might cause the Department to pursue enforcement.

2. The second step is mere conjecture: Would this failure to act also increase the likelihood of private litigation? Bearing in mind the obstacles to such litigation outlined in our prior Q&As, it is nonetheless certainly plausible that an individual or class action alleging improper sales practices would likely allege the failure to adopt such special "prudent supervisory mechanisms" aimed at preventing violations of the Impartial Conduct Standards as a crucial element to its cause of actions. Moreover, the Department's statement of its view that "*the impartial Conduct Standards require that fiduciaries, during the Transition Period, exercise care in their communications with investors, including a duty to fairly and accurately describe recommended transactions and compensation practices*"[vi] would suggest current obligations not contemplated by many of these financial institutions, as noted by the footnote references in the DOL release.[vii]

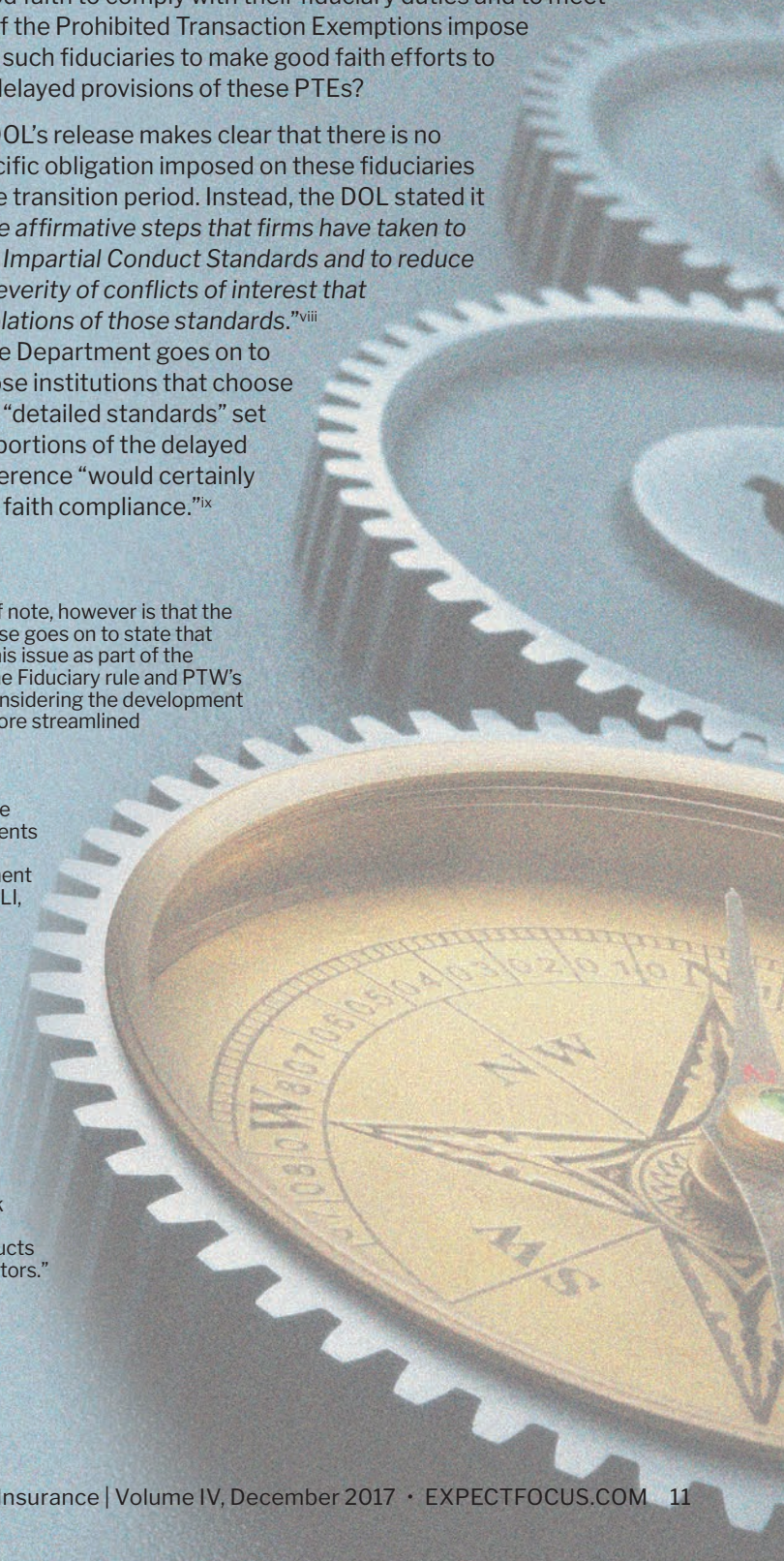
3. The third step requires even more conjecture: Would these allegations only be relevant in private litigation that involves an ERISA violation? For example assume there is an allegation of improper advice from a financial institution annuity representative to move assets from a 401k plan — in which case, the argument, hypothetically, would be that the failure to adhere to the Department's clear mandate in the Release involves a fiduciary breach under ERISA (whether it does or not is not the issue here, we are simply noting the potential argument).

   Another hypothetical: What about private litigation allegations that do not involve a violation of ERISA — such as a class action alleging widespread elder abuse or fraud and misrepresentation in the sale of "unsuitable" annuities? Given the history of the plaintiff's bar in connection with class actions against both life insurers and their life insurance sales agents, it obviously should not be surprising if such claims were to be made. Would the failure to meet the standards articulated by the Department advance such claims? I doubt it. Most state court judges attempting to analyze the merits of a garden variety fraud, misrepresentation or abuse claim will likely be constrained to rely on state law and state court precedents.

Q Final Question: Does the Department's comment that it will not pursue claims against investment advice fiduciaries who are working diligently and in good faith to comply with their fiduciary duties and to meet the conditions of the Prohibited Transaction Exemptions impose an obligation on such fiduciaries to make good faith efforts to implement the delayed provisions of these PTEs?

A No. The DOL's release makes clear that there is no such specific obligation imposed on these fiduciaries during the transition period. Instead, the DOL stated it will "*focus on the affirmative steps that firms have taken to comply with the Impartial Conduct Standards and to reduce the scope and severity of conflicts of interest that could lead to violations of those standards.*"[viii] Nonetheless, the Department goes on to note that for those institutions that choose to adhere to the "detailed standards" set forth in various portions of the delayed PTE's, such adherence "would certainly constitute good faith compliance."[ix]

i. Release at 14.
ii. Release at 15.
iii. Release at 16.
iv. Release at 17. Of note, however is that the Department's release goes on to state that it will "reevaluate this issue as part of the reexamination of the Fiduciary rule and PTW's in the context of considering the development of additional and more streamlined approaches."
v. Release at 18.
vi. Release at 19.
vii. See f.n. 29 to the Release and comments therein, including reference to Comment Letter 48 of the ACLI, to wit; "we strongly oppose a delay approach, based on undefined and ambiguous factors, such as whether firm has taken 'concrete steps' to 'harness market developments', would require the Department to subjectively and inappropriately pick and choose among providers and products based on vague factors."
viii. Release at 30.
ix. Id.



The Ghosts of Christmas Past, Present, and Future Haunt Insurers' Use of Big Data and Algorithmic Tools

BY ANN BLACK, JAMIE BIGAYER, & ADRIANA PEREZ

Watching as legislators, regulators, and policymakers' consider what changes, if any, are necessary for insurers' use of big data and algorithmic tools, is like being visited by the Ghosts of Christmas Past, Present, and Future. Insurance is all about data – data collected to determine whether to issue an insurance policy, how to service the policy, and whether to pay claims on the policy. However, as more data on the insured risk and more algorithmic tools become available, legislators, regulators, and policymakers seek to ensure that insurers do not become Ebenezer Scrooge.

Like a visit from the Ghost of Christmas Past, the National Association of Insurance Commissioners (NAIC) Big Data (EX) Working Group (Big Data WG) reviewed existing models for property and casualty insurance, some of which have been around for decades, to determine if revisions are needed to cover insurers' use of big data and algorithmic tools. Similarly, the U.S. Senate Committee on Banking, Housing, and Urban Affairs touched on this subject as part of its Examining the FinTech Landscape hearings, which included testimony from the U.S. Government Accountability Office on the regulation and oversight of alternative data use.

Recent visits from the Ghost of Christmas Present include the New York Department of Financial Services (NY DFS), which issued a 308 letter to insurers doing business in New York. As reported in our July 7 alert, the NY DFS is seeking information about the use of external consumer data or information sources in connection with accelerated or algorithmic underwriting programs that may supplement traditional medical underwriting. In addition, the BIG Data WG just concluded its 2017 Fall National Meeting where it discussed issues haunting consumers, industry, and regulators, including:

- The consumers' rights to the data used, to be notified of the data used, and to correct the data used;
- Data points that should not be used;
- The level of correlation and/or causality necessary for data points be used; and
- Additional regulation over data vendors.

NY DFS personnel have also played a role as the Ghost of Christmas Future, providing insight as to what the future might hold. While the NY DFS has not yet foretold and is not trying to stifle innovation, several apparitions are circling, including whether:

- Using purchasing data is appropriate;
- The data points used are predictive;
- Consumers have been given adequate disclosure; and
- Third party constructed insurance scores should be permitted.

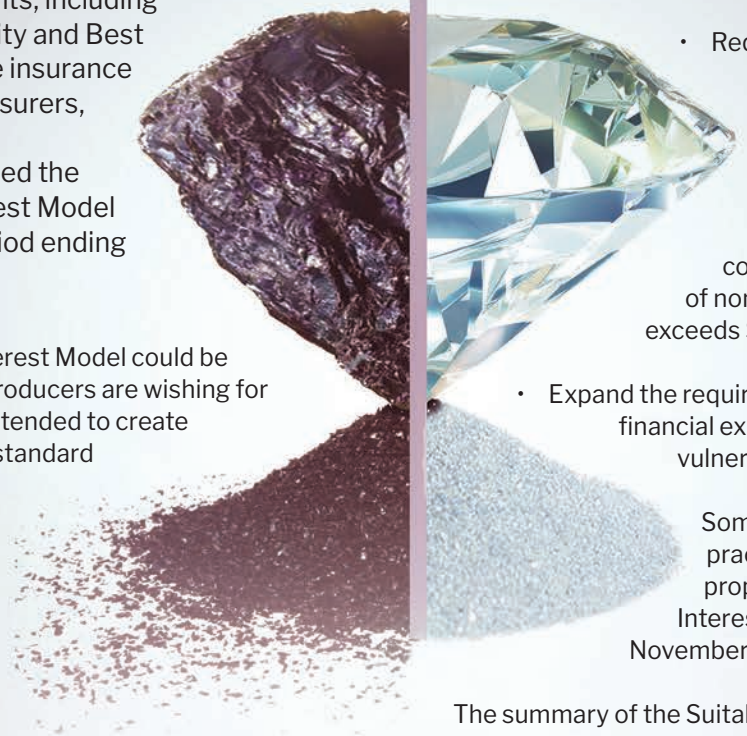
While the regulators seek transparency, some academic spirits have warned that the goal of transparency in algorithmic tools may not be desirable as it may prevent society from fully using new technologies that could provide societal benefits. Unlike, Ebenezer Scrooge, our journey with the Ghost of Christmas Future has not yet ended. We may yet encounter a regulatory headstone or two before we wake to enjoy all the benefits that big data and algorithmic tools may bring.

Did Santa Give the Insurance Industry a Lump of Coal or a Diamond in the Rough?

The Proposed Suitability and Best Interest Standard of Conduct in Annuity Transactions Model Regulation

BY ANN BLACK, JAMIE BIGAYER, & ADRIANA PEREZ

As reported in our November 28 client alert, the National Association of Insurance Commissioners' (NAIC) Annuity Suitability Working Group (Suitability WG) circulated the proposed *Suitability and Best Interest Standard of Conduct in Annuity Transactions Model Regulation* (Suitability and Best Interest Model). At the 2017 Fall National Meeting, the Suitability WG heard initial "comments, including concerns" on the Suitability and Best Interest Model from state insurance regulators, consumers, insurers, agents and brokers. The Suitability WG also exposed the Suitability and Best Interest Model for a public comment period ending January 22, 2018.



The Suitability and Best Interest Model could be the gem that insurers and producers are wishing for this holiday season as it is intended to create a state based best interest standard of care that is harmonized with the Department of Labor's rules for fiduciary investment advice. However, as drafted the Suitability and Best Interest Model includes provisions that, if adopted, would raise various interpretative and practical issues giving the industry a lump of coal instead.

In general, the proposed Suitability and Best Interest Model contains inclusions that:

- Broaden the scope and arguably require insurers to determine if an annuity "is reasonable prior to issuance," even if no recommendation is made unless the transaction is exempted under Section 4.
- Include consideration of "changes in nonguaranteed elements in an annuity contract" as part of the "suitability information" that must be considered in making an annuity purchase recommendation.
- Impose additional duties for recommended annuity transactions, including requiring that the recommendation be in the consumer's best interest.

The proposed Suitability and Best Interest Model revisions define "best interest" as "acting with reasonable diligence, care, skill and prudence in a manner that puts the interest of the consumer first and foremost." It also makes clear that best interest does not require a recommendation of "the least expensive annuity product, or the annuity product with the highest stated interest rate or income payout rate, available in the marketplace at the time of the annuity transaction … or the single 'best' annuity product available in the marketplace at the time of the annuity transaction." [Put into a call-out]

- Require additional disclosures to consumers in making the annuity purchase recommendation, including disclosure of cash compensation if it exceeds 3 percent, whether by commission or fee, and disclosure of non-cash compensation if it exceeds $100 per producer per year.
- Expand the required producer training to include financial exploitation of seniors and other vulnerable adults.

Some of the interpretive and practical issues arising from the proposed Suitability and Best Interest Model are discussed in our November 28 client alert.

The summary of the Suitability WG's meeting reflects an acknowledgement of the various stakeholders' concerns. By providing a charitable comment period, the Suitability WG also appears to be willing to entertain meaningful comments and discussion on ways to facet the Suitability and Best Interest Model. There appears to be an opportunity for the Suitability WG and industry to work together and create a sparkling standard of conduct.

Preparing for New York Regulation 210's Effective Date

BY STEVE KASS

The Preamble to New York's Regulation 210 (the "Regulation") contains a March 19, 2018 effective date. However, the Regulation's scope paragraph supports an interpretation that the Regulation's requirements apply only when an insurer makes a "determination or readjustment of a non-guaranteed element [an "NGE action"] occurring on or after the effective date … , including any readjustment of non-guaranteed elements occurring on or after the effective date" for any policy issued prior to the effective date. The Regulation defines the term policy as "any individual life insurance policy, individual annuity contract, or applicable group contract."

Thus, an insurer may not need to come into compliance with the Regulation's requirements unless and until it takes an NGE action. For example, a central requirement of the Regulation is that an insurer obtain an actuarial memorandum signed and dated by a qualified actuary (i) prior to the issuance of any policy under a new policy form, (ii) prior to the issuance of any policy form for which NGEs have been changed only for new issues, or (iii) prior to any change in an NGE (subject to certain limited exceptions) on an existing policy. Logically, an actuarial memorandum is unnecessary until one of these events occurs. Likewise, certain of the Regulation's requirements are triggered only by an "adverse" change in a policy's current NGE scale (i.e., a change "that increases or may increase a charge or reduces or may reduce a benefit").

Other provisions of the Regulation present a spectrum of possible required compliance deadlines. At one end is Section 48.3(a), which requires insurers to provide a policy owner with the current NGE scale *no later than the policy's date of issue*. Although not tied to an NGE action in the Regulation, the Department has explained in its assessments of public comments that "policyholders and annuitants should know the non-guaranteed elements that are expected to apply to their policies so that actual credits and charges may be tracked over time and can be compared to what was originally expected." Thus, an insurer would be well advised to provide this disclosure for all policies issued on and after March 19, 2018. Other provisions present a closer call, as their requirements appear to be dependent on the existence of an NGE action:

- Section 48.2(a)(1), which requires that an insurer's board of directors (or a committee thereof) adopt written criteria that are the basis for determining NGEs.
- Section 48(a)(2), which requires that insurers assign policies into classes for purposes of determining NGEs.
- Section 48.2(b), with requires that insurers identify the anticipated experience factors underlying a policy's NGE scale as of the date of the NGE action as well as the date of issue (or the last NGE revision, if later) so that any NGE changes are reasonably based on the differences between such factors.

Insurers should remain cognizant that because the Regulation so broadly defines NGEs, an insurer may engage in an NGE action more quickly than it realizes. For example, a variable annuity writer that sets withdrawal benefit percentages or withdrawal rider charges as frequently as monthly will likely have taken an NGE action as soon as the insurer makes its first monthly adjustment. And in any event, the actuarial related work required by Section 48.2 could require substantial lead time before an NGE action may be effected.

Insurers subject to Regulation 210 may wish to consider these points (along with the host of other thorny interpretive issues) as they perform their initial Regulation 210 compliance work.

When Innovation Meets Regulation

The Effect of InsurTech on Insurance Rebating Laws

BY JO CICCHETTI & CHRISTINE STODDARD

The rise of InsurTech — which brings technological innovations to the business of insurance — has recently had a significant impact on the insurance industry, including through advancements in cybersecurity tools, the introduction of blockchain, and the use of big data for underwriting and claims. Funding in this area has grown exponentially over the past year, and, in just the past few months, several major conferences have brought together insurers and innovators to share ideas about the future of the industry and to promote new products and services. Yet many worry that complex insurance regulations will slow or even prevent further innovation. This article is the first in a series discussing the regulatory issues impacting InsurTech.

One such area is insurance rebating, which occurs when an insurer or producer offers something of value, not specified in the policy, as an incentive to purchase insurance. The practice became prevalent in the late 19th and early 20th centuries when high pressure sales emerged as a tool to sell life insurance. In response, states began passing laws prohibiting rebates, both to prevent insurer insolvency and to protect consumers from discrimination and high rates. Today nearly all states have anti-rebating statutes, most of which are substantially similar to the model law promulgated by the National Association of Insurance Commissioners (NAIC). NAIC Model 880, the Unfair Trade Practices Act, contains a provision on rebates that prohibits insurers and others engaged in the insurance business from offering premium rebates, special favors, or other benefits not included in the policy as an inducement to purchase insurance.

Yet as insurers and producers modernize their marketing and business practices to keep up with new technological advancements, regulators and legislators have been taking a closer look at the types of activities that constitute rebating. As a result, some states have begun clarifying and even amending the laws in this area to prohibit — or, more often, allow for — InsurTech and modern marketing. For example, some state insurance departments such as the Louisiana Department of Insurance have issued guidance regarding "value-added services," allowing insurers, producers, and brokers to provide services that are incidental to insurance for free or below market value as long as such services are offered in a nondiscriminatory manner. In Utah, the legislature went even further in 2015 by amending its anti-rebating law to expressly allow this practice. Utah Ins. Code § 31A-23a-402.5(10). This development was a direct response to the activity of the software company Zenefits, which provides HR software to small businesses for free but earns commissions when its users purchase insurance from its insurance company partners. After the Utah Insurance Department determined the company's business model violated the state's inducement and anti-rebating statutes, the legislature stepped in to amend the law and expressly permit such businesses to operate in the state.

This same tension between regulators and the legislature has also been playing out in Washington. There, the Insurance Commissioner similarly found that Zenefits' provision of free software to residents violated the state's anti-rebating laws. However, an administrative law judge later determined that the company was permitted to offer its software to the public for free but ran afoul of the state's anti-rebating laws when it offered additional benefits solely to those who purchased insurance. Yet the legislature had already stepped in. In January 2017, the Washington State Senate introduced a bill (still pending) that, like Utah's, would amend the state's anti-rebating laws to permit similar businesses to operate in the state as long as the goods and services they offer are not contingent on the purchase of insurance. SB 5242. Maine subsequently followed suit. On May 26, 2017, the legislature adopted an amendment to its rebating laws to specify that insurers and producers may not only provide value-added services incidental to insurance but can also offer services for free or below market value as long as these benefits are offered to all potential consumers and are not contingent on the purchase of insurance. Maine Senate Bill LD 1161, amending 24-A Me. Rev. Stat. § 2163-A.

As more states take similar action, regulator interest in this area continues to increase. To stay informed about technological advances impacting the insurance industry, the NAIC established the Innovation and Technology Task Force, which monitors new developments and develops regulatory guidance. And, although it is not yet clear whether other states will follow the innovation-friendly approach of states like Louisiana, Utah, and Maine or resort to a strict interpretation of anti-rebating statutes as originally seen in Washington, it is clear that the legal and regulatory landscape will continue to shift as the insurance industry adapts to changing technology.

SEC Exam Staff: "Surprise, We're Back"

BY GAIL JANKOWSKI

In August, Kevin Kelcourse, the associate director for examinations at the SEC's Boston Regional Office, confirmed that his office has been making "surprise" examination visits to registered advisers in the region. This departs from the typical way in which SEC staff initiate exams – by sending firms a document request list and specifying a time, usually a few weeks later, for an onsite inspection. For many years, surprise examinations have usually occurred only if the staff believed that malfeasance had occurred or was ongoing at a firm.

Recently, however, reports of surprise visits have revealed that while onsite, the SEC has requested to speak with chief compliance officers and, in some instances, made document requests. Kelcourse, whose remarks were delivered to an industry news outlet, stated that by catching firms off guard, the SEC hoped to gain a better perspective on how firms operate when they think nobody is watching.

Although these visits have created some concern throughout the industry, out of the 220 exams initiated by the Boston office in 2017, only about a dozen were unannounced. Kelcourse reportedly clarified that no particular type of advisory firm is being targeted as part of this surprise exam initiative. Nor is it apparent that the surprise examinations focus on any particular type of adviser activities about which the staff may be especially suspicious.

Accordingly, it is unclear how the Boston regional office is deciding which advisory firms to surprise or whether other regional offices will follow suit.

SEC Committee Advocates for Summary Mutual Fund Shareholder Reports

BY THADDEUS EWALD

On December 7, the Investor Advisory Committee of the Securities and Exchange Commission (SEC) adopted a recommendation that the SEC seriously explore the development of a summary disclosure document for mutual fund companies to use to satisfy their shareholder report delivery requirements. Such summary documents would be relevant to many insurance companies and their affiliates, because they would, for example, reduce the costs of delivering mutual fund shareholder reports to holders of variable insurance products that invest in such funds.

The committee's recommendation comes on the heels of the SEC's failure late last year to adopt a rule allowing electronic delivery of periodic shareholder reports unless the shareholder opted for paper delivery. The SEC's inaction last year was probably influenced by investor advocates who opposed the rule because its reliance on implied consent to electronic delivery reduced transparency and investor access to the reports, and by many consumers' continued preference for paper delivery of disclosure documents. Importantly, the committee characterized its recommendation as a stop-gap of sorts that could significantly improve on the status quo while the SEC continues to explore ways to transition more comprehensively to electronic delivery.

The summary disclosure document envisioned by the committee would include high-level information investors care about and need to know: e.g., fund costs, performance, and fund holdings. It would also prominently notify investors about the availability of the full report and where to find it. The summary document would be designed for mail or email delivery depending on the individual investor's preferences. And, for electronic users, the committee encouraged a "layered disclosure approach" under which users could "click through" to obtain more detailed disclosures on desired topics. Lastly, the committee recommended the SEC seek public comment on the concept, content, and format of such a summary disclosure document, as well as conduct investor testing of the summary disclosure.

Treasury Department Urges SEC to Act on Life Company Products

BY GARY COHEN

The U.S. Department of the Treasury published an October 2017 report, "A Financial System That Creates Economic Opportunities — Asset Management and Insurance" in response to President Trump's Executive Order 13772 on "Core Principles for Regulating the United States Financial System."

The report's numerous recommendations include the following steps that the SEC could take to "reduce regulatory costs and improve consumer disclosure":

1. **Authorize a summary prospectus for variable annuities.** The report finds it problematic that "a variable annuity prospectus can range from 100 to 300 pages in length and contains dense legal, actuarial, and regulatory language not readily understood by retail investors." The SEC official who is specifically tasked with promoting investors' interests has also supported this initiative. See "SEC Investor Advocate's 2018 Objectives Target Key Issues for Life Insurers," Expect Focus, Vol. III, 2017.

2. **Streamline annual update prospectuses for variable annuities.** The report observes that "the insurance industry has advocated for … "a streamlined annual update document that is available online at any time, for both new investors and investors who already own annuity contracts."

3. **Permit online delivery of annual and semiannual underlying mutual fund reports.** The report notes that the SEC previously proposed Rule 30e-3 that "would allow mutual funds to provide statutorily required shareholder reports on the Internet." As to a somewhat similar proposal, see "SEC Committee Advocates for Summary Mutual Fund Shareholder Reports" on page 16.

4. **Provide registration statement forms tailored for non-variable products.** The report finds it problematic that companies "are increasingly offering annuity contracts that are not exempt securities," but "must use registration forms designed for equity or debt offerings by public companies." The report seems also to endorse the use of statutory financial statements by referring to the fact that life companies "utilize an accounting standard known as Statutory Account Principles" that is "tailored to permit regulators to analyze the unique nature of the business of insurance."

SEC Whistleblower Awards to Insurance Department Employees?

BY LAURA WALL

Many federal, state, and local governmental employees may be eligible for awards pursuant to the SEC's whistleblower program under the Dodd-Frank Act. If a report to the SEC leads to an enforcement action that results in sanctions of more than $1 million, a whistleblower could receive up to 30 percent of the sanction amount. However, under the terms of the program, employees of "law enforcement organizations" are ineligible to receive such whistleblower awards.

On July 25, the SEC issued an order granting a whistleblower award to a governmental employee for the first time. The order explains the term "law enforcement organization" as generally having to do "with the detection, investigation, or prosecution of potential violations of law." In this case, the government agency that employed the whistleblower did have such law enforcement responsibilities, but those responsibilities were performed by a "clearly separate agency component." Because the whistleblower did not work in that component of the agency, the SEC found it appropriate to grant an award.

The SEC's conclusion, however, was limited to that particular instance, which was "not a situation where a [whistleblower] sought to circumvent the potential responsibilities that his or her government agency might have to investigate or otherwise take action for misconduct." The order does not provide many other facts – such as the identity or nature of governmental employer – that could help predict how the SEC will resolve similar questions in future cases.

Accordingly, it is difficult to ascertain the extent to which various categories of persons employed by state insurance regulatory entities might be able to claim whistleblower awards. The SEC would likely make a determination based on the facts and circumstances of each individual case, which could vary widely given the considerable diversity in the organization and operations of such regulators. Nevertheless, this order certainly increases the possibility that employees of state insurance regulators who become aware of potential securities law violations by insurance companies or affiliates will have an economic inducement to advise the SEC.

Major Disruption in the Use of Technology and Trademarks in the Insurance Industry

BY ETHAN HORWITZ & ALEX B. SILVERMAN

A major study recently emerged regarding insurance industry brands. The study, conducted on the world's top 10 insurance companies by brand value, shows that an industry transformation is occurring, and that insurers that embraced new technology have seen their brand value rise.

Brand values of the world's top insurance companies have fluctuated over the past 10 years as the global economy has recovered. Several insurers have seen steady brand growth in recent years, particularly those in Asian markets that embrace new technology. The study shows that many insurers that have been resistant to new technology have not seen this brand value increase. An industry survey found that for the most part, insurers are among the last to use modern data resources and technology. For instance, smart technology is available that could allow insurers to enhance their core business — underwriting of risk — by providing access to real-time customer data. This technology presents significant opportunities for insurers to provide better products and services, and, in turn, build goodwill and brand recognition.

But looking at trademark filings, the study found that few of the top insurers are adapting to keep up with new technology. A notable exception is Ping An, an Asian insurer that has seen the greatest annual increase in brand value of any insurer in the top 10. The study found that in 2016, the percentage of Ping An's digital and technology trademark filings was significantly higher than other studied insurers, while its percentage of filings in more traditional areas, such as insurance and financial services, was significantly lower. The data suggests that Ping An's willingness to embrace technology may correspond with its year-over-year brand recognition increase.

The study separately found that top insurers have recently focused their IP efforts on emerging Chinese and Latin American markets, where opportunities for insurance premium growth are expected to be the highest of any market. Although early, there are still many opportunities for insurers to build brand value by capitalizing on the potential of modern data resources and targeting emerging markets.

This study reveals that embracing technology has a direct effect on brand value.

NEWS & NOTES

Washington, D.C. shareholder **Richard Choi** co-chaired an advanced American Law Institute CLE conference on life insurance company products on November 2-3 in Washington, D.C. The conference, co-founded by shareholder **Jim Jorden** 35 years ago, is the premiere industry conference of its kind for life insurance companies, mutual funds, broker-dealers, and investment advisers. Every year since its inception, various members of the financial services — regulatory practice group have participated as presenters. This year, Washington, D.C. shareholder **Chip Lunde** served on a panel with industry speakers and SEC staff that focused on the latest disclosure, regulatory, and accounting developments and issues for SEC registered insurance products. Washington, D.C. shareholder **Gary Cohen** served on a panel with SEC staff, including the SEC's first ombudsman, on pending and future SEC regulatory reforms in the Trump era.

Washington, D.C. shareholder and co-chair of the firm's privacy and cybersecurity task force **Josephine Cicchetti** spoke at the PLI Fundamentals of Privacy Law Seminar on December 20 in New York, concerning business associates and vendor issues.

Carlton Fields Miami attorney **Francis X. Suarez** was elected mayor of the City of Miami. His four-year term began November 15, 2017.

Carlton Fields earned national first-tier rankings for four of its practices in the *2018 U.S. News and World Report and Best Lawyers* "Best Law Firms" guide. The firm also received high rankings for numerous practices in several metropolitan areas. Firms achieve tiered rankings based on the high quality of their practices and broad legal experience.

For the ninth year in a row, **Carlton Fields** earned a perfect score of 100 percent on the Human Rights Campaign (HRC) Foundation's Corporate Equality Index (CEI) for its LGBTQ-inclusive policies, earning the distinction of the "Best Places to Work for LGBTQ Equality." CEI is a national benchmarking survey and report on corporate policies and practices related to LGBTQ workplace equality, administered by HRC. Carlton Fields is one of 127 law firms in the country that scored 100 percent for 2018.

The Leadership Council on Legal Diversity (LCLD) named **Carlton Fields** a 2017 Top Performer at its annual meeting in Washington, D.C., October 16-17. Carlton Fields is one of only 52 LCLD organizations that earned this distinction for its participation in and support of the LCLD's mission. This designation recognizes organizations that are most active in LCLD over the course of a year.

Carlton Fields Miami shareholder **Ann Black** has been appointed vice chair of the Securities Section of the ALIC. Section chairs and vice chairs are responsible for developing legal scholarship for their section, and Annual Meeting discussion topics

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