LIFE INSURANCE INDUSTRY

Volume I, March 2018

# EXPECTFOCUS®

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

## NEW RULES AHEAD FOR FINANCIAL ADVISERS

## REVERSAL OF DOL FIDUCIARY RULE A GAME-CHANGER

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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# Fifth Circuit Vacates DOL Fiduciary Rule

BY STEPHEN KRAUS

On March 15, the Fifth Circuit, in *Chamber of Commerce, et. al. v. United States Department of Labor*, a 46-page opinion, reversed the district court's ruling upholding the Department of Labor (DOL) fiduciary rule and vacated the rule. The fiduciary rule is a shorthand definition for a package of seven different rules promulgated by the DOL. The rules reinterpreted the definition of an "investment advice fiduciary," created two new prohibited transaction class exemptions, and significantly modified a number of existing prohibited transaction class exemptions. The Fifth Circuit's decision essentially moots the fiduciary rule and returns the law to what it was prior to April 2016 when the rule was finalized.

In vacating the rule, the Fifth Circuit determined that the original DOL regulation defining "investment advice" drew an appropriate distinction between "an 'investment adviser,' who is a fiduciary regulated under the Investment Advisers Act, and a broker or dealer, whose advice is 'solely incidental to the conduct of his business as a broker or dealer and who receives no special compensation therefor." In reaching this conclusion, the Fifth Circuit determined that the rule was valid only if it was authorized by ERISA Titles I and II. After extensive analysis, the court determined that it was not.

The Fifth Circuit also relied on "Step 2" of the U.S. Supreme Court's decision in *Chevron U.S.A., Inc. v. NRDC* that "if [a] statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." The Fifth Circuit found that not only was the DOL fiduciary rule unreasonable but it was also arbitrary, capricious, contrary to law, and in excess of statutory authority.

As of publication, it was unclear whether the DOL would request a panel rehearing, an en banc hearing, or ask the Supreme Court to review the decision. It is also unclear what impact, if any, the decision might have on the SEC's development of its own fiduciary rule or the various state activities (both legislative and regulatory) surrounding this issue.

# Illinois Federal Court Rejects Twin Suits Challenging Dividend Payment Practices

BY SHAUNDA PATTERSON-STRACHAN

Challenges to mutual life insurers' discretion in setting dividend scales date back over 100 years. Earlier this year, in *Anderson v. Country Life Insurance Company* and *Ochoa v. State Farm Life Insurance Company*, a federal court in Illinois dismissed twin putative class action lawsuits filed against a pair of insurers. The suits alleged that the insurers breached their respective participating life insurance policies by failing to pay the full amount of annual policy dividends contractually owed to policyholders. Via a single January 16 ruling, however, the district court judge rejected the plaintiffs' theory of liability.

Notably, the plaintiffs' breach of contract claims were not predicated on the express language in their policies. Instead, Anderson and Ochoa pointed to sections 243 and 224(e) of the Illinois Insurance Code. As summarized by the court, section 243 "dictates how much life insurance companies can retain in a 'contingency reserve,'" and Section 224(e) "mandates a number of provisions that must be included" in participating policies, including "a provision that the policy shall participate annually in the surplus of the company."

The plaintiffs conceded that Section 243, which, as the court pointed out, "addresses the financial management of life insurance companies, not the relationship between the companies and their policies," does not address disbursement of dividends. Moreover, the court explained that the plaintiffs "implicitly acknowledge" that their policies comply with Section 224(e). Nevertheless, the plaintiffs contended that Section 224(e)'s requirements were wrongfully "weakened" as a result of the insurers' alleged failure to comply with Section 243. According to the plaintiffs, Section 243 is incorporated into their policies as a matter of law, making any noncompliance a contractual breach. The court found this contention "flatly wrong."

First, characterizing it as part of a "complicated narrative," the court rejected the plaintiffs' effort to support their contention with legislative history, including that of jurisdictions outside Illinois. The court reasoned that this was "simple: because the court finds plaintiffs' policies unambiguous ... the court need not, and should not, look to legislative history at all." Nor, it continued, should it "consider any evidence beyond the four corners" of the life insurance policies. Next, the court recognized the plaintiffs' failure, and inability, to allege that their policies even mentioned Section 243. Indeed, Section 243 "says nothing of insurance contracts or policyholders, and plaintiffs' policies say nothing of Section 243."

Ultimately, the court concluded that the plaintiffs could not seek relief through a breach of contract claim. At best, notwithstanding an absent private right of action to enforce the statute, the plaintiffs' theory was tantamount to an alleged failure on the part of the insurers to comply with Section 243. But even if plaintiffs were right that the defendants had failed to comply, it would have "no bearing on plaintiffs' contracts with the defendants."

Both plaintiffs have appealed the ruling to the Seventh Circuit, which has consolidated the appeals.

# Court Rejects Insurer's *Spokeo*-Based Standing Challenge to TCPA Action

BY THADDEUS EWALD

In a February 20 ruling, the Northern District of Illinois cleared the way for a plumbing company's putative class action against Allstate Insurance Company and an insurance agency co-defendant by denying the defendants' motions to dismiss, which were inspired by recent U.S. Supreme Court decisions, including *Spokeo v. Robins* in 2016. The plaintiff in *Abante Rooter & Plumbing, Inc. v. Oh Ins. Agency* alleged that the defendants violated the Telephone Consumer Protection Act (TCPA) when they placed two phone calls to it: one went to voicemail, and a company employee answered the other. The company's purported injuries were the statutory violation as well as business interruption, annoyance of the company's principal, and invasions of privacy. The defendants moved to dismiss on two grounds: lack of standing because the plumbing company had not alleged sufficiently concrete injuries under *Spokeo*; and mootness based on a 2016 Supreme Court ruling in *Campbell-Ewald v. Gomez*, a TCPA action, because Allstate had offered a settlement and deposited the money into an escrow account.

First, the district court found the plumbing company suffered sufficiently concrete injuries and thus had standing to sue. It noted that several courts in the Seventh Circuit held, post-*Spokeo*, that alleged TCPA violations satisfied Article III's requirement for concrete injury-in-fact. Under *Spokeo*, a statutory violation can constitute sufficient injury where the violation risks harm to the "underlying concrete interest" Congress intended to protect in the statutory enactment. Not only did the complaint allege harm to the interest Congress intended to protect in the TCPA, the court concluded, but the plumbing company also alleged injuries of business interruption, invasion of privacy, and annoyance of an employee which were *in addition* to the pure statutory violation.

Second, the court rejected the defendants' contention that, based on *Campbell-Ewald*, Allstate's proffer of a settlement and deposit of funds into an escrow account mooted the claims. In Campbell-Ewald, the Supreme Court held that an unaccepted Rule 68 offer of judgment by a defendant cannot moot a putative class action. And subsequent to the parties briefing the mootness issue here, the Seventh Circuit weighed in. As the district court pointed out, "the Seventh Circuit has issued a series of decisions" extending *Campbell-Ewald's* reasoning against forced settlements to circumstances similar to this case, including a reversal of a district court decision Allstate heavily relied upon in its briefing. Accordingly, the district court held that Allstate's "offer of judgment and deposit of funds into an escrow account" did not moot the claims. Additionally, the facts here encouraged this specific holding because the escrow agreement's terms restricted the bank's disbursement until a court order directed it to do so, an impossible outcome because mooting the claims would deprive the court of any jurisdiction to enter a merits judgment.

# CAFA's Local Controversy Exception Requires Class Claims Against Local Defendant

BY GAIL JANKOWSKI

As we previously reported, in September 2017, a federal district court in Louisiana dismissed with prejudice as time-barred putative class action RICO and state racketeering claims related to alleged wrongful conduct by an agent in connection with annuities issued by Sun Life. *See Expect Focus*, Volume IV, Dec. 2017.

*Robertson v. Sun Life Financial*, commenced in state court in 2008, arose after the plaintiff, an annuity owner, noticed fraudulent withdrawals from his Sun Life annuity account. He asserted state common law claims predicated on a theory that the insurer negligently breached the annuity contract by failing to follow certain industry standards, thereby failing to prevent the wrongful conduct. There was a concurrent criminal proceeding against one of the civil defendants, Matthew Pizzolato, the son of one of Sun Life's agents. Pizzolato pleaded guilty to multiple counts of mail fraud and other offenses related to the fraudulent withdrawal and was sentenced to a 30-year prison term in 2010.

During the civil litigation, the plaintiff amended his petition several times, culminating in a fourth amended petition asserting new federal and state racketeering putative class action claims, alleging that Sun Life was liable for Pizzolato's fraudulent activity because it either conducted or acquired a racketeering enterprise through which its agent and Pizzolato created and used individual retirement accounts to steal from customers' accounts. Sun Life then removed the case to federal court based on federal question jurisdiction and subject matter (Class Action Fairness Act) jurisdiction. After the district court dismissed the federal and state racketeering claims, the plaintiff filed a remand motion, seeking to prosecute his remaining state court claims in state court. However, in a January 2018 ruling, the district court rejected the effort.

The court was unpersuaded by the plaintiff's effort to place the case within CAFA's local controversy exception by pointing to the existence of a "significant local defendant," Louisiana citizen Pizzolato. First, the district court agreed that Pizzolato's conduct "forms a significant basis for the class claims" as, *inter alia*, his conduct "appears to have affected all members of the putative class." However, the plaintiff failed to meet his burden to demonstrate the exception applied because he failed to show that Pizzolato "is a defendant 'from whom significant relief is sought by members of the plaintiff class.'" Specifically, the class allegations were directed at "the Racketeering Defendants." Pizzolato, however, while mentioned several times in the complaint, "[was] not named as one of the Racketeering Defendants and [did] not appear to be the target of the class claims." The court also noted that "[u]nder Louisiana law, an action is abandoned when the parties fail to take any step in its prosecution," and in this case, it had been over three years since the complaint was filed and Pizzolato was never served.

# SDNY Ruling Narrows Claims in COI Suit

BY PAUL WILLIAMS

In *EFG Bank AG, Cayman Branch v. AXA* and *The Duffy 2004 LLC v. AXA,* in a February 14 ruling, AXA Equitable Life Insurance Company earned a sweet victory on its motion for partial dismissal of the complaints in two consolidated proceedings actions challenging its COI rate increases . The Southern District of New York dismissed the plaintiffs' breach of implied covenant of good faith and fair dealing claims (both contractual and tortious) and requests for punitive damages and declaratory relief. AXA did not move to dismiss the plaintiffs' express breach of contract claim. Its narrowly-focused motion succeeded in all respects.

The contractual implied-covenant claims were dismissed as duplicative of the express breach of contract claim. Notably, the court distinguished these cases from prior COI opinions, denying defendants' motions to dismiss and stating: "the policies at issue in those cases did not explicitly constrain the insurers to apply COI increases 'equitably' or use only 'reasonable' assumptions in increasing COI rates .... Thus, the plaintiffs could state implied-covenant claims by alleging that the defendants had 'exercis[ed] their limited discretion under the Policies in an unreasonable and unfair manner.'" The AXA policies, however, "expressly required AXA to exercise its discretion reasonably and equitably" when changing policy cost factors.

The tort-based implied covenant claims were dismissed under California law. The court recognized that "an insured cannot maintain a claim for tortious breach of the implied covenant of good faith and fair dealing absent a covered loss." It found that plaintiffs' claims "do not allege that AXA has withheld insurance benefits owed under the policies."

Due to its dismissal of the tort claims (in this ruling), the court also dismissed the plaintiffs' requests for punitive damages, as that relief was sought only in connection with plaintiffs' tort claims. Finally, as other district courts have done in recent COI action rulings, the court exercised its discretion to entertain declaratory relief claims consistent with the Declaratory Judgment Act, or to decline to do the same, and dismissed the plaintiffs' declaratory relief claims as duplicative of the breach of contact claim.

# Plaintiffs' Notice That the 'Taxman Cometh' Was Sufficient to Trigger Statute of Limitations

BY TODD M. FULLER

In a November 16, 2017 ruling, a California appellate court affirmed a summary judgment ruling in favor of several financial advisors, and insurer American General Life Insurance Company, holding that plaintiffs' fraud and negligence based claims relating to alleged faulty financial planning advice were time-barred.

In *Choi v. Sagemark Consulting*, plaintiffs alleged that in 2003 their financial advisors induced them to establish a defined benefit plan under § 412(i) of the Internal Revenue Code, funded with life insurance policies, based on alleged misrepresentations regarding the validity and favorable tax consequences associated with the plan and policies. According to the plaintiffs, although the defendants knew or should have known that the plan as structured would likely be scrutinized by the IRS and deemed an abusive tax shelter, they nevertheless represented that the plan was "bullet proof," and carried no substantial risk of adverse IRS action or negative tax consequences. In November 2010, plaintiffs filed their complaint, alleging that based on the faulty tax advice, they suffered damages beginning in 2008, and extending through the completion of the IRS audit and assessment of back taxes, interest, and penalties in 2009.

Defendants moved for summary judgment contending that the claims were time-barred because plaintiffs were on notice of indeterminate damages at the latest by September 2007. They argued that a November 2006 notice to plaintiffs by the IRS – which was auditing plaintiffs' plan – identifying numerous defects in the plan, and the need to unwind or alter the plan, should have raised plaintiffs' suspicion. Defendants further argued that a September 2007 email exchange between plaintiffs and defendants put plaintiffs on notice that there would be IRS penalties associated with their plan participation, although the amount and potential to offset options were unknown. Plaintiffs countered that there was no actual injury at that point, and that their claims had yet to accrue, because no penalty or tax assessment had been issued rendering any damages uncertain. The appellate court disagreed.

Specifically, the court recognized that the existence of appreciable actual injury for claim accrual did not depend on plaintiffs' ability to quantify the sum of damages, but required only the suspicion that some wrongdoing injured them. It explained that, in this case, "by the time plaintiffs learned that the IRS's adverse assessment of the 412(i) Plan would result in penalties, neither the lack of a numeric assessment nor the hope of offset by another source negated the fact that plaintiffs were on notice of actual injury." The court, thus, held that plaintiffs' claims accrued in September 2007 because, by that point, "plaintiffs had knowledge of harm to their financial interest sufficient to trigger inquiry notice and to support a legally cognizable claim for damages."

Plaintiffs also argued that even if the September 2007 email exchange constituted notice of actual damages, the limitations periods should be tolled because defendants continued to advise and advocate on plaintiffs' behalf in a fiduciary capacity during the pendency of the audit. The court again disagreed, noting that "the only conclusion to be drawn from the evidence leading up to and including the September 2007 e-mail is that plaintiffs were not shielded from the knowledge that the IRS was questioning the validity of 412(i) Plan, had identified multiple defects that would require unwinding or conversion to another type of plan," and had informed other professionals of forthcoming penalties. Thus, the court held that even assuming the existence of a fiduciary relationship, there was nothing to prevent or delay plaintiffs from discovering the wrongdoing beyond September 2007.

# An Illustration Saga Continues in California

BY DAWN WILLIAMS

As we previously reported, the Ninth Circuit in March 2017 held that violation of California's illustration statutes could serve as a predicate for an Unfair Competition Law (UCL) action, partially reversing the trial court's decision in *Walker v. Life Ins. Co. of the Southwest* on the plaintiff's UCL claims following a jury verdict for the insurer. *See Expect Focus*, Volume I, March 2017.

On remand, plaintiffs filed a third amended complaint, which alleged only that the insurer violated California's UCL by failing to adhere to the illustration statutes. Specifically, this iteration of the complaint alleged that the insurer: (i) provided incomplete illustrations; (ii) portrayed nonguaranteed elements as guaranteed; (iii) failed to define terms in language understandable to a consumer; (iv) illustrated nonguaranteed elements not described in the policies; and (v) used illustrations that depict policy performance more favorable than that which could be reasonably based on actual historical experience.

In December 2017, the district court granted in part and denied in part the parties' cross motions for summary judgment. First, the court rejected the insurer's argument that the named plaintiffs lacked standing. The court found that, although plaintiffs were required to demonstrate reliance, there was a genuine issue of fact on nearly all of the claims because all policy owners received illustrations and the insurer "set forth no evidence to demonstrate a lack of actual reliance." Plaintiffs similarly demonstrated a genuine issue as to the materiality of the alleged omissions.

The court then addressed each of the specific purported violations. The court granted summary judgment for the insurer on the "incomplete" allegation, finding that the illustration statute did not require that every policy feature be included in a basic illustration. Based on its previous holding that the guaranteed interest rates were in fact guaranteed, the court also granted the insurer's motion on the nonguaranteed element allegation. Finding that some terms were defined and some were not, the court granted in part each party's motion on various terms not being defined. The court found that a statute providing that language should be "understandable" did not impose a mandate on insurers, and thus granted the insurer's motion on that allegation. Finally, the court granted summary judgment for plaintiffs on nearly all of their allegations that certain nonguaranteed elements that were not in the contract were found in the illustration.

The litigation continues on the few limited remaining factual issues, and has been set, again, for trial next year.

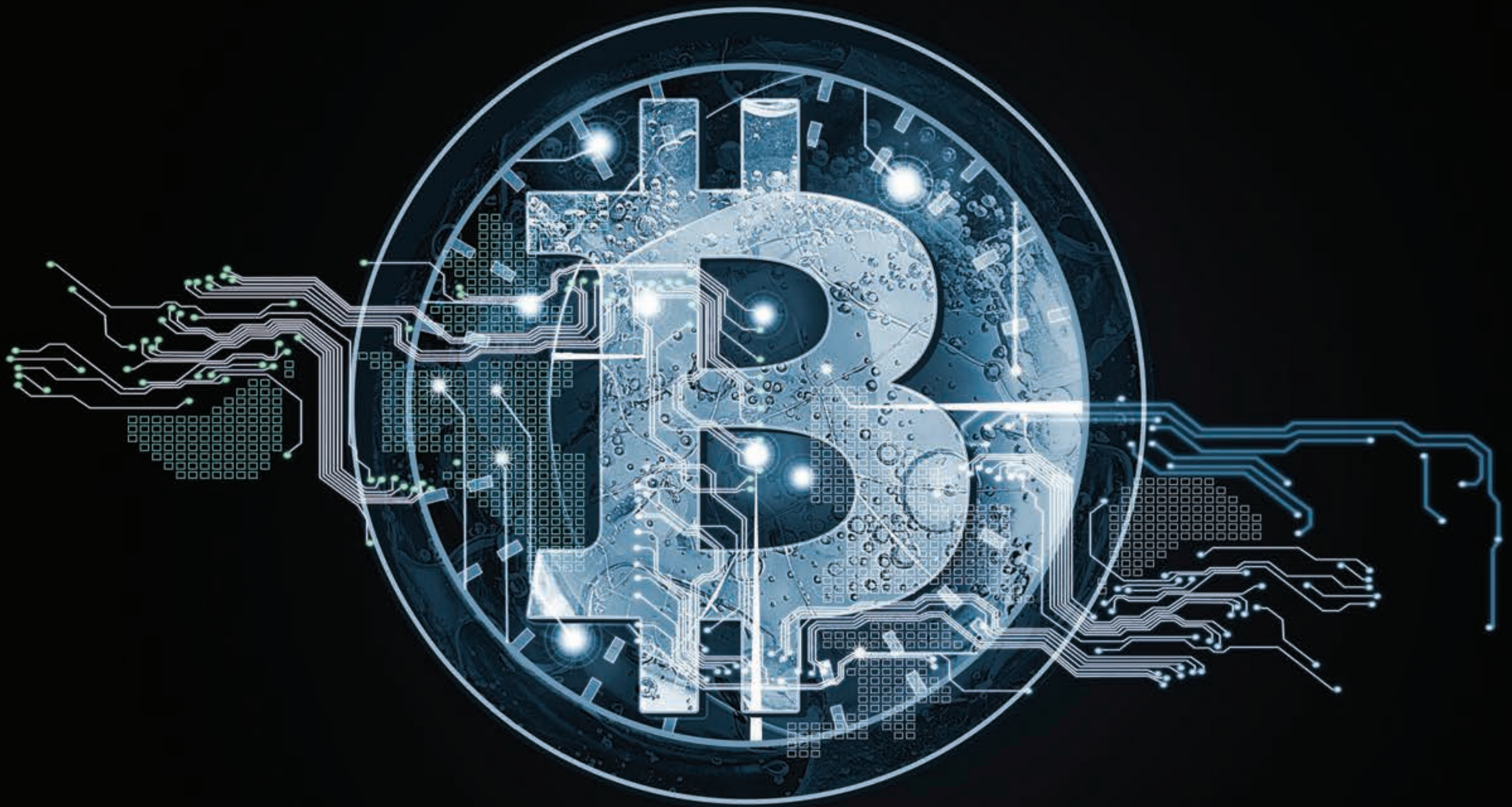
# Nonpayment of an Insurance Claim is Not Elder Abuse

BY IRMA REBOSO SOLARES

Does the failure to pay an insurance claim constitute elder abuse? Not under Oregon's elder financial abuse laws. In January, the Oregon Supreme Court, answering a certified question from the Ninth Circuit, held that "[a]llegations that an insurance company, in bad faith, delayed the processing of claims and refused to pay benefits owed to vulnerable persons under an insurance contract do not state a claim under ORS 124.110(1)(b) for wrongful withholding of money or property." The plaintiffs in *Bates v. Bankers Life and Casualty Company* accused Bankers of developing onerous procedures that were intended to delay and deny long-term care insurance claims. They argued that the failure to pay insurance claims to which they were entitled violated Oregon's elder financial abuse laws because the insurance company was retaining money or property that belonged to them.

The payment and administration of insurance claims is not the type of conduct the financial abuse statute was intended to govern. The Oregon Supreme Court applied fundamental tenets of insurance law to determine that neither the long-term care policies, nor plaintiffs' contractual right to receive benefits under the policies, constitute money or property that was acquired by the insurance company. The money the plaintiffs paid for the insurance (premiums), is "factually and legally" distinct from the insurance benefits themselves which are subject to payment upon the occurrence of certain risk contingencies. Plaintiffs were thus unable to demonstrate a key element of their claim – that Bankers acquired ownership or control of money or property belonging to them.

The federal government, states, territories, and the District of Columbia all have laws designed to protect older adults from financial exploitation. While it does not appear that these laws are patterned on a model act, and they can vary considerably from jurisdiction to jurisdiction, the laws generally address improper use of assets or property belonging to the vulnerable or elderly adult. Consequently, the *Bates* decision could have far-reaching implications beyond Oregon.



# SEC Sidelines Funds Focused on Cryptocurrencies

BY EDMUND ZAHAREWICZ

In a January 18 letter to two of the fund industry's leading advocacy groups, the staff of the SEC's Division of Investment Management advised fund sponsors not to initiate registration of funds that intend to invest substantially in cryptocurrency and related products until the staff's questions, which the letter identified, are satisfactorily addressed. This applies to funds that are publicly offered as well as to registered funds that support variable insurance products. The letter identifies a host of "outstanding questions" regarding certain core requirements under Investment Company Act of 1940 (1940 Act) governing valuation, liquidity, and custody of fund assets. For example, the letter questions how funds can:

- value or "fair value" cryptocurrency products,
- assess and manage the liquidity of such products, and
- satisfy the applicable standards for safeguarding fund assets if they hold such products directly.

"In light of the fragmentation, volatility and trading volume of the cryptocurrency marketplace," the letter also questions, for ETFs, the efficacy of the arbitrage mechanism such funds rely on to ensure that their market price does not materially deviate from the fund's net asset value. The letter also highlights general concerns over the greater opportunities for fraud and manipulation within the cryptocurrency markets and asks how such concerns would factor into the sponsor's consideration of such matters as the fund's compliance with the requirements of the 1940 Act, as noted above, and whether a proposed fund is appropriate for retail investors. Finally, the letter queries whether sponsors understand how broker-dealers and investment advisers would discharge their suitability and fiduciary obligations when recommending or investing on behalf of retail investors in cryptocurrency-related funds.

According to the letter, due to the myriad questions and concerns, the staff has asked sponsors that have registration statements filed for cryptocurrency-related funds to withdraw them. The letter also advises that such funds should not use Rule 485(a), which allows post-effective amendments to previously-effective registration statements for a new series to go effective automatically. It is safe to say that sponsors aiming to launch a cryptocurrency-related fund have their work cut out for them as far as the SEC staff is concerned.

# When Innovation Meets Regulation: InsurTech and State Licensing Laws

BY JOSEPHINE CICCHETTI & CHRISTINE STODDARD

The rise of InsurTech — which brings technological innovations to the business of insurance — is having 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. Yet many worry that complex insurance regulations will slow or even prevent further innovation. This article is the second in a series discussing the regulatory issues impacting InsurTech.

As innovations continue to transform the insurance industry, so too will regulatory issues continue to arise. A number of InsurTech companies have attempted to enhance the consumer experience by increasing efficiency and convenience, such as by offering mobile apps, providing on-demand services, and implementing rewards programs. Forming relationships with these businesses can be a boon to insurance companies as well, enabling them to offer new products and services, modernize their marketing, increase internal efficiencies, and attract and retain customers.

And while InsurTech impacts multiple aspects of the insurance business, it has the potential to — and, indeed, has significantly changed — how insurance is sold and marketed. But innovation in this area comes with unique challenges. The insurance industry is highly regulated, and these regulations — enacted before new technology existed — affect not only insurance companies but their industry partners as well.

Each state has its own licensing requirements, necessitating that insurance producers obtain licenses in each state in which they sell, solicit, or negotiate insurance, an issue further complicated by digital sales that cross state lines. The National Association of Insurance Commissioners (NAIC) promulgated the Producer Licensing Model Act (Model 218) to require the licensing of producers. Many states have adopted the NAIC's Model Act in whole or in part, and, consistent with the model, all states require producers to be licensed in that state in order to sell, negotiate, or solicit insurance.

Whether it is necessary to obtain a producer license has long been a question for insurance-related actors. The answer depends, in large part, on what it means to sell, solicit, and negotiate insurance. This, however, is not always clear, and can vary by state. The NAIC model defines selling insurance as "exchang[ing] a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company." What it means to solicit or negotiate insurance can be even more nuanced. NAIC Model 218 defines "solicit" as "attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company," while "negotiate" means "the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchases."

Regulators have commonly found that a person is "soliciting, negotiating, or selling" insurance when she engages in activities such as explaining coverage, providing recommendations about insurance, quoting insurance rates, or advising prospective consumers to buy a certain policy or obtain insurance from a particular company. However, most states do not require a license if a person's activities are limited to advertising without the intent to solicit insurance. Similarly, a license is not required for information provided by employees of an insurer or producer who perform administrative or other tasks that are only indirectly related to sales and who do not receive commissions on policies. Additionally, providing general information that does not include advice or recommendations or relaying the name and contact information of a licensed producer to a prospective policyholder may be exempt from licensure requirements.

The advent of InsurTech has put these issues front and center for many startups. The industry saw one cautionary tale after multiple state regulators fined a software company that partnered with insurers to sell insurance policies to businesses using its products, finding it had allowed unlicensed employees to sell, solicit, and negotiate insurance. The activities at issue included not only the sale of policies but also presentations to potential customers about the insurance products the company offered through its partners. This ultimately led to a change in the company's business model, as it began working with outside insurance brokers.

Licensing is an area of concern both for InsurTech companies that may solicit or sell insurance and for the insurance companies that partner with them, as state laws also regulate how non-licensees may be compensated. Section 13(A) of NAIC Model 218 prohibits insurers and producers from paying commissions to a person for selling, soliciting, or negotiating insurance unless the person is licensed in that state, though the NAIC Model and many states have various exceptions to the general rule. Such laws pose challenges for insurers partnering with tech startups to market and sell their insurance across new digital platforms.

For example, regulators and others have recently taken a closer look at a digital property and casualty insurer that sells policies online and through an app and uses technology to provide insurance and pay claims in minutes. The company recently received approval from regulators in multiple states to sell renters and homeowners insurance policies. However, after it enabled partnering companies to offer its insurance policies on their own apps and websites last year, some began questioning whether this implicated state licensing laws. The insurer at least planned ahead: the company has stated that its compliance program helps ensure those using its platform are not themselves selling insurance and it does not pay commissions to unlicensed producers —though only time will tell if regulators agree. Still, other startups looking to enter the insurance industry would also be wise to consider — in advance — the various licensing regulations applicable in each state and what impact those regulations will have on their particular business model.

# SEC Issues Cybersecurity Disclosure Guidance

BY EDMUND ZAHAREWICZ

On February 21, the SEC published interpretive "Guidance" to help public operating companies prepare disclosures about cybersecurity risks and incidents. The Guidance reinforces and expands guidance issued by the Division of Corporate Finance in 2011 regarding disclosure obligations related to cybersecurity risks and incidents. Although the new Guidance lends the Commission's imprimatur to the earlier staff guidance, two SEC commissioners took the somewhat unusual step of publishing separate statements arguing that the SEC should do more.

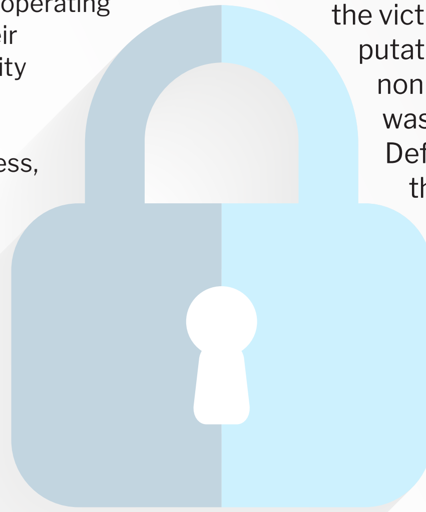
The Guidance highlights the disclosure requirements under the federal securities laws that public operating companies must heed when considering their disclosure obligations regarding cybersecurity risks and incidents. Such disclosure requirements include those regarding the company's risk factors, description of business, legal proceedings, and financial statements, as well as management's discussion and analysis and the board of directors' role in overseeing the company risk management process.

In contrast to the Division's 2011 guidance, the SEC's Guidance is notable for its emphasis on:

- the potential for selective disclosure or other misuse by insiders of cybersecurity-related material nonpublic information,
- the importance of maintaining comprehensive and effective policies and procedures governing cybersecurity-related disclosures and insider trading, and
- the role of the company's board in overseeing cybersecurity risks.

The Guidance, however, "does not address the specific implications of cybersecurity to other regulated entities under the federal securities laws, such as registered investment companies, investment advisers, brokers, dealers, exchanges, and self-regulatory organizations."

Given the increasing frequency, magnitude and cost of cybersecurity incidents, some — including SEC Commissioners Jackson and Stein — believe the SEC should do more to help companies provide investors with comprehensive, particularized and meaningful disclosure about cybersecurity risks and incidents. While generally supportive of the Guidance, the separate statements issued by these commissioners question whether it will be any more successful than the Division's 2011 guidance in eliciting more robust cybersecurity disclosures from public companies. Only time will tell.



# Supreme Court Denies Insurer's Petition to Review Standing in Data Breach Class Actions

BY KRISTIN ANN SHEPARD

In recent years, the insurance and financial services industries have been targets of high profile data breaches. The breached companies – themselves the victims of cyberattacks – often face putative class actions by consumers whose nonpublic financial and health information was allegedly compromised in the breach. Defendants in these cases have argued that a plaintiff's mere fear of future identity theft in the wake of a data breach is too speculative to be an injury in fact giving rise to standing to sue under Article III of the United States Constitution. Thus far, the standing question has split the federal circuits. The answer may make or break the future of data breach consumer class actions, as the majority of individuals whose information is compromised never experience identity theft or fraudulent charges traceable to the breach.

When will the Supreme Court weigh in? Unfortunately, not soon. On February 20, the Supreme Court denied a petition for writ of certiorari in *Attias v. CareFirst* to resolve a circuit split on the standing issue. Absent Supreme Court guidance on this issue, we anticipate that district courts within the District of Columbia, Sixth, and Seventh Circuits – which have ruled favorably for plaintiffs on the standing issue – will emerge as the forums of choice for data breach class actions. By contrast, defendants will likely seek to consolidate data breach class actions in the district courts within the Eighth and Fourth Circuits, which have held that fear of future identity theft is insufficient to confer standing to sue.

# SEC Targets Variable Insurance Products

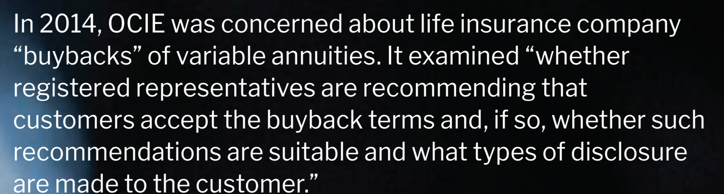
BY GARY COHEN

Once again, the SEC's Office of Compliance Inspections and Examinations (OCIE) has made variable insurance products an exam priority.

The SEC announced this priority on February 7 in a 10-page booklet of OCIE's 2018 priorities that was at least twice as long as the booklets for the last four years. However, the additional length doesn't shed much more light on OCIE's precise interest in variable insurance products. Generally, OCIE says it will conduct exams of "investment advisers and broker-dealers that offer services and products to investors with retirement accounts." More specifically, OCIE says it "will focus on ... sales of variable insurance products."

For 2012 and the following years, OCIE announced that variable insurance products — or, at least, variable annuities — were an exam priority. The only exception was for 2015.

Regarding variable insurance products, OCIE's focus has shifted over the years. For 2012, OCIE said it was interested in "growth in variable insurance product assets and the emergence of new channels of distribution." In 2013, the focus was on "the growing use of alternative and hedge fund investment strategies in ... variable annuity structures."



In 2014, OCIE was concerned about life insurance company "buybacks" of variable annuities. It examined "whether registered representatives are recommending that customers accept the buyback terms and, if so, whether such recommendations are suitable and what types of disclosure are made to the customer."

In 2016, OCIE examined "the suitability of sales of variable annuities to investors (e.g., exchange recommendations and product classes) as well as the adequacy of disclosure and the supervision of such sales." Similarly, in 2017, OCIE reviewed "registrants' recommendations and sales of variable insurance products."

Looking back, OCIE has principally been interested in the distribution of variable insurance products, particularly suitability of recommendations and disclosure of pertinent information. However, OCIE hasn't identified any dominant concern, much less undertaken any enforcement initiative.

# Implementation Delay and Q&As for Fund Liquidity Rule

BY CHIP LUNDE

On February 21, the SEC approved a six-month extension for mutual funds to comply with the classification (bucketing) requirements and related elements of its new liquidity rule. The extension was responsive to comments from the Investment Company Institute and others that fund vendors would not be ready to provide the necessary services by the deadline. The new compliance deadline for the rule's bucketing requirements is June 1, 2019 for fund complexes with more than $1 billion in assets, and December 1, 2019 for smaller firms.

Also on February 21, the SEC staff issued 19 additional Q&As regarding compliance with the rule's requirements. In the new guidance, the staff confirmed previous indications that funds would enjoy significant flexibility in meeting classification requirements and testing for liquidity, but indicated there were limits to such flexibility. For example, the staff said:

- A17: funds may rely on a "reasonable framework" to identify exceptions to asset class classifications, ***but*** must conduct periodic testing of the framework.

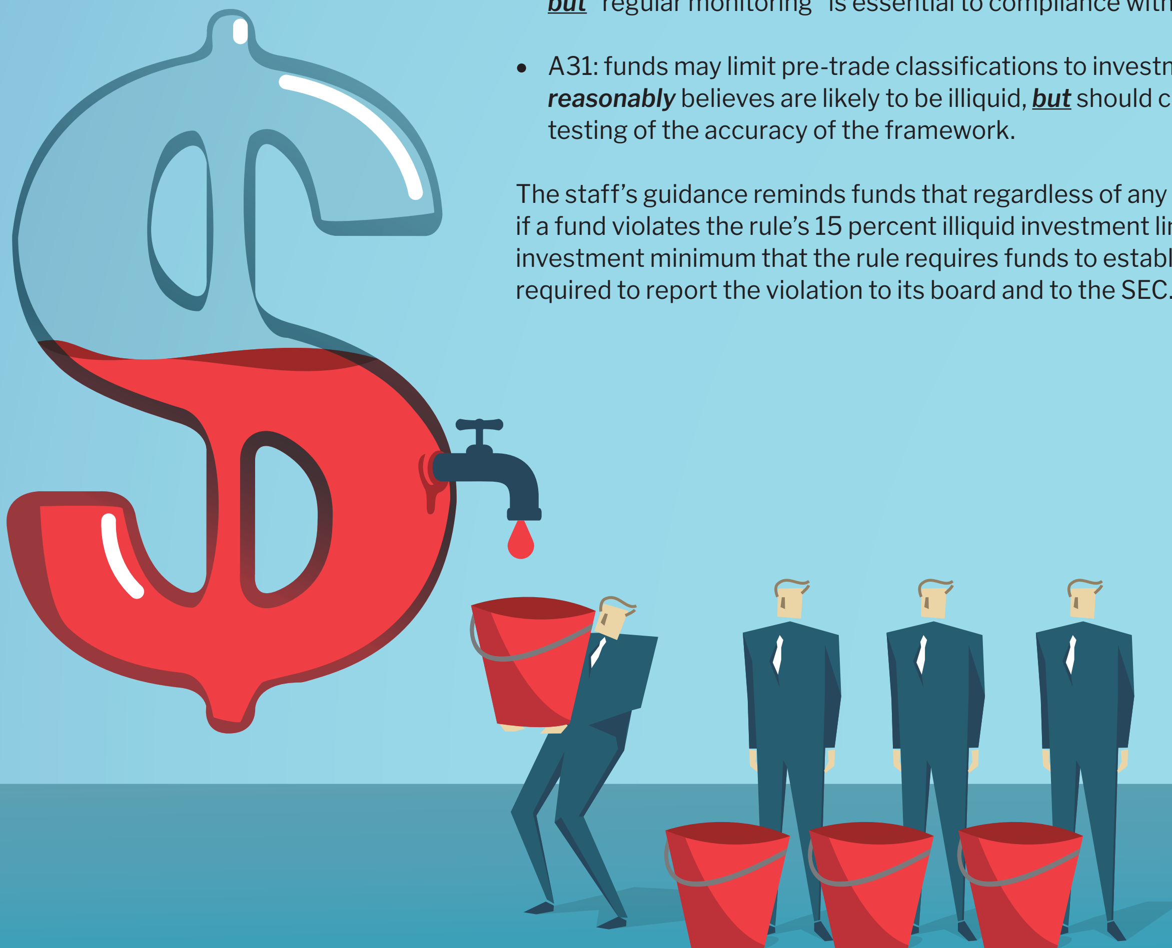
- A21: funds are free to make reasonable assumptions regarding the investments they may choose to sell to meet redemptions, ***but*** a zero or near zero reasonably anticipated trading size would "not be a reasonable assumption."

- A23: funds of funds can focus on the liquidity of their underlying funds' shares without "looking through" to the underlying fund's investments, ***but*** may need to look through if there is "reason to believe" circumstances merit.

- A24: funds are not required to reclassify their investments on a daily basis, ***but*** "regular monitoring" is essential to compliance with the rule.

- A31: funds may limit pre-trade classifications to investments that the fund ***reasonably*** believes are likely to be illiquid, ***but*** should conduct periodic testing of the accuracy of the framework.

The staff's guidance reminds funds that regardless of any flexibility in methods, if a fund violates the rule's 15 percent illiquid investment limit or the highly liquid investment minimum that the rule requires funds to establish, the fund would be required to report the violation to its board and to the SEC.



# Investment Adviser Fee Table on the Table

BY TOM LAUERMAN

On February 7, the Massachusetts Securities Division asked for public comment on a fee table requirement for Massachusetts-registered investment advisers.

**Difficult Disclosure Problem**

The Division is concerned that investment advisers may not provide information about their fees that is clear, or on a basis that is comparable among different investment advisers. This problem arises because advisers offer many different types of services, for which they receive compensation under a wide variety of fee arrangements: e.g., hourly fee, subscription charge (for publications), fixed fee, commissions, performance-based fee, or fees based on the customer's net worth or household income.

The Division's laudable objective of ensuring comprehensible and comparable disclosure may be particularly elusive, as even the same adviser may:

- offer different variations or "levels" of the same general type of service;
- allow customers to use more than one type of fee to pay for a given type of service;
- as to any fee type, make a range of fee levels available to different types of customers or accounts; or
- be willing to negotiate some types of fees and not others (or under some circumstances and not others).

Clarity and comparability of adviser fee disclosure is further complicated because:

- Even within the same general type of service, the nature and level of that service may differ markedly from one adviser to another.
- For example, some advisers may rely on third parties, such as other money managers or robo advisers, to perform important services for the customer.
- In some cases, the adviser's fee also covers the cost of any such third party, while in other cases the customer is charged an additional amount.

**Relationship of Fee Table to Form ADV Brochures**

The information that would be included in the Division's proposed investment adviser fee table is generally required in the Form ADV "brochures" that state registered advisers generally must deliver and make available to customers. However, Form ADV does not prescribe any particular format for that disclosure, and, due to complexities such as those discussed above, a brochure's disclosure about all of an adviser's fees is often in narrative form which may not be clear when compared to other advisers' brochures.

The Division's proposal would be in addition to the brochure disclosure. The Division envisions the new fee table as a relatively compact chart with one column that would list each of the different "Fees Charged by Investment Adviser." A few additional columns would succinctly state other pertinent information about the charges, such as "Fee Amount," "Frequency Fee is Charged" and "Services." The Division hopes to be able to develop requirements for such charts that will make them a worthwhile addition to the information already contained in the Form ADV.

**Where this Might Lead**

The more types of services and fee arrangements included in a single fee table, the less useful a fee table is likely to be. If a single table is used, all the material variations and distinctions in the fee arrangement would need to be disclosed, which may reduce the effectiveness of the table as a comparison tool.

Perhaps this could be alleviated by requiring multiple tables: e.g., a separate table for each type of service, with each customer getting only the tables for those services that concern that customer. Form ADV, for example, permits separate brochures for substantially different services (and indeed *requires* separate brochures for wrap fee programs). Any requirement for an adviser to have multiple fee tables, however, would be more costly for advisers to administer.

The Massachusetts fee table disclosure, if adopted, could become an anomaly. While it could help customers compare one Massachusetts state-registered adviser to another, customers would have no comparable tables related to the federally-registered advisers with whom the Massachusetts-registered advisers also compete.

# FINRA Requires Order Taker Registration

BY ANN FURMAN

In late 2017, FINRA pronounced in Regulatory Notice 17-30 that, "Beginning on October 1, 2018, unregistered persons cannot accept an order from a customer under any circumstances. Only appropriately registered persons can accept an order from a customer." At the same time, FINRA decided to eliminate the Series 11 registration category for order processing assistant representatives.

FINRA is of the view that accepting unsolicited customer orders for the purchase or sale of securities is not considered a clerical or ministerial function. Supplementary Material to new FINRA Rule 1230 proclaims that "associated persons who accept customer orders under any circumstances shall be registered in an appropriate registration category pursuant to Rule 1220."

But does order taking always involve broker activity? FINRA's position may raise a number of issues for variable insurance product operations. For example, when a contract owner places a subaccount transfer order or partial surrender order, what is the "security" – the variable contract itself or the units of interest in the separate account? The answer to this question may turn in part on the title of securities being registered on the facing sheet of an insurer's variable annuity or variable life insurance policy registration statement. Some may argue that, to the extent the security is the variable contract itself, and not the units of interest in the separate account, the security has already been sold and any subsequent order to transfer or surrender accumulation units is a contract administrative activity that does not involve a securities order.

By way of further example, what order taking activities may variable product call center and branch office personnel perform without a Series 6 (investment company and variable contracts products representative) registration? Some clerical and ministerial order taking activities – address changes, beneficiary changes, and requests for performance – clearly do not involve securities transactions. But some branch office order taking activities may be unclear: 1) Could an unregistered branch office employee forward orders to the insurer/distributor on behalf of customers without being deemed to "accept" the order? 2) Does "accepting an order" mean accepted by or on behalf of the broker-dealer? 3) Might such acceptance occur only after the broker-dealer receives the order at the home office/central processing center?

FINRA's position on order taker registration also raises a potential regulatory anomaly. For example, in the *Universal Pensions, Inc.* (UPI) SEC Staff No-Action Letter (Jan. 30, 1998), the SEC staff took the position that a third party administrator to pension plans could, through automated telephone voice response and internet systems, accept participant orders without registering as a broker-dealer. The staff was of the view that this type of order taking was clerical and ministerial activity that did not require registration. The SEC's 2015 Transfer Agent Concept Release cites UPI for this point and notes, "depending on the type of securities being administered and the scope of administration services being performed, an entity may or may not be required to register with the Commission in the capacity of a transfer agent and/or a broker-dealer." Query whether FINRA's position would apply, for example, to a broker-dealer's associated person who also is an employee of a transfer agent, if that employee's acceptance of an order is clearly in a transfer agency capacity.

Supplementary Material to Rule 1230 states that an unregistered person is not accepting an order "when an appropriately registered person is unavailable, [and] the associated person transcribes order details submitted by a customer and the registered person contacts the customer to confirm the order details before entering the order." Whether this so-called exception to the rule will prove helpful in practice remains to be seen.

For some insurers and their principal underwriters, requiring registration of call center and branch office personnel may impact variable product operations. As a result, insurers and principal underwriters are evaluating what changes, if any, may need to be made to their variable product operations and personnel registrations before October 1.

# State Suitability, Fiduciary Duty and Disclosure Initiatives Roundup

BY ANN BLACK, JAMIE BIGAYER & ADRIANA PEREZ

States are stampeding to impose additional duties on those who provide financial advice or make recommendations to consumers. Some of these initiatives result from the states' belief that action is required to wrangle perceived wrongdoings that they thought were lassoed by the DOL's Fiduciary Duty Rule and exemptions, but have now been let out of the barn. Other initiatives seek to include in the herd other types of products and services subject to suitability, best interest, or fiduciary duty. The states' initiatives include:

- **Connecticut** – Effective July 5, 2017, financial planners, who are not regulated by state or federal law, may have to disclose whether they have a fiduciary duty.
- **Delaware** – On November 15, 2017, the Delaware Department of Insurance proposed adding legislation requiring agents, producers, brokers, and companies to complete a written suitability review prior to any issuance of any life, limited benefit, long-term care, and Medicare supplement policy.
- **Illinois** – On February 13, 2018, a placeholder bill without proposed language, titled "Investment Advisor Disclosure Act," was introduced.
- **Maryland** – In January 2018, the Maryland Financial Consumer Protection Commission (Commission) issued its 2017 Interim Report recommending "Maryland take steps to further protect consumers and investors" and extend a "fiduciary duty … to all financial professionals who provide investment advice." Bills introduced in the Maryland House and Senate require the Commission to monitor the SEC's "actions in addressing conflicts of interest of broker-dealers' offering investment advice" and "changes to State law" addressing fiduciary duty standards of care. The Senate bill also requires that the Commission "study the U.S. Department of Labor rule."
- **Massachusetts** – On February 7, 2018, the Massachusetts Securities Division asked for public comment on a fee table requirement for Massachusetts-registered investment advisors (see page 17).
- **Nevada** – Effective July 1, 2017, Nevada law imposes a statutory fiduciary duty on broker-dealers and investment advisers and authorizes the Administrator of the Nevada Securities Division to adopt regulations defining acts, practices, or courses of business that violate the fiduciary duty owed to clients.

  The Nevada Division of Insurance circulated its January 22, 2018 proposed revisions to Nevada's suitability requirements. These revisions mirror many of the revisions in the NAIC's proposed Suitability and Best Interest Standard of Conduct in Annuity Transactions Model (discussed on page 21), including the same definition of best interest and duties for insurers and producers.
- **New Jersey** – Not dissuaded by being bucked in 2016 and 2017, legislation requiring non-fiduciary investment advisors to disclose that they do not have a fiduciary relationship with the client and are not required to act in the client's best interest was re-introduced.
- **New York** – On December 27, 2017, the New York Department of Financial Services (NYDFS) issued amendments to its proposed Suitability in Life Insurance and Annuity Transactions regulation. The revisions seek to broaden the scope of the rule to apply to life insurance policies as well as in-force policies, expand the information required for suitability analysis, create a best interest standard, and expand disclosures to the consumer, among other requirements. The NYDFS is considering the public comments submitted.

All this state activity leaves the crowd wondering what lies over the horizon.

## Enforcement of DOL's New Best Interest Contract Exemption's Anti-Arbitration Condition is Enjoined

BY BRIAN PERRYMAN

A number of lawsuits have been brought challenging aspects of the United States Department of Labor's "fiduciary rule," which expanded the definition of "fiduciary" of an employee benefit plan or individual retirement account as a result of giving investment advice for compensation to retirement investors. To provide relief from portions of the fiduciary rule, the Department promulgated several regulatory exemptions that would permit qualifying entities to receive certain forms of compensation and engage in otherwise prohibited transactions. One such exemption is the "Best Interest Contract Exemption." To qualify for that Exemption, affected financial institutions and professionals must agree to a number of conditions. These conditions must be contained in a contract between the financial institution and the retirement investor. While these contracts may include individual arbitration agreements, the Exemption is unavailable for contracts that waive or qualify the investor's right to bring or participate in a class action or other representative action in court.

Most recently, via a March 2018 ruling, the United States Court of Appeal for the Fifth Circuit vacated the Department's entire rulemaking package, including the Best Interest Contract Exemption. In a separate lawsuit in the United States District Court for the District of Minnesota, however, Thrivent Financial for Lutherans, had challenged the Exemption's anti-arbitration condition. Thrivent has long required that disputes with its members related to its insurance products be resolved through its "Member Dispute Resolution Program." The Program provides for a multi-tiered dispute resolution process, escalating eventually (if necessary) to binding arbitration. All arbitration must be individual in nature; representative or class claims, arbitral or judicial, are barred. Thrivent contended that its commitment to individual arbitration was important to its membership because it reflects Thrivent's "Christian Common Bond." Asserting that it could not currently comply with the Exemption's requirements, Thrivent brought a suit under the Administrative Procedure Act. Thrivent argued that the Exemption's requirement contravenes the Federal Arbitration Act, which reflects a federal policy favoring arbitral dispute resolution.

The Minnesota court granted Thrivent's motion for preliminary injunction in a November 2017 order. The Department conceded that the Exemption's anti-arbitration condition violates the Federal Arbitration Act. Further, Thrivent sufficiently demonstrated the threat of irreparable harm. Notwithstanding the Department's efforts to extend the Exemption's applicability date, regulated entities like Thrivent would likely incur undue expense to comply with conditions or requirements that the Department ultimately determines to revise or repeal. Given the Department's reassessment of the Exemption, the court also stayed the action indefinitely pending the outcome of the ongoing regulatory process. The court, however, denied the parties' cross-motions for summary judgment – the Department had withdrawn its own motion and Thrivent's motion was denied without prejudice to its later refiling, if needed. Of course, it remains to be seen where this litigation might head given the Fifth Circuit's vacatur of the entire rulemaking package.

## Insurers Keep Providing Corporate Governance Disclosures Without Complaint—Yet

BY ROBERT SHAPIRO

Following the financial crisis, the NAIC undertook a solvency modernization initiative (SMI) to update insurance regulators on insurance companies' regulatory frameworks. One part of the SMI, meant to keep regulators informed on insurers' financial conditions, involves the insurance companies' corporate governance and risk management.

The NAIC defines corporate governance "as structures, policies and processes through which an organization or entity is managed and controlled." The NAIC passed model acts first requiring insurers to file annually an enterprise risk management (ERM) report and an own risk and solvency assessment (ORSA) report. However, those model acts deal more with the insurer's exposure to risks from external factors. So, the NAIC, which was determined to never face the financial issues banks faced in 2008, enacted the Corporate Governance Annual Disclosure Model Act (CGAD) and supporting model regulation, both of which took effect January 1, 2016.

Information required in a CGAD report includes the rationale for the board size and structure; the duties of the board and its significant committees; how the insurer is governed

(e.g., bylaws or a charter); board leadership structure; and the defined roles and responsibilities of the chairman of the board and CEO. The CGAD is intended to give insurance regulators a way to assess the filing insurer's governance structure as well as provide a report on the insurer's practices and policies regarding governance. Unlike the ERM and ORSA filings, the CGAD has no exemption based on size. Both small companies and fraternal insurers are subject to the CGAD filing requirements. The CGAD must be filed annually by June 1.

So far, 19 states have enacted the model act or something very close. However, since the CGAD will likely be included in the NAIC financial standards accreditation program effective January 1, 2020, all states will have to enact the CGAD and the supporting regulation or a similar version before 2020.

The information in the reports required by the model act is to be kept confidential and may be made at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level according to the insurer's governance framework. Moreover, no specific form or format need be used to provide the required information.

So far, reporting insurers have had no major complaints. However, that could change quickly if enacting states don't maintain confidential treatment of the information or if some states start dictating the format reports must take.

# Another Bout in the NAIC Best Interest Standard Title Fight

BY ANN BLACK, JAMIE BIGAYER & ADRIANA PEREZ

In response to the National Association of Insurance Commissioners' (NAIC) Annuity Suitability Working Group's (Suitability WG) proposed revisions to the "*Suitability and Best Interest Standard of Conduct in Annuity Transactions Model Regulation*" (Model), 23 comment letters were submitted by regulators, consumer groups, industry groups, and companies (the Contenders). Several rounds of sparring are likely at the NAIC's Spring National Meeting in March, with the following points of contention:

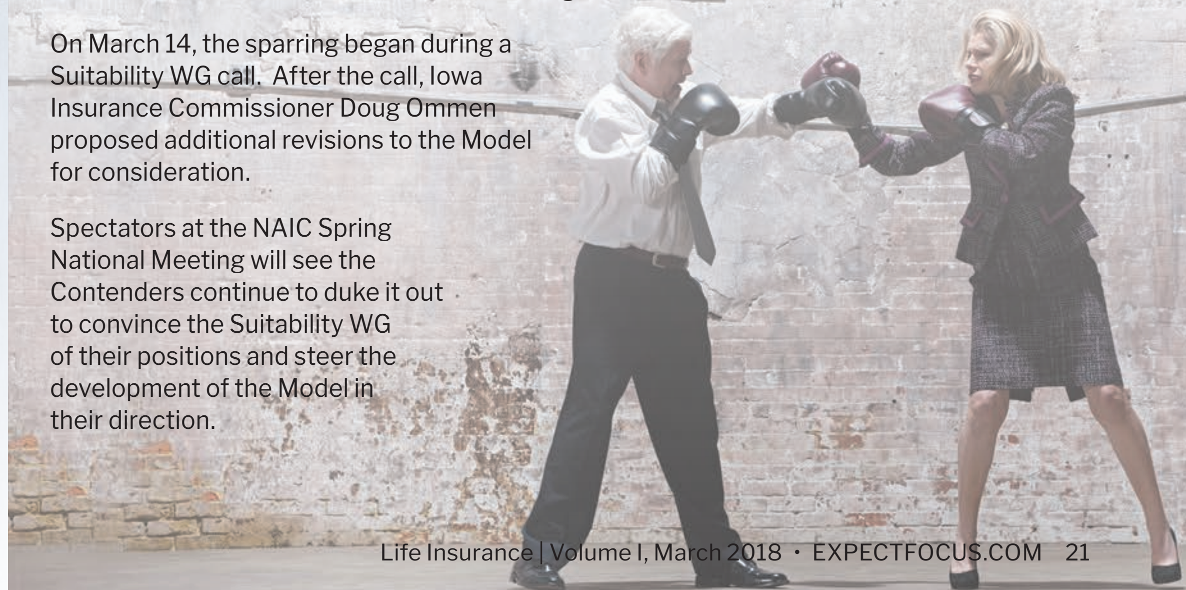
**Scope of Model**: The first round will be a no holds barred fight over the appropriate scope of the Model. Regulators and consumer groups argue the Model should also cover life insurance products that are "marketed based on features … virtually indistinguishable from the features of annuities." Industry jabbed back that any regulation needs to recognize life insurance and annuities are fundamentally different. The Contenders will also square-off on the activities to be covered by the Model. Industry only wants the Model to cover recommendations made at the point of sale, not solicitations, negotiations, and other product transactions (such as subsequent deposits) after a product is issued. Regulators and consumer groups counterpunched that the Model's scope is too narrow and should specifically cover recommendations and transactions under in-force policies.

**What is Best Interest?** In the second round, the Contenders will trade punches over the meaning of "Best Interest." Industry contends Best Interest does not require a recommendation of the: (i) least expensive annuity product, (ii) annuity product with the highest stated interest rate or income payout rate, or (ii) single "best" annuity product available in the marketplace at the time of the transaction. Consumer groups and regulators counterattacked that the Model should require a recommendation be "the best of the available options for the consumer, taking into account costs, performance, liquidity, and other relevant product features, as well as the customer's particular circumstances."

**Compensation Disclosure**: The Contenders will also shadowbox on producer compensation disclosure. While all the Contenders agree the Model's requirement to disclose cash compensation above 3 percent and non-cash compensation above $100 is arbitrary, they disagree on the required disclosure. Industry asserts non-cash compensation disclosure should "be triggered only when the producer's receipt of the non-cash compensation is related to the producer's recommendation of the particular annuity." Regulators swung back, recommending disclosure of all non-cash compensation regardless of whether it is tied to a sale, including "bonuses, contests, special awards, differential compensation, and other incentives won or received as a result of having sold a threshold dollar amount of annuities."

On March 14, the sparring began during a Suitability WG call. After the call, Iowa Insurance Commissioner Doug Ommen proposed additional revisions to the Model for consideration.

Spectators at the NAIC Spring National Meeting will see the Contenders continue to duke it out to convince the Suitability WG of their positions and steer the development of the Model in their direction.



## NAIC Disclosure Developments

BY TOM LAUERMAN & ANN BLACK

**Annuity Illustration Standard Changes:** On March 2, the Annuity Disclosure (A) Working Group of the National Association of Insurance Commissioners agreed to recommend the adoption of a revision to the NAIC's Annuity Disclosure Model Regulation illustration standards. Currently, the Disclosure Model limits non-guaranteed elements underlying non-guaranteed illustrated values to be no more favorable than current non-guaranteed elements and prohibits assumed future improvements of any non-guaranteed element. The revision will allow the dividends assumed to be paid under certain participating annuities to be calculated using historic levels of interest rates rather than using currently prevailing interest rates. Under today's interest rate environment, this would allow insurers to illustrate higher dividend rates for the participating annuities. The next step is adoption of the revisions by the Life Insurance and Annuities (A) Committee.

While the Disclosure WG has also been considering changes that will allow for illustration of certain indices that have existed for less than 10 years, there was insufficient support for revising the Disclosure Model. Absent revision, the Disclosure Model prohibits illustrating interest credited based on an index that has not existed for at least 10 years. The American Council of Life Insurance, which developed criteria for recently developed indices, is trying to develop a modified proposal for consideration.

**Life Insurance Buyer's Guide:** The NAIC Life Insurance Buyer's Guide (A) Working Group seems to be nearing consensus on non-controversial revisions to the current Life Insurance Buyer's Guide that is required under the NAIC's Life Insurance Disclosure Model Regulation. Of potential controversy is the Buyer's Guide WG's intention to develop a detailed interactive web-based tool to assist consumers in assessing their needs and selecting the type of life insurance product that would satisfy such needs. The tool would lead consumers through an in-depth review of their individual objectives, preferences, financial circumstances, etc. The Buyer's Guide WG, however, must first seek to change its charges to include such a project.

**Life Insurance Policy Overview:** The NAIC Life Insurance Illustration Issues (A) Working Group continues its work to improve disclosures to life insurance purchasers. It seeks to supplement the disclosures contained in the narrative summary required under the NAIC's Life Insurance Illustrations Model Regulation and is looking at potential amendments to the Illustration Model and the Life Insurance Disclosure Model Regulation to include a new policy overview as well as drafting proposed template disclosures. It has already developed a template for term insurance and is beginning work on a whole life template.

## NEWS & NOTES

**Carlton Fields** is a sponsor of the Insured Retirement Institute's ACTION 18 Conference, a new IRI conference that combines the Government, Legal & Regulatory Conference (GLRC) and Operations & Technology Conference (OTC). The conference will take place May 9-11, in Washington, D.C., and will include Carlton Fields attorneys on the faculty.

**Carlton Fields** is a sponsor of the Global Insurance Symposium, which takes place on April 24-26 in Des Moines, Iowa. The symposium will give industry professionals the opportunity to hear and discuss unique insights on cutting-edge ideas and challenges facing traditional insurance companies, insurtech, startups, and industry professionals

**Ed Zaharewicz** (Miami) spoke on the emergence of blockchain technology and its impact on the insurance industry at the ACLI Financial & Investment Roundtable, which took place March 18-21 in Sea Island, Georgia.

**Richard D. Euliss** (D.C.) spoke on navigating IRS challenges to micro captive insurers at the American Bar Association which took place February 9 in San Diego, California. He will also speak on the current state of the law concerning the IRS's tax enforcement efforts against small captive insurers and captive managers at the Delaware Captive Insurers Association's Spring Forum on May 14-15 in Rehoboth, Deleware.

**Carlton Fields** Tallahassee attorney **Matthew Z. Leopold** became General Counsel of the Environmental Protection Agency (EPA) on December 14, 2017. He will serve as the highest ranking lawyer and chief legal advisor to the EPA, the federal agency with primary responsibility for implementing the nation's environmental laws.

**Carlton Fields** has launched CyberAPP, a free cyber incident response mobile application. With resources like incident response checklists and a compendium of state breach notification laws, CyberAPP gives businesses the readily-accessible guidance they need to protect themselves against increasingly advanced cyber threats.

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