

North Dakota Insurance Department
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Commissioner Hamm's presentation



North Dakota
INSURANCE
DEPARTMENT
PROTECTING THE PUBLIC GOOD
ADAM HAMM, COMMISSIONER

Essential Health Benefits

Background and Potential Decision Implications

Background

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (PPACA) charges the Secretary of the U.S. Department of Health and Human Services (HHS) with defining Essential Health Benefits (EHB), and instructs the Secretary to ensure that they are equal to the scope of benefits provided under a typical employer plan, supplemented as necessary to ensure that plans cover each of the 10 statutory categories of EHB. It requires all non-grandfathered health insurance plans offered in the small group and individual markets to cover all EHB by January 1, 2014. The EHB package must be included in plans inside and outside of the Exchange.

HHS has defined the requirements of an EHB benchmark package and then in a Bulletin issued on December 16, 2011 (and other non-regulatory guidance) described the method for states to “choose” an EHB package. However, no formal EHB rule has been released and as of today we do not know when the final rule will be issued or what type of specific information it will include. In other words, North Dakota and all of the other states are expected to make an extremely important EHB “choice,” affecting almost all of our consumers and businesses, as well as providers, without knowing the rules of the game.

Making the “Choice”

The current information provided to states lays out the following process:

1. The state determines the potential benchmark plans from the following four options given by HHS (as they existed on March 31, 2012):

- a. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market (as suggested by HHS);
 - b. Any of the largest three state employee health benefit plans by enrollment;
 - c. Any of the largest three national FEHBP plan options by enrollment; or
 - d. The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.
2. The State selects one of the benchmark health plans by October 1, 2012.
 3. The Secretary will review (and predictably modify) the choice to determine if the plan:
 - a. Meets the requirement for coverage in ten broad categories of health benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
 - b. Reflects typical employer health benefit plans and reflects balance among the categories;
 - c. Accounts for diverse health needs across many populations;
 - d. Ensures there are no incentives for coverage decisions, cost sharing or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life;
 - e. Ensures compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
 - f. Provides states a role in defining EHB; and
 - g. Balances comprehensiveness and affordability for those purchasing coverage.

4. Should a state not choose a benchmark plan, the default benchmark plan would be the small group plan with the largest enrollment in the state.
5. The chosen plan would be the benchmark for the years 2014 and 2015. HHS intends to review and update EHB for 2016 and beyond.

Plan Benefits

The benefits covered in the chosen plan become the EHB package for that state, subject to the addition of any missing categories. For example, most health insurance plans do not include pediatric dental services which are a required category of EHB. Limits in the scope and duration of benefits in the benchmark plan are incorporated in EHB requirements. However, there can be no dollar value limits on EHB benefits. If an insurer wants to substitute a service for an EHB required category of benefits, the substitution must be actuarially equivalent.

In designating a benchmark, the state is designating that benchmark plan's benefit package as the minimum benefit package required for all non-grandfathered small group and individual plans sold in North Dakota (i.e. mandates). If the designated benchmark plan does not include benefits in all ten required EHB categories, the state must supplement the benchmark plan by selecting missing benefits from other benchmark options or from the state's Children's Health Insurance Program (CHIP). States may only supplement benefits that are not covered in the benchmark or the state must pay for any added mandates.

Potential Decision Implications

States may choose any plan in the benchmark options. Some of these plans are considered more basic in the coverage of benefits and others richer. All of the North Dakota benchmark choice plans will require additional benefits to be added to them to meet the ten required

categories and all must be modified to take out the dollar limits on the existing benefits.

Specific coverage that is included in specific plans may cause a plan to be more or less expensive as it relates to the premium cost of that particular coverage, i.e., coverage for certain fertility benefits with no dollar limitations is a more expensive benefit to add to plans than certain laboratory services without dollar limitations.

Given that all non-grandfathered small group and individual plans must include the EHB benefits after 2014, this set of benefits is often thought of as a floor. Insurers may add to those benefits in any way they like (and price the products accordingly), but they may not take benefits away.

The impacts of choosing a more basic plan versus a rich plan are various and include potential premium pricing increases, premium value as it compares to the necessity of specific coverage, market disruption, insurer competition, network adequacy and provider payments.

Choosing a richer plan, especially given no dollar limitations, will most likely cause most existing insurers to request higher premium rate increases due to the additional benefits likely to be paid. Affordability becomes a serious concern for policyholders.

Some policy holders may want to know most benefits are covered by their plans, thereby wanting a rich plan. Choosing a richer plan may force employers and individuals to purchase insurance they do not want or need.

Choosing a more basic plan in a state like North Dakota where most of the existing small group and individual plans have traditionally been fairly rich may possibly cause market disruption. Small employers may terminate previous, richer plans especially if the more basic plans cost

less. This may leave employees with far fewer benefits than previously or without an employer-sponsored plan at all.

A perceived positive impact of choosing a more basic plan is that it would allow insurers to design plans in a unique way to compete against other insurers by adding select benefits that distinguish one plan from another. This would also allow for better variation when employers and individuals shop for insurance whether inside or outside of the Exchange.

Certain areas of the state may not have adequate provider networks for all benefits in a rich plan. Just because the benefit is covered doesn't mean every policyholder will be able to take advantage of that coverage easily.

Lastly, providers are likely to want more benefits covered instead of fewer because insurance is a better payer than an individual who has to pay for his/her own services, Medicaid or Medicare.

Actuarial consultant's analysis and a weighing in by the North Dakota Legislature's Health Care Reform Committee

Earlier this year, the State of North Dakota engaged an actuarial consulting firm to review the benchmark options outlined by HHS and to assist North Dakota in its "choice" of a benchmark plan.

The scope of work for the consultants was to:

1. Review all benchmark choices for North Dakota using the Bulletin from HHS, including the type and level of benefits, the number of policies issued and lives covered.
2. Compare the benchmark choices to the HHS ten specified areas to determine the extent to which they provide coverage of the EHB package as defined in PPACA and subsequent guidance and summarize

the benefits that would have to be added to the potential EHB benchmark to be inclusive of the ten statutory categories.

3. Discuss the specific impact of any of the ten coverage areas that are not included in most North Dakota plans (i.e. habilitative services, pediatric vision and dental).

4. Estimate the potential premium rate impact of adding currently noncovered benefits that will be required taking into account, among other things, the cost-sharing provisions associated with each benchmark plan.

5. Consider the cost to the state of a potential EHB benchmark plan that does not include North Dakota mandated benefits.

6. Consider the capacity of both individual and group health plans in their ability to provide the potential EHB benchmark plan. Capacity could be assessed by considering:

i) Network adequacy in terms of the ability of plans to deliver the EHBs.

ii) Whether the EHB package is too rich for plan sustainability and premium affordability in the North Dakota marketplace.

7. Consider the impact, if any, of individuals moving to and from Medicaid.

8. Note any specific issues related to existing North Dakota state mandates.

9. Note any issues where federal guidance is unclear and may impact the final decision.

10. Analyze whether the State should consider some other definition of the EHB package in North Dakota for plan years 2014 and 2015.

11. Would it be more or less beneficial in terms of premium costs to have stand-alone dental plans offered through the Exchange?

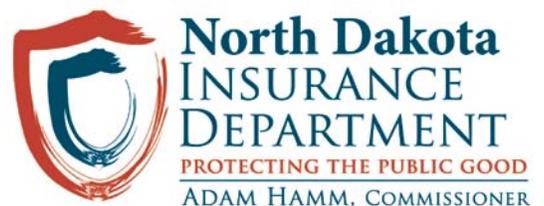
On September 6th, the consultants appeared before the North Dakota Legislature's Health Care Reform Committee and testified on their report (as well as testimony from me at that same committee meeting and three other meetings in 2012 that covered the points discussed here today).

At the conclusion of that legislative committee meeting, the legislators on the committee took a vote regarding which of the ten benchmark options North Dakota should “choose.” The legislators overwhelmingly voted for the most basic plan of the ten benchmark options (Sanford plan).

As a result of that legislative meeting, North Dakota conveyed to HHS last week that the benchmark option “selected” by our state is the Sanford plan. HHS will now review (and predictably modify) that “choice” (HHS’s additional work is described in #3 in the “making the choice” section on page 2 of this document).

So, that’s the update on EHB. Regarding the rest of PPACA, a refresher of what’s to come is in order (election on November 6th could obviously influence this).

Health Care Reform Timeline 2010–2018



2010

Issue	What law will do	Effective date
Health insurance consumer assistance offices and ombudsmen	<p>States may establish and operate offices of health insurance consumer assistance or health insurance ombudsman programs to:</p> <ul style="list-style-type: none"> • Assist with the filing of complaints and appeals • Collect, track and quantify problems and inquiries • Educate consumers on their rights and responsibilities • Assist consumers with enrollment in plans • Resolve problems with obtaining subsidies <p>States may be required to collect and report data of all the types of problems and inquiries encountered by consumers.¹</p>	Effective as of date of enactment (3/23/2010)
Preservation of right to maintain existing coverage	<p>The following provisions will apply to grandfathered plans:</p> <ul style="list-style-type: none"> • Excessive waiting periods • Lifetime limits only • Rescissions • Extension of dependent coverage • Uniform summary of benefits and coverage and standardized definitions • Medical loss ratios¹ 	Effective as of date of enactment (3/23/2010)
\$250 Medicare Part D rebate	A \$250 rebate will be available to seniors reaching the Medicare Part D donut hole. ¹	June 2010
Temporary high-risk pool program	<p>The Secretary of Health and Human Services (HHS) is required to establish a temporary high-risk health insurance pool program to provide coverage to individuals with preexisting conditions who have been without coverage for at least six months.</p> <p>Pools must:</p> <ul style="list-style-type: none"> • Have no preexisting condition exclusions • Cover at least 65% of total allowed costs • Have an out-of-pocket limit no greater than the limit for high deductible health plans (\$5,950 for individuals and \$11,900 for families) • Utilize adjusted community rating with maximum variation for age of 4:1 • Have premiums established at a standard rate for a standard population <p>The state's current high risk pool, the Comprehensive Health Association of North Dakota (CHAND), does not meet the requirements.¹</p>	Effective 90 days after enactment (June 23, 2010)

Issue	What law will do	Effective date
Temporary reinsurance program for early retirees	The Secretary of HHS shall establish a temporary reinsurance program to reimburse employment-based plans for 80% of costs incurred by early retirees age 55 and over but not eligible for Medicare between \$15,000 and \$90,000 annually. ¹	Effective 90 days after enactment (June 23, 2010)
Web portal to identify affordable coverage options	The Secretary of HHS shall establish a mechanism, including a website through which individuals and small businesses may identify affordable health insurance coverage. ¹	07/01/ 2010
Annual and lifetime limits	Plans may not establish lifetime limits on the dollar value of essential benefits. Plans may only establish restricted limits prior to Jan. 1, 2014 on essential benefits. ¹	09/23/2010
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions-effective six months after enactment for under age 19. ¹	Effective Sept. 23, 2010 for individuals 19 and under. Effective Jan. 1, 2014 for all others.
Rescissions	Insurers cannot rescind coverage after a sickness. Coverage may be rescinded only for fraud or intentional misrepresentation of material fact. ¹	09/23/2010
Coverage of preventative health services	<p>Plans must provide coverage without cost-sharing for:</p> <ul style="list-style-type: none"> • Services recommended by the U.S. Preventive Services Task Force • Immunizations recommended by the Advisory Committee on enactment Immunization Practices of the Centers for Disease Control • Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration • Preventive care and screenings for women supported by the Health Resources and Services Administration <p>Current recommendations from the US Preventive Services Task force for breast cancer screenings will not be considered.¹</p>	09/23/2010
Extension of adult dependent coverage	Plans that provide dependent coverage must extend coverage to adult children up to age 26. ¹	09/23/2010
Provision of additional information	<p>All plans must submit to the Secretary of Health and Human Services (HHS) and state insurance commissioners and make available to the public the following information in plain language:</p> <ul style="list-style-type: none"> • Claims payment policies and practices • Periodic financial disclosures • Data on enrollment • Data on disenrollment • Data on the number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage¹ 	09/23/2010

Issue	What law will do	Effective date
Appeals process	<p>Internal claims appeal process:</p> <ul style="list-style-type: none"> • Group plans must incorporate the Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. • Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS. <p>External review:</p> <ul style="list-style-type: none"> • All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Uniform External Review Model Act (Model 76) with minimum standards established by the Secretary of HHS that is similar to the NAIC model.¹ 	09/23/2010
Patient protections	<p>A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians.</p> <p>If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider.</p> <p>A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider.¹</p>	09/23/2010
Ensuring that consumers get value for their dollars	<p>The Secretary of HHS, in conjunction with the states, shall develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the State and the Secretary a justification for an unreasonable premium increase and post it online.</p> <p>The Secretary shall award \$250 million in grants to states over a 5-year period to assist rate review activities, including reviewing rates, providing information and recommendations to the Secretary, and establishing Medical Reimbursement Data Centers to develop database tools that fairly and accurately reflect market rates for medical services. Amounts of grants to states are to be determined by the Secretary.</p>	Effective 2010 plan year
Small business tax credit	Available to small businesses offering coverage to employees ¹	Tax credits of up to 35 percent of the cost of premiums will be available in 2010 and will reach 50 percent in 2014.

2010 (continued)

2011

Issue	What law will do	Effective date
Loss ratio	Medical loss ratios of 80 and 85 percent, respectively, are required for individual/small group and large group plans. Loss ratio is the fraction of revenue from a plan's premiums that goes to pay for medical services. ²	01/01/2011
Bringing down the cost of health care	Carriers must report to the Secretary of HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums. Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets. All hospitals must establish and make public a list of its standard charges for items and services, including for diagnosis-related groups. ¹	01/01/2011
Long-term care	A voluntary long-term care program will begin, financed through payroll deductions. ²	01/01/2011
Study of large group market	The Secretary of HHS shall conduct a study of self-insured and fully-insured plans to compare the characteristics of employers, plan benefits, plan reserves and solvency and determine the extent to which the bill's market reforms will cause adverse selection in the large group market and prompt small and mid-size employers to self insure. ¹	Due no later than one year after enactment (3/23/2011)
GAO study regarding the rate of denial of coverage and enrollment by health insurance and group health plans	The GAO shall conduct a study of the incidence of denials of coverage for medical services and denials of application to enroll in health insurance plans by group health plans and health insurance issuers. ¹	One year after enactment (3/23/2011)

2012

Issue	What law will do	Effective date
Ensuring quality of care	<p>Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan:</p> <ul style="list-style-type: none"> • Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management • Implement activities to prevent hospital readmission • Implement activities to improve patient safety and reduce medical errors <p>Implement wellness and health promotion activities¹</p>	2 years after enactment (3/23/2012)
Uniform explanation of coverage documents and standardized definitions	The Secretary must develop standards for a summary of benefits and coverage explanation to be provided to all potential policyholders and enrollees. ¹	Standards must be developed by March 2011; implementation by March 2012

2013

Issue	What law will do	Effective date
Health benefit exchange	The Secretary of HHS must determine by Jan. 1, 2013 whether states intend to operate qualified exchanges.	01/01/ 2013
Administrative simplification requirements	The Secretary of HHS will develop operating rules for the electronic exchange of health information, transaction standards for electronic funds transfers and requirements for financial and administrative transactions. ¹	Rules adopted by July 1, 2011 to become effective by January 1, 2013
Employer requirement to inform employees of coverage option	Employers must provide employees with written notice at the time of hiring informing them of the existence of the Exchange and the availability of subsidies through the Exchange if the plan covers less than 60% of the cost of covered benefits. ¹	03/01/2013

2014

Issue	What law will do	Effective date
Health benefit exchange	<p>The Secretary of HHS must determine by Jan. 1, 2013 whether states intend to operate qualified exchanges. If a state does not create a qualified exchange, the Secretary must create one.</p> <p>Some functions to be performed by an exchange include:</p> <ul style="list-style-type: none"> • Certify qualified plans to be sold in the exchange • Maintain a website • Provide for initial, annual and special open enrollment periods • Maintain a toll-free number • Create a rating system for plans and perform satisfaction survey • Provide a calculator to determine enrollee premiums and subsidies • Identify those individuals exempt from the individual mandate and notify treasury • Require participating plans to provide justification for rate increases¹ 	Exchanges must be operational by Jan. 1, 2014.
Free choice vouchers	Employers must provide a voucher in the amount of the employer's contribution towards the group health plan to each employee whose household income is below 400% FPL if the employees' cost of coverage under the group health plan is between 8% and 9.8% of household income and the employee does not enroll in the employer's group health plan. Employees may use these vouchers to purchase coverage through the Exchange. ¹	01/01/2014
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions on anyone. ¹	01/01/2014
Requirement to maintain minimum essential coverage	U.S. citizens and legal residents are required to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: \$95 in 2014, \$325 in 2015, and \$695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016.	01/01/2014

	Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples). ³	
Issue	What law will do	Effective date
Guaranteed issue and renewability in all markets	The law requires guaranteed issue and renewability and allows rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the exchanges. ³	Plan years beginning 01/01/2014
Employers must offer coverage	Imposes a mandate on employers with 50+ workers: offer coverage by 2014 or pay \$2,000/full time worker (excluding the first 30); if offer unaffordable coverage, pay \$3,000/employee receiving taxpayer assistance to buy it or a total of \$2,000/employee, whichever is more. Employers of 50 or fewer workers are exempt. ²	01/01/2014
Guaranteed availability of coverage	Insurers must accept every employer and every individual that applies for coverage except that: an insurer may restrict enrollment based upon open or special enrollment periods. ¹	Plan years beginning 01/01/2014
Prohibiting discrimination against individual participants and beneficiaries based on health status	A plan may not establish rules for eligibility based on any of the following health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, generic information, evidence of insurability (including conditions arising out of domestic violence), disability, any other health-status related factor deemed appropriate by the Secretary. ¹	Plan years beginning 01/01/2014
Non-discrimination in health care	Plans may not discriminate against any provider operating within their scope of practice. Does not require that a plan contract with any willing provider or prevent tiered networks. ¹	Plan years beginning 01/01/2014
Comprehensive health insurance coverage	All plans must include the essential benefits package required of plans sold in the Exchanges and must comply with limitations on annual cost-sharing for plans sold in the Exchanges. ¹	Plan years beginning 01/01/2014
Prohibition on excessive waiting periods	Group health plans and group health insurance may not impose waiting periods that exceed 90 days. ¹	Plan years beginning 01/01/2014
Coverage for individuals participating in approved clinical trials	A plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial. ¹	Plan years beginning 01/01/2014
Rating reforms must apply uniformly to all health insurance issuers and group health plans	Any standard or requirement adopted by a State must be applied uniformly to all health plans in each market to which the standards or requirements apply. ¹	Plan years beginning 01/01/2014

2014 (continued)

2016

Issue	What law will do	Effective date
Provisions relating to offering of plans in more than one state	Two or more states may enter into a “health care choice compact” under which individual market plans could be offered in all compacting states, subject to the laws and regulations of the state where it was written or issued. Plans must be licensed in each state in which they sell coverage or must submit to the jurisdiction of the states with regard to the above laws. ¹	01/01/2016

2017

Issue	What law will do	Effective date
Waiver for State Innovation	<p>A state may apply for waivers of the following requirements:</p> <ul style="list-style-type: none"> • Requirements for Qualified Health Benefits Plans • Requirements for Health Insurance Exchanges • Requirements for reduced cost-sharing in qualified health benefits plans • Requirements for premium subsidies • Requirements for the employer mandate • Requirements for the individuals mandate <p>The state will receive funds for implementing the waiver equal to any subsidies or tax credits for which residents would otherwise receive if the state had not received a waiver.¹</p>	Plan years beginning 01/01/ 2017

2018

Issue	What law will do	Effective date
Tax on "Cadillac" plans	Imposes new taxes on so-called "Cadillac" health insurance policies; ² 40% tax on health insurance plans worth more than \$27,500 for a family plan, \$10,200 for an individual plan (family coverage now averages \$13,375) ³	01/01/2018

Sources:

- 1 National Association of Insurance Commissioners
- 2 National Conference of Insurance Legislators
- 3 Kaiser Health News

Exchange Issue

Regarding the entire issue of Exchanges, I'm sure a lot of folks in the room have heard my position. For those that haven't, here it is: because of all the fiscal, regulatory and political uncertainty that surrounded the Exchange issue in November 2011, I agreed with the North Dakota Legislature's decision during the special legislative session not to build and run a PPACA compliant Exchange.

Fast forward ten months and all that uncertainty still exists. Fiscal uncertainty still exists as it is unclear whether the Exchanges will be able to pay for themselves or will become a money pit for states. Regulatory uncertainty still exists as all the rules and regulations regarding how the Exchanges must be run have not been set by the federal government. Political uncertainty still exists as PPACA may not survive depending on the results of the November elections. As such, my opinion has not changed that the North Dakota Legislature made the right decision not to build and run a PPACA compliant Exchange (as of September 14, 2012, only 14 states have decided to build and run a state Exchange).

Further, and based on what we know now, even if the law survives after the results of the November elections, there is so much fiscal uncertainty regarding the Exchanges that the best course of action would be to make

the federal government prove that they can make the Exchanges work. Let them prove to us and to other states that Exchanges can work financially. If they can prove that, North Dakota could, if it wanted to, take over the Exchange operations.

NAIC's Health Care Reform Regulatory Alternatives Working Group

At the NAIC's summer national meeting, the NAIC's Executive Committee voted to create a new Health Care Reform Regulatory Alternatives Working Group, which North Dakota and 23 other states have joined so far. The working group's charges are to:

1. Provide a forum for discussion of and guidance on the alternatives to implementing a state-based Exchange and the implications of such alternatives on state regulatory authority;
2. Identify and assist states in resolving open issues that need to be addressed with regard to non-state Exchange alternatives;

3. Analyze the impact of PPACA on existing state regulatory authority both inside and outside of a federal Exchange as well as the impact on NAIC Model Laws (Unfair Insurance Practices Act, Producer Licensing Model Act, Model Law on Examinations, etc.); and
4. Identify opportunities for states to continue to innovate and regulate outside of a federal Exchange.

FEDERAL INSURANCE OFFICE (FIO) UPDATE

- The states and the NAIC continue to engage frequently with the FIO Director (former Illinois Insurance Commissioner Mike McCraith) as this office in the Treasury Department continues to take shape.
 - Created under Dodd-Frank, FIO's scope covers all lines of insurance except health, long term care and crop insurance.
 - Under the law, FIO is **not** a regulator but has a number of other functions, including acting as a “monitor” to identify perceived issues or gaps in the regulation of insurers that could contribute to “A systemic crisis in the insurance industry or the United States Financial System.”
 - FIO also has a role as a federal voice on international matters (i.e. coordinating federal efforts and developing federal policy on international insurance matters). The hope is that its voice will be a constructive addition to the voice of the state regulators and the NAIC in those discussions.
- FIO also has authority to subpoena information from insurers (data collection).
 - Under Dodd-Frank, FIO is required to consult with insurance regulators and seek such information from regulatory and public sources prior to exercising such authority.
 - Legislation has been introduced in the House (H.R. 3559) by Representative Stivers (OH) seeking to limit such authority.

The states position is that it is critical that FIO seek out information from the NAIC and state regulators first to adhere to the law and to avoid any unnecessary duplication.

- Dodd-Frank required FIO to issue a report on insurance regulation by mid-January--it has still not been released.
 - The states and the NAIC are concerned that FIO's report will contain a bias against the state based regulatory system.
 - The statutory provision in Dodd-Frank requiring the FIO to write the report, added by the proponents of an optional federal charter, requires FIO to examine the feasibility of the federal regulation of insurance.
 - It is also worth noting that the report is being written by a new federal office that could clearly have an incentive to empower itself.
 - The states and the NAIC look forward to reviewing the report once it is finally released and hope the final product contains a balanced view of the insurance regulatory system.
- Going back to the third sub-bullet on the first page of this FIO update, the states/NAIC and FIO have just had our first substantial disagreement. The President of the NAIC (Kevin McCarty-Florida Insurance Commissioner) and FIO (Mike McCraith) both submitted their names to be chair of the Technical Committee of the International Association of Insurance Supervisors (IAIS). The IAIS is the global version of the NAIC, and the Technical Committee is the

major IAIS committee—it establishes global insurance regulatory and supervisory standards.

- Mike and Kevin were the only two running for this chairmanship. The contested election was unprecedented at the IAIS and was awkward to put it mildly given that it was two Americans running against each other (one federal-one state). Additionally, Mike ran against Kevin despite never previously being on the Technical Committee. In contrast, Kevin has been a member of the Technical Committee for 3 years and is universally recognized as an expert on these issues and a strong voice for America.
- A document was drafted and sent to every IAIS member who voted in the Technical Committee election on September 21, 2012, fully explaining America's system and FIO's role in it. The document was necessary because we were hearing from numerous sources that FIO was telling countries a different story as it was lobbying for weeks for votes. The relevant part of the document states:

“Finally, in the context of my candidacy, it has become clear that there is some confusion about the role of the NAIC and state regulators relative to the Federal Insurance Office in international matters going forward. Our national system of state-based regulation in the U.S. is unique, so let me take this opportunity to clarify what the law says and the appropriate roles of the various parties.

While the Dodd-Frank Act created the Federal Insurance Office with certain responsibilities, U.S. insurance regulation continues to be predominantly state-based. Except for narrow circumstances under which a state is found to be discriminating against a foreign insurer – and a covered agreement can be used to address the situation -- the Federal Insurance Office's role consists largely of monitoring and

advising. The Federal Insurance Office is tasked with establishing federal policy on certain insurance matters, but outside of the narrow circumstances I've just described, that policy has no binding power over the states and cannot compel them to adopt or implement regulatory policy. More specifically, any changes in regulation will depend on state legislatures and/or regulators taking action, and the NAIC will continue to be the organization that sets national standards through its Accreditation Committee. As FIO does not speak for the U.S. insurance regulators, this distinction is noteworthy. While we expect to coordinate with the FIO Director, it is important to understand that any implementation of international standards remains the purview of the states and the NAIC."

- Mike McRaith strongly disagreed with the document and told the IAIS members during the discussion just prior to them voting that the document was wrong and that it was not worth responding to.
- Unfortunately, FIO then won the election to become Chair of the Technical Committee.

*** So, here is the bottom line: 1) it is now apparent that FIO and the Treasury Department have a far more expansive interpretation of Dodd-Frank than the state regulators and the NAIC; 2) if FIO/Treasury Department is expanding its footprint globally, it's not a stretch to believe that they will attempt to do so domestically; and 3) we all need to be extra vigilant in the coming months to be prepared to preserve and protect the state based system of insurance regulation.

Principles-Based Reserving in Life Insurance

- The NAIC's Life Insurance (A) Committee adopted the revisions to its Valuation Manual on a conference call on August 17, 2012. This manual provides for a principles-based approach for valuing life insurance reserves. It is expected that a call will be scheduled in the next few weeks so that the Valuation Manual may be considered by the NAIC's Executive Committee and all the nation's Insurance Commissioners. Assuming that the Valuation Manual is adopted by the NAIC membership (42 members, or three-fourths of the members voting, whichever is greater), it will then start being put in front of state legislatures beginning next year (including in North Dakota).
- This action is another important step in the NAIC's development of a principles-based reserving methodology. In 2009, the NAIC amended its Standard Valuation Law to enable a principle-based approach to valuation for life insurance reserves. The amended Standard Valuation Law refers to the Valuation Manual, which contains the detailed requirements of a principle-based approach to valuation. It is anticipated that the Valuation Manual will not be static, but will undergo periodic revision to ensure the methodology remains consistent with best practices for life insurance reserves.
- To implement principles-based reserving, the Standard Valuation Law must be enacted by 42 state/territory legislatures as well as states representing greater than 75% of the direct premiums written

as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

- The effort to develop a principles-based approach to valuation of life insurance reserves has been underway for nearly a decade. A number of factors led to the decision to develop a principles-based approach to reserving.
 - The existing formulaic reserving methodology, which considers only interest rates and mortality, is not well-suited to new and more complicated product designs. This tends to result in inadequate reserves for some product designs, while producing excessive reserving requirements for other products. The Principles-based reserving methodology will consider a wide range of risks and aim to “right-size” reserves for all products.
 - Regulators were concerned that some policy designs skirted around existing requirements. Considerable regulatory resources were being used to respond to the development of new products and possible regulatory arbitrage, with concerns that arbitrage could lead to inadequate reserves for some products. At the same time, companies developed ways to reduce reserves where they were excessive (i.e. through the use of captive reinsurance arrangements).
 - Principles-based reserving has been the approach used in the U.S. in other areas of insurance (i.e. property/casualty

and health insurance). Additionally, actuarial science has continued to develop new methods for modeling risk and new financial modeling software has allowed companies to better measure risk.

- Principles-based reserving would help protect consumers by allowing companies to more accurately price their products and by ensuring companies are properly reserved.
- The bottom line is that a move to principles-based reserving would be a win-win-win: a win for consumers, a win for regulators and a win for the life insurance industry.



2012 Producer Forums

Ethics for Insurance Producers

Presented by Melissa Hauer,
General Counsel,
North Dakota Insurance Department

What Are Professional Ethics?

- ▶ Professional ethics are standards or codes of conduct set by people in a specific profession.
- ▶ Professional ethics are a system of expectations of those involved in a certain line of work to ensure that the profession does not condone bad, dishonest or irresponsible behavior if it does occur by someone in their field.



How Do Ethics Apply to Me?

Ethics give us a foundation for understanding the concepts of right and wrong. Ethics help us to have a ready understanding of how to react to a certain situation before the situation occurs.



Purpose

This ethics course will be taught through the use of case studies which will link learning to real life and the experiences of the learners.



Purpose

The case studies will provide:

- Opportunities for identifying and analyzing ethical problems;
- Practice at applying ethical concepts, principles and theories to actual situations;
- Opportunities to identify and evaluate options for action in response to ethical problems.



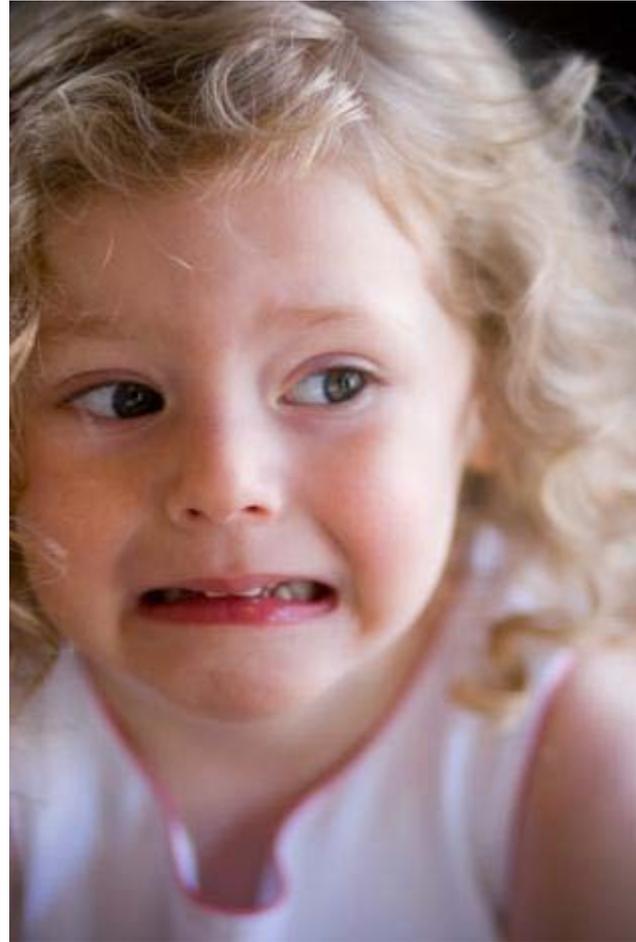
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Legal Duties of Producers

Producers have a responsibility to obey the laws and regulations that govern their profession.



Now, the scary stuff!



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Failure to meet legal obligations may result in a loss of license, fines, criminal prosecution, and other penalties.



Legal Duties of Producers

- ▶ **State Laws.** The state laws governing producers are found mainly in N.D.C.C. ch. 26.1–26.
- ▶ **Administrative Rules.** The administrative rules governing insurance producers are found in N.D Admin. Code title 45.



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Ethical Duties of Producers

Producers have a responsibility to behave in an ethical manner that is above that standard of conduct required for adherence to laws and rules.



Ethics For Producers

- ▶ Codes of ethics define minimum behavior standards for a given profession.
- ▶ Producers may agree to abide by a code of ethics when they join a group or association that espouses such standards.



What Are Professional Ethics?

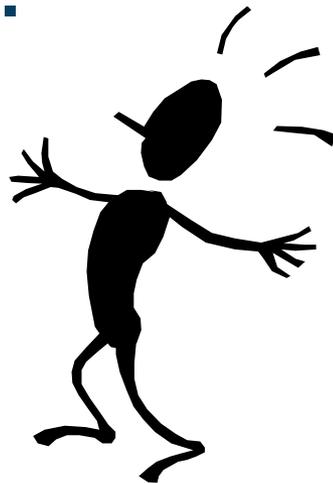
Professional ethics are a system of expectations of those involved in a certain line of work to ensure that the profession does not condone bad, dishonest or irresponsible behavior if it does occur by someone in their field.



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What Are Professional Ethics?

These codes of ethics help to prevent exploitation of the client and preserve the integrity of the profession. This is not only to the benefit of the client but to the benefit of those belonging to the profession.



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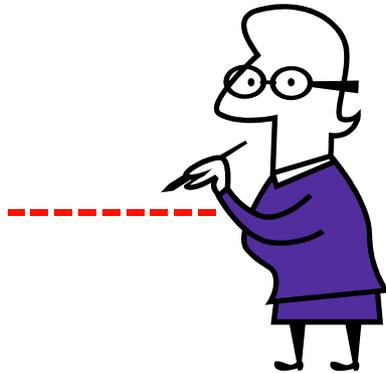
Goal of Presentation

The purpose of this presentation is to reinforce a producer's ethical competence, contribute to a producer's understanding of the complexities of ethical decision-making, and provide tools to help a producer identify, prevent and constructively resolve ethical dilemmas.



State Regulation of Producers

- ▶ Across the U.S., States license more than 3.2 million individuals to provide insurance services.
- ▶ The North Dakota Insurance Department alone licenses 55,722 insurance producers.



State Regulation of Producers

Producers who fail to comply with regulatory requirements are subject to sanctions including:

- fines,
- probation,
- suspension of license,
- revocation of license,
- refusal to continue or issue a license.

State Regulation of Producers

In 2000, nearly 16,000 insurance producers in the U.S. had their licenses suspended or revoked.

Source: NAIC



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Let's get to the case studies already!





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Case Study One

Alec has a large insurance agency and he likes to say thank you to his loyal customers. Each summer he books a tour bus and takes his 30 best clients to Deadwood for a weekend of gambling. He provides the transportation, one night in a hotel, three meals, and \$60 cash each for the slots.



Did Alec roll the dice with his license?

- A. No, it is a perfectly acceptable business practice to thank your clients with such a trip.
- B. No, it is okay as long as the cost of the trip is less than the amount of premium each client paid.
- C. Yes, this would be an illegal rebate.
- D. None of the above.

Case Study One Discussion

If the cost does not exceed an aggregate retail value of \$50 per person per year, an insurance producer may give a gift, prize, promotional article, logo merchandise, meal, or entertainment activity directly or indirectly to a person in connection with marketing, promoting, or advertising the business.

N.D.C.C. sections 26.1-04-03(8), 26.1-04-06, 26.1-25-16).

Case Study One Discussion

The term "person" means the named insured, policy owner, or prospective client or the spouse of any of these individuals, but the term does not include a certificate holder, child, or employee of the named insured, policy owner, or prospective client.



Case Study One Discussion

Within the \$50 limit, an insurance producer may give a gift card for specific merchandise or services such as a meal, gasoline, or car wash but may not give cash, a cash card, any form of currency, or any refund or discount in premium.



Case Study One Discussion

An insurance producer may not condition the giving of a gift, prize, promotion article, logo merchandise, meal, or entertainment activity on obtaining a quote or a contract of insurance.



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Case Study One Discussion

Insurance producers may not “stack” rebates. For example, a producer may not give a \$50 gift to a client and the client’s wife and additional \$50 gifts to each of their two children.



Case Study One Discussion

- ▶ Likewise, a producer who sold a group health policy to a business with 30 employees may give a \$50 gift to the policyholder/business owner but may not give \$50 to each employee.
- ▶ This stacking of gifts is not allowed because it goes beyond the token thank you gift for doing business and crosses the line into being an inducement to buy insurance.



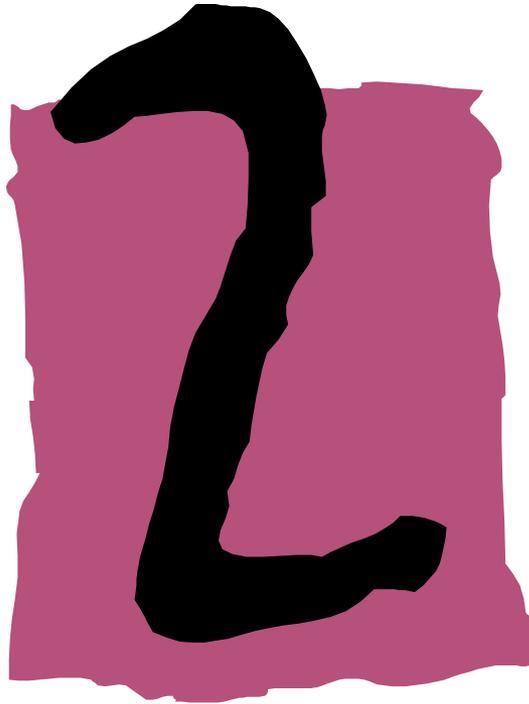
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Case Study One Discussion

An insurance producer may make a donation in any amount to a nonprofit organization that is exempt from federal taxation under Internal Revenue Code Section 501(c)(3) as long as the donation is not given as an inducement to obtain a quote or a contract of insurance.



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Case Study Two

Earnest is a new agent in a small town, family-run agency. Earnest sees that many clients pay their premium to the agency in cash or check, which is deposited into the agency's bank account. Earnest's paychecks sometimes bounce and several customers have come in lately complaining that they are getting notices of cancellation for nonpayment of premium.

Case Study Two

He also overheard the owner of the agency on the phone with several insurance company employees who sound like they're complaining that payments out of the sweep account have also bounced.



Case Study Two

What should Earnest do?

- A. Find a job in the oil field so his paychecks don't bounce.
- B. Report the situation to the Insurance Commissioner's office.
- C. Say nothing to anyone and hope this is just a temporary rough patch for the agency.
- D. Tell clients to find another agency.



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Case Study Two Discussion

A person engaged in the business of insurance having knowledge or a reasonable belief that a fraudulent insurance act is being, will be, or has been committed must report it to the Commissioner. N.D.C.C. section 26.1-02.1-06.

Case Study Two Discussion

- ▶ Insurance fraud is a class C felony if the value of any property or services retained exceeds \$5,000. N.D.C.C. section 26.1-02.1-02.1.
- ▶ Insurance producers must not use fraudulent, coercive, or dishonest practices and must not be incompetent, untrustworthy, or financially irresponsible. N.D.C.C. section 26.1-26-42.

Case Study Two Discussion

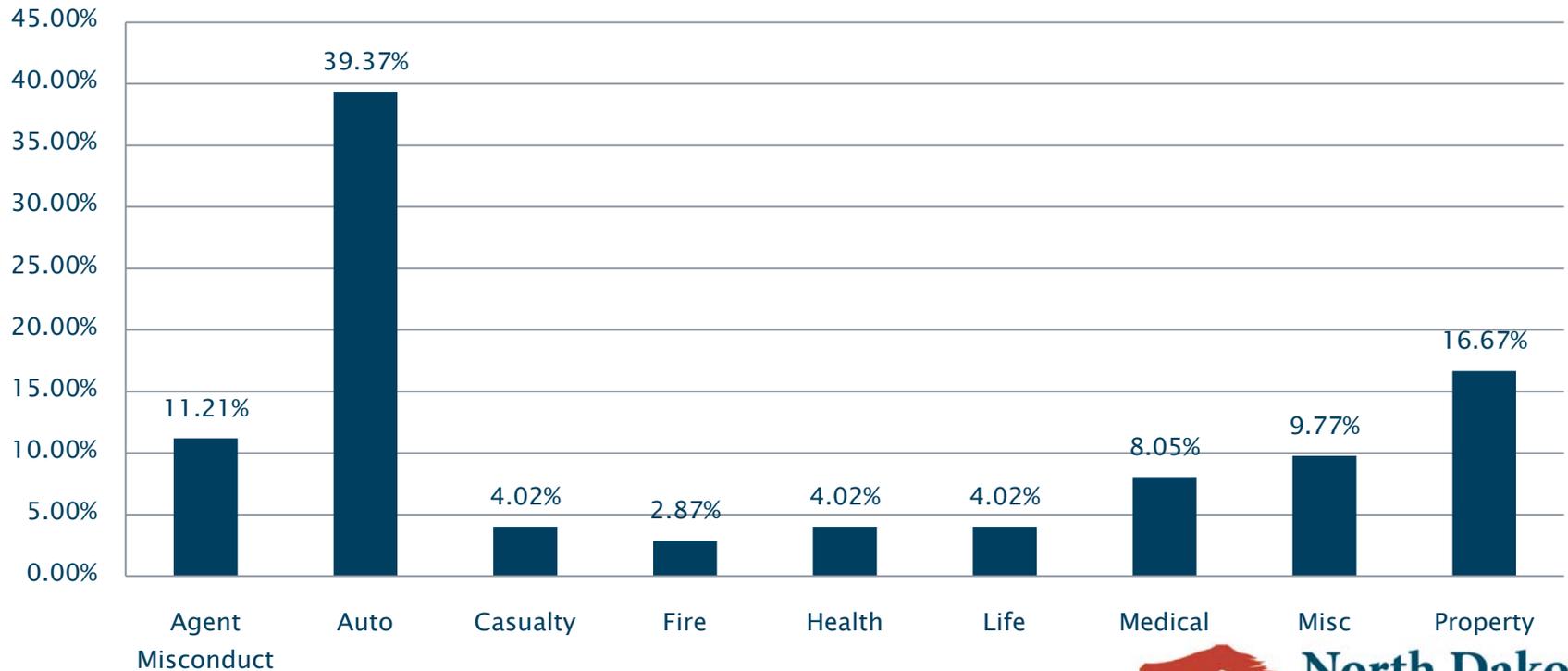
- ▶ The agency owner's license must be revoked if he is convicted of felony insurance fraud. He cannot be in the business of insurance with that type of felony conviction. N.D.C.C. 26.1-02.1-02.1.
- ▶ Even if he isn't convicted of felony fraud, the license may be revoked, suspended or placed in a probationary status for using fraudulent, coercive, dishonest practices, or for financial irresponsibility. N.D.C.C. 26.1-26-42



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ND Fraud Statistics

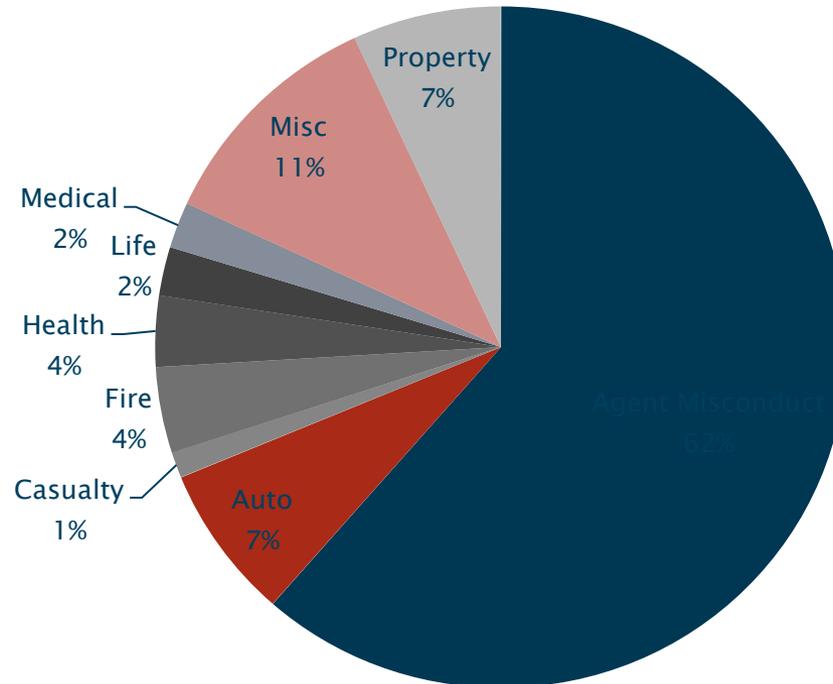
Percentage of Fraud Cases By Case Type



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ND Fraud Statistics

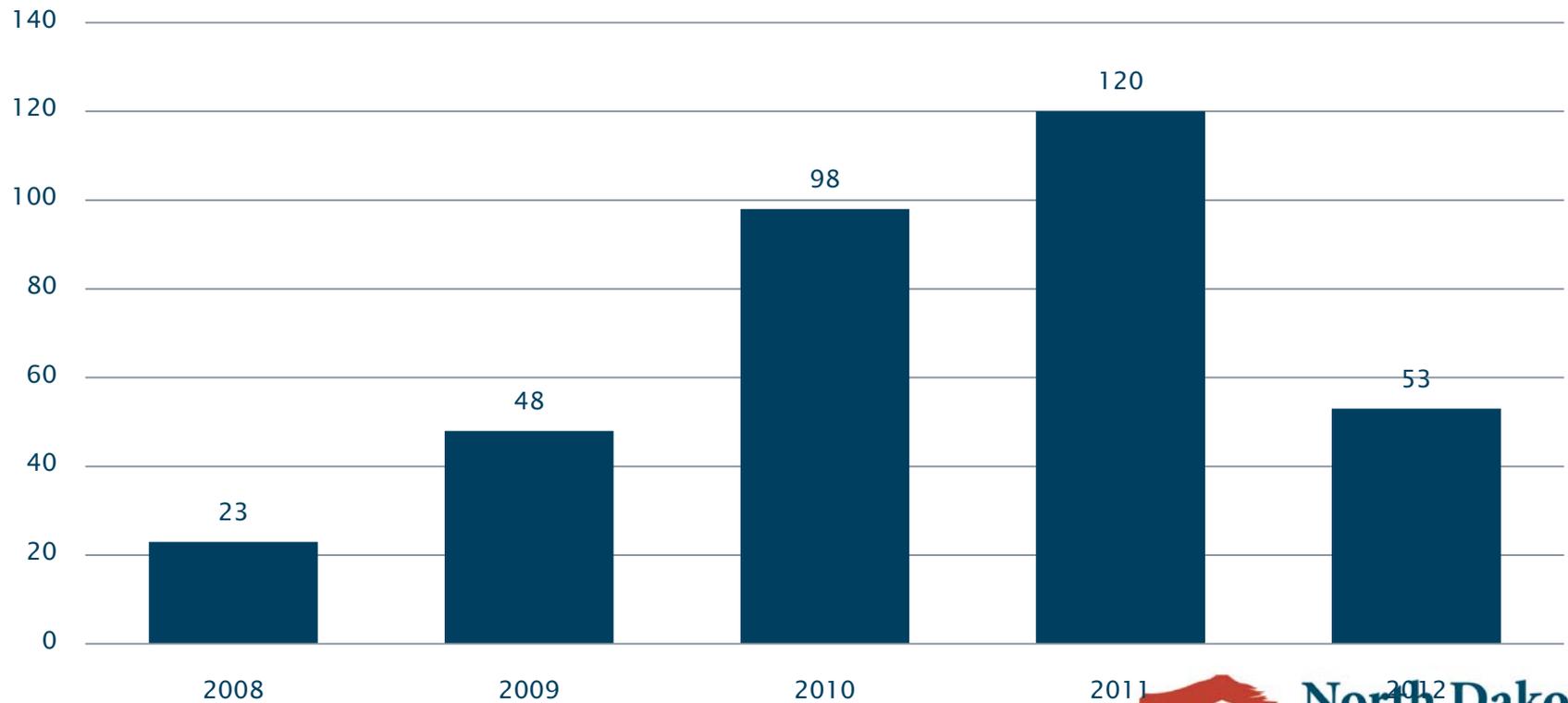
Actual Loss Amount



ND Fraud Statistics

Cases by Date Reported

(2012 as of September 1, 2012)



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Case Study Three

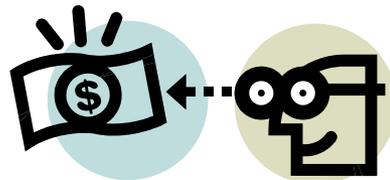
- ▶ Judy is seeing a new client, Lisa, who is 35 years old, single, with two kids and a mortgage. Judy could sell her a whole life insurance policy with \$30k in coverage for about \$40 per month. Or she could sell Lisa a 20 year term policy with \$350,000 coverage for about \$25 per month.
- ▶ Even though the term policy is \$15 less per month and has 10 times more coverage, Judy knows that selling the whole life policy will result in a much higher commission for her.



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Case Study Three

- ▶ Even though Lisa needs more coverage than \$30,000, Judy tells her that she should buy the whole life policy because it is an investment and very soon the policy will pay for itself (even though that is not true).
- ▶ Lisa agrees to buy the whole life policy.



Case Study Three

What should Judy have done?

- A. Sell the whole life policy to Lisa even though it probably won't cover the mortgage and cost to raise the kids.
- B. Sell the term life policy to prevent loss of wages, child-care, or funeral expenses from being life-changing for Lisa's survivors.
- C. Get more information from Lisa about her long-term goals and needs.
- D. Refer her to another producer who sells more life insurance than she does.



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Case Study Three Discussion

Producers are prohibited from making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy or for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance. N.D.C.C. section 26.1-04-03.



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Case Study Three Discussion

Producers must not knowingly solicit, procure, or sell unnecessary or excessive insurance coverage to any person. N.D.C.C. 26.1-26-42.



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Case Study Four

Tom, an insurance producer, borrowed \$20,000 from his client Ms. Pearson to be paid back in six months with 8% interest. Tom and Ms. Pearson execute a promissory note to this effect.



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Case Study Four

- ▶ Tom assisted Ms. Pearson in cashing out two annuities with Big National Life Insurance Company. The annuity proceeds funded the loan to Tom.
- ▶ Tom did not pay back any of the \$20,000 or interest owed.

Case Study Four

When did Tom violate state laws and rules?

- A. As soon as he took the loan from the client.
- B. When he failed to repay the loan.
- C. He didn't violate any laws or rules because the U.S. Constitution protects people's freedom to engage in commerce.
- D. None of the above.



Case Study Four Discussion

A licensed insurance producer or consultant may not solicit or accept a loan from an individual with whom the insurance producer or consultant came into contact in the course of the person's insurance business, or sold an insurance policy to, within the past ten years. N.D Admin. Code section 45-02-02-14.1.

Case Study Four Discussion

This does not prohibit a licensed insurance producer or consultant from accepting loans from financial institutions; immediate family members, which shall mean only a spouse, parents, siblings, and children; or other loans upon the prior written approval of the insurance commissioner. N.D Admin. Code section 45-02-02-14.1.



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Case Study Five

Jennifer is a producer who is helping Bob, a long-time, large commercial client, to find coverage at renewal. She is going to request quotes from several insurers.



Case Study Five

Bob states that he's sure she wants to help him secure the best premium possible and asks her to "downplay" the amount of prior losses he's had when she's giving information for the quotes.



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Case Study Five

- ▶ This client represents a large part of the agency's business. So large, in fact, that if Bob takes his business elsewhere, the agency would have to lay off at least one employee.
- ▶ If they lose Bob's business, other commercial accounts would find out about it and could also leave because they might perceive the agency as not competent.

Case Study Five

Feeling a great deal of pressure, Jennifer provides information to several prospective insurers that doesn't mention several claims that Bob's business had over the past few years.



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Case Study Five

Did Jennifer do anything wrong?

- A. No, it is her client who wasn't truthful.
- B. No, the insurer should look out for itself by doing follow up with Bob.
- C. Yes, she should have been honest about the client's loss history.
- D. Yes, but it's not really big enough to affect her license.



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Case Study Five Discussion

- ▶ Jennifer has violated the duty of a producer to be honest.
- ▶ A producer's license may be revoked or suspended if the producer has used fraudulent, coercive, or dishonest practices, or has shown oneself to be incompetent, untrustworthy, or financially irresponsible. N.D.C.C. section 26.1-26-42(6).

Case Study Five Discussion

- ▶ She has also committed insurance fraud.
- ▶ Insurance fraud is a class C felony if the value of any property or services retained exceeds \$5,000. N.D.C.C. section 26.1-02.1-02.1.
- ▶ A person engaged in the business of insurance having knowledge or a reasonable belief that a fraudulent insurance act is being, will be, or has been committed must report it to the Commissioner. N.D.C.C. section 26.1-02.1-06.

Case Study Five Discussion

- ▶ An insurance producer's license must be revoked if he or she is convicted of felony insurance fraud. A person cannot be in the business of insurance with that type of felony conviction. N.D.C.C. 26.1-02.1-02.1.
- ▶ Even if not convicted of felony fraud, a producer's license may be revoke, suspended or placed in a probationary status for using fraudulent, coercive, dishonest practices, or for showing oneself to be incompetent, untrustworthy, or financially irresponsible. N.D.C.C. 26.1-26-42.



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Case Study Six

Vanessa operates her own agency. Her cash flow is kind of tight one month so she starts paying clients' premiums on a monthly basis even though they have paid her for the entire years' premium. She thinks there is no harm since the premium will get paid eventually and she can have the use of the money in the meantime.



Case Study Six

But Vanessa has some unexpected expenses and her financial situation gets worse. Pretty soon, she can't make even the monthly premium payments and several clients ask her why they are getting cancellation notices.



Case Study Six

She tells them it must be a mistake but they want proof that she paid the company. So she makes out a check to the company and sends a photo copy of it to the client to show it was paid.



Case Study Six

She doesn't, however, ever actually send the checks to the company. By this time her checks are bouncing right and left and she is charged with issuing checks without sufficient funds. She is convicted of misdemeanor NSF.



Case Study Six

What should Vanessa do now?

- A. Get credit counseling.
- B. Report her criminal conviction to the North Dakota Insurance Department.
- C. Report her criminal conviction to any other state in which she is licensed.
- D. Nothing.

Case Study Six Discussion

- ▶ Within 30 days after a criminal conviction, an insurance producer must report to the Commissioner any criminal conviction of the producer in any jurisdiction. N.D.C.C section 26.1 – 26-45.1.
- ▶ The report must include a copy of the initial complaint, the order issued by the court, and any other relevant legal documents.



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Case Study Six Discussion

- ▶ The report can be made electronically through the NIPR attachments warehouse.
- ▶ This system can be used to simultaneously report to all states in which the producer is licensed.



VII

Case Study Seven

Reed sells group life and health policies to small businesses. He met with Laddie, one of his clients who owns a bakery. Laddie agreed to buy group health insurance from Reed and signed paperwork that Reed put in front of him. A few months later, Laddie realized that the amount being automatically debited from his business account for the health insurance was more than Reed told him.

Case Study Seven

Laddie calls the company and is told the amount being taken from his account is for a group health policy as well as a group life policy that he had specifically told Reed he did not want. At about the same time, Ken, who managed a small business and had purchased group health insurance through Reed learned that his business also was being charged for a group life insurance policy of which he was unaware.



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Case Study Seven

Upon investigation, the Insurance Department finds that there are many more small businesses that Reed signed up for group life coverage they did not want.



Case Study Seven

What should happen to Reed?

- A. He should be required to repay the commissions he earned from the bogus sales.
- B. His license should be revoked.
- C. His license should be suspended.
- D. His employer should decide what consequences he should pay.



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Case Study Seven Discussion

By creating applications for insurance policies that clients did not want and accepting commissions for those policies, Reed improperly presented to an insurer false or misleading information as part of, in support of, or concerning a fact material to an application for the issuance or renewal of an insurance policy.

Case Study Seven Discussion

By accepting advance commissions for the policies Reed engaged in an act of theft by deception or otherwise, or embezzlement, abstracting, purloining, or conversion of moneys, funds, premiums, credits or other property of an insurer, reinsurer, or person engaged in the business of insurance in violation of N.D.C.C. § 26.1-02.1-02.1(1).

Analyzing Ethical Issues

Identify that an ethical issue exists. This is probably the most important step. Ask yourself:

Could this decision or situation be harmful to someone? To my client? To me? To the insurance companies I represent?

Does this decision involve a choice between a good and bad alternative, or perhaps between two "goods" or between two "bads"?



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Weigh the Options

- ▶ What are the options for acting? Have I identified all the options?
- ▶ Which option leads me to act as the sort of person I want to be?
- ▶ Which option will produce the most good and do the least harm?
- ▶ Which option best respects the rights of all who have a stake?
- ▶ Which option passes your personal “gut” check?



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Weigh the Options

Ask yourself: would I be comfortable telling my mother, a newspaper reporter, or the Insurance Commissioner, which option I have chosen?

Parting Thoughts on Ethics

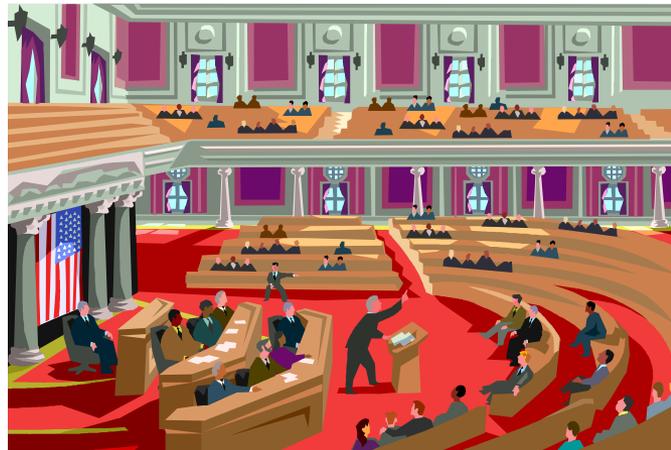
When I do good, I feel good; when I do bad, I feel bad. That's my religion.

– Abraham Lincoln



2013 Proposed Legislation of Note

- ▶ Personal and medical information received by Department can be held confidential.
- ▶ Increase in penalties for insurers.





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Try our new Producer Landing Page! It has links to valuable NIPR resources for Producers such as licensing applications, Address Change Requests, license printing options and Personal PDB report requests.

LATEST NEWS RELEASES



08/10/12 - NIPR Provides States with Needed Repository for Surplus Licensing Information
The National Insurance Producer Registry (NIPR) has successfully assisted a majority of the states to complete their Surplus Lines Licensing Initiative as mandated by the Dodd-Frank Wall Street Reform and Consumer Protection Act (the Act).

NAIC Home Page

Link to Departments of Insurance Sites

Regulator Information +

NIPR Focus Group

User Guides

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NIPR Acronyms

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ACLI
October 21-23, 2012
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November 8-11, 2012
Boston, MA

West Virginia Renewals - Your West Virginia license number has been changed to your National Producer Number (NPN). If you do not know your NPN, you can find it using the National Producer Number (NPN) Access application (<https://pdb.nipr.com>) located on the bottom, left-hand corner of the page. To update your license, click on the bottom, left-hand corner of the page to move any leading zeros from the



ELECTRONIC RESIDENT LICENSING OR RENEWAL

ANNOUNCEMENTS

Alabama Resident Business Entities: You may now renew your Resident Business Entity Producer license online.

Alabama license numbers will no longer include the beginning alpha character or any leading zeros. Example: "A012345" will be "12345" or "A001234" will be "1234"

Arizona Resident Applicants: Effective immediately, the fingerprint processing fee has been reduced to \$22 from \$24. The NIPR application will implement this fee change on March 23, 2012.

Arizona Non-Resident Adjuster Applicants: Effective immediately, Arizona Non-Resident Adjuster licenses will no longer be available electronically until further notice.

Connecticut Applicants: The State of Connecticut Insurance Department is pleased to announce that licensees will now have the ability to print their own licenses free of charge. We will no longer mail hard copies of licenses, effective December 1, 2010.

The Print -A-License option may be found under "Verify a License" on our website at <http://www.catalog.state.ct.us/cid/CLIC/VerifyLicense.aspx>

Please contact the Licensing Unit at cid.licensing@ct.gov or 860-297-3845 with any questions.

- Home >
- State Specific Requirements >
- Fees >
- Contact Us >
- Print Your License >
- FAQs >
- Attachments Warehouse >
- Producer Landing Page >
- Begin Application >**

- Use one of the following credit cards: Visa, MasterCard, American Express.
- Accept the Terms of Use displayed when you click on BEGIN.

You can search for your national producer number using the hyperlink next to the NPN field.

Begin



ELECTRONIC RESIDENT LICENSING OR RENEWAL

USE AGREEMENT

THIS IS A LEGAL AGREEMENT BETWEEN YOU ("USER") AND NATIONAL INSURANCE PRODUCER REGISTRY ("NIPR"). BY CLICKING ON THE AGREE BUTTON OR USING THE SERVICES PROVIDED HEREIN, USER IS CONSENTING TO BE BOUND BY AND IS BECOMING A PARTY TO ALL OF THE TERMS AND CONDITIONS OF THIS AGREEMENT. PLEASE READ THIS ENTIRE AGREEMENT CAREFULLY BEFORE ACCEPTING ITS TERMS.

1. Description of Services

The following Services are provided by NIPR to allow USER to submit information electronically for transmittal to state insurance departments through the NIPR Gateway. USER acknowledges that NIPR may charge a transaction fee for use of the Services. These services are for personal and non-commercial use only unless specifically stated elsewhere in this Agreement:

- o Non-Resident Licensing ("NRL") Services: allows USER to electronically complete and submit the Uniform Application for a Non-Resident License ("Uniform Application") for purposes of filing a non-resident license application and non-resident license renewal with state insurance departments.
- o NIPR's Producer Access Services: allows USER to electronically complete and submit license applications, renewals and notification forms ("Producer/Adjuster Applications") to NIPR for transmittal to state insurance departments and allows USER to obtain certain information about USER contained in NIPR's Producer Database ("PDB").
- o Resident Licensing ("RL") Services: allows USER to electronically complete and submit the Uniform Application for a Resident License ("Uniform Application") for purposes of filing an original resident license or a resident renewal, if applicable, with state insurance departments.
- o Address Change Request ("ACR") Services: allows USER to electronically complete and submit

[Main menu](#)

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Version: V1.ERL.00

Fri Sep 28 11:35:43 CDT 2012

Please select the state for which you wish to apply, whether you would like to work with individual or business licensing, and whether you will be renewing a license, applying for a new license, or if you are returning to work on a previously saved application. For business entity renewal applicants: you may login using FEIN or Agency NPN, both are not required. Not all business entities have assigned NPNs.

*Resident State:	<input type="text" value=""/>
*License Type:	<input type="radio"/> Business <input type="radio"/> Individual
*What do you want to do:	<input type="radio"/> Apply for a new Resident License OR resume an existing application. <input type="radio"/> Apply to renew an existing Resident License OR resume an existing renewal application.
* Please Enter the corresponding information for Application Type	
Resident License	
SSN or FEIN	<input type="text" value=""/>
Last Name or Firm Name	<input type="text" value=""/>
Resident License Renewal	
FEIN	<input type="text" value=""/>
NPN	<input type="text" value=""/> NOTE: not required for business entities if FEIN is supplied.
License Number	<input type="text" value=""/>

*Click on the link to look up your NPN

NEXT->

Search nd.gov/ndins

GO

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Producers/agents

Companies

Fraud

Complaints

Forms

SHIC

Prescription Connection

Special Funds

Communications

About us

Contact us



Health care reform

Click here to learn more



Learn how NDID reviews
**health insurance rate
increase requests**



Click here to apply for
Prescription assistance



**Do you need
renter's insurance?**

Click here to learn more

Adam Hamm, Commissioner

Welcome Ask Adam Bio



CONSUMERS

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Health insurance plans in ND

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Studies and reports

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**PRODUCERS
AGENTS**

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Search for an agent, agency or

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Non-Resident Licensing and Renewal

CE course providers info

Annuity suitability training

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Filing requirements for licensed companies

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LATEST NEWS

Monday, September 17, 2012

Hamm invites insurance agents to annual Department forums

Friday, September 14, 2012

Hamm revokes Bismarck insurance agent Samuel Neutgens' license

Friday, August 31, 2012

Hamm: Be prepared for Labor Day weekend with WreckCheck mobile app

MORE

CALENDAR

10/1/2012

Agent forum - Grand Forks

10/1/2012

Agent forum - Jamestown

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Resident renewal

Resident insurance producer renewal requirements

Please read this entire page before starting your renewal application. In order to maintain an insurance producer license, every individual insurance producer, regardless of continuing education requirements or exemptions, must biennially by the last day of their birth month:

- Complete a renewal application,
- Pay the \$25 fee,
- If continuing education is required, have the required number of continuing education hours on file with the Department.

[Click here to look up license expiration dates.](#)

[Click here for information regarding continuing education requirements.](#)

[Click here to view your CE](#)

Please note:

1. **There is no grace period after the due date.** If not renewed before the expiration date, your license and appointments will be cancelled and you will have to reapply with an initial application and \$100 fee.
2. **Your record must show compliance with continuing education requirements.** Continuing education providers have 15 days from course completion to file the credits with the Insurance Department, so courses taken less than 15 days before the expiration date may not be credited in time for license renewal.
3. Make sure you answer all questions completely and disclose all information requested. You must report anything not previously reported to the Department. In addition to the information requested on the application form, licensed insurance producers are required to report to the Commissioner within 30 days any administrative action or any criminal conviction in any jurisdiction (N.D.C.C. § 26.1-26-45.1). This requirement to report does not allow you to exclude any criminal convictions. Please read [Bulletin 2009-2](#). If you have any questions about what needs to be reported or disclosed, contact the Department before submitting your application.

Please submit the renewal application electronically by using the link below:

<https://pdb.nipr.com/html/erlWelcome.html>

The filing fee is \$25 and is paid by credit card or electronic check. Filing electronically will also require a \$5 transaction fee which must be paid along with the North Dakota filing fee.

Hints for completing the electronic renewal

1. Your North Dakota license number is your National Producer Number (NPN). You must enter it twice: once when asked for your NPN and again when asked for your North Dakota license number.
2. Your addresses cannot be updated by making changes on the renewal application. If the addresses are wrong or incomplete, file a separate address change request. [Click here](#) to file an electronic address change (no charge), or print out the [paper address change form](#) and mail or fax to the Department.
3. You do not have to complete the section asking about your agency or business entity affiliations. This is not required for North Dakota.
4. If you are completing the application for yourself, you check the "producer" box. If you are completing the application for someone else, you must identify yourself as an authorized submitter and complete the information requested.

After your application has been approved, you can confirm your new license expiration date on the website's [agent/agency search](#). You can also print your license one time free of charge. [Click here to print your license](#). North Dakota no longer mails paper license.

The Department strongly encourages filing electronic applications, however, if you need to submit a paper application, [click here to print a paper form](#).

Complete the form, print and mail to the Department along with the \$25 fee. Paper applications must be received the Insurance Department by the last day of the insurance producer's birth month in the due date year.



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PRODUCERS/AGENTS

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Auto/car rental companies

Company appointment listings

Company appointments

Home : Producers/agents : Resident licensing, renewal and continuing education

Resident licensing, renewal and continuing education

For information on applying for a North Dakota resident insurance producer license or in resident continuing education requirements or resident renewals, choose that option on the left-hand side under resident licensing and continuing education.

For information regarding other licensing procedures such as address or name changes, see the left-hand side.

North Dakota Insurance Department
Agent Licensing Division
ndlicensing@nd.gov
600 E. Boulevard Ave.
Bismarck, ND 58505-0320

701.328.2440
701.328.4880 fax
800.247.0560 toll free
800.366.6888 TTY line

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Designated responsible producers

Home : Producers/agents : Resident licensing, renewal and continuing education : Resident renewal

Resident renewal

Resident insurance producer renewal requirements

Please read this entire page before starting your renewal application. In order to maintain insurance producer license, every individual insurance producer, regardless of continuing education requirements or exemptions, must biennially by the last day of their birth month:

- Complete a renewal application,
- Pay the \$25 fee,
- If continuing education is required, have the required number of continuing education hours on file Department.

[Click here to look up license expiration dates.](#)

[Click here for information regarding continuing education requirements.](#)

[Click here to view your CE](#)

Please note:

1. **There is no grace period after the due date.** If not renewed before the expiration date, your and appointments will be cancelled and you will have to reapply with an initial application and \$100 fee.
2. **Your record must show compliance with continuing education requirements.** Continuing providers have 15 days from course completion to file the credits with the Insurance Department, so taken less than 15 days before the expiration date may not be credited in time for license renewal.
3. Make sure you answer all questions completely and disclose all information requested. You must report anything not previously reported to the Department. In addition to the information requested on the application form, licensed insurance producers are required to report to the Commissioner within 30 days any administrative action or any criminal conviction in any jurisdiction (N.D.C.C. § 26.1-26-45.1). This requirement to report does not allow you to exclude any criminal convictions. Please read [Bulletin 2009-2](#). If you have any questions about what needs to be reported or disclosed, contact the Department before submitting your application.

Please submit the renewal application electronically by using the link below:



Education Transcript

Support

How do I?

- ▶ [Find state not listed](#)
- ▶ [Find my NPN or License Number](#)
- ▶ [Understand my education transcript](#)
- ▶ [Print my education transcript](#)
- ▶ [Print my license](#)

Education Transcript Search

*License State:

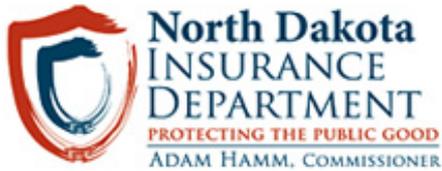
*Last Name:

*Last 4 Digits of SSN:

* Choose One

*Required fields

Click the "Search" button to view your course completions, education transcript and compliant status.



PRODUCERS/AGENTS

Search [nd.gov/ndins](#)

GO

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Producers/agents

Find an agent, agency, license status

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Home : [Producers/agents](#) : [Resident licensing, renewal and continuing education](#) : [CE course sponsor list](#)

CE course sponsor list

[Click here to access a list of **approved continuing education courses and course providers.**](#)

[Click here to access scheduled courses by providers.](#)



North Dakota Insurance Department

Chrystal Bartuska
Product Filing Division Director

Rate Filing Process

- ▶ NDID utilizes State Electronic Rate and Form Filing system (SERFF).
- ▶ Effective 1-1-2010 the NDID began using the SERFF system as the sole repository for all filings.
- ▶ Very few of the filings still come in as paper filings.
- ▶ Public access computer – no internet access

Filing Stats

- ▶ Filings received by NDID:
 - Jan. 1, 2012 to Aug. 31, 2012: 3,734 total
 - 2011 filings: 5,935 total
 - 2010 filings: 6,161 total

Topics

- ▶ Property and Casualty
 - 2011 Market Analysis Summary
 - Legislative Updates
 - Rate Filing Trends/Concerns
 - Coverage Levels
 - Certificates of Insurance

Market Analysis Report Summary

- ▶ Personal Auto – Highly Competitive
- ▶ Commercial Auto – Highly Competitive
- ▶ Commercial Multi-peril – Highly Competitive
- ▶ Farmowners – Low Competitive level
- ▶ Homeowners – Moderately Competitive
- ▶ Medical Malpractice – Low Competitive level
- ▶ Other Liability – Moderately Competitive
- ▶ Crop Hail – Low Competitive level



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Loss Ratios– Homeowners and Auto

Homeowners		Private Auto		Commercial Auto	
2007	98%	2007	53%	2007	38%
2008	73%	2008	57%	2008	53%
2009	46%	2009	57%	2009	55%
2010	48%	2010	56%	2010	47%
2011	53%	2011	58%	2011	57%

Loss Ratios– continued

Crop/Hail		Farmowners		Multi-Peril	
2007	75%	2007	55%	2007	63%
2008	55%	2008	65%	2008	58%
2009	20%	2009	58%	2009	43%
2010	58%	2010	101%	2010	40%
2011	147%	2011	96%	2011	62%

For more information on the 2012 Market Analysis visit:
www.nd.gov/ndins/communications/studies-and-reports

P&C Legislation

- ▶ Amend– N.D.C.C 26.1–41–18
 - Amend to provide that no–fault benefits from the ND Automobile Assigned Claims Plan are not available to non residents.

Rate Filing Trends/Concerns

- Coverage Levels
- Certificates of Insurance

Certificates of Insurance

- ▶ Certificates are intended to provide a summary of coverage to an interested party.
- ▶ The summary of coverage must reflect the coverage in the policy.
- ▶ The certificate can not be used to modify the policy.
- ▶ ACORD and ISO are advisory organizations that have filed specific certificates on behalf of many companies.
- ▶ We accept filings only from insurance companies and advisory organizations on the companies behalf.



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The following are filings made by advisory organizations of Certificates of Insurance:

Standard Acord forms approved

<u>Form</u>	<u>Edition Date</u>
Acord 24–Property (Fire and Allied)	09/2009
Acord 25– Liability	05/2010
Acord 27– Property	12/2009
Acord 28– Property	12/2009
Acord 21–Aircraft	12/2009
Acord 23–Vehicle/Equipment	05/2010
Acord 20– Aviation	12/2009
Acord 22– Intermodal	03/2010
Acord 28– Evidence of Flood	12/2010 – personal



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Standard Acord Forms Approved, cont.

<u>Form</u>	<u>Edition Date</u>
Acord 29 – Evidence of Flood	12/2010 – commercial
Acord 30 – Commercial Auto	12/2010
Acord 28 – Commercial Other	11/2011
Acord 22 – Commercial Other	04/2012
Acord 31 – Marine/Energy	08/2012

As of August 10, 2012

L & H Topics

- ▶ Life and Health
 - Legislative Updates
 - Rate Filing Trends/Concerns
 - Filing requirements
 - LTC rate increases
 - STOLI/STOA

L&H Rate Requirements

- Minimum loss ratio requirements
- Key assumption is trend
- Other factors are considered.
- Principle: benefits must be reasonable in relation to premiums charged



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Long Term Care

- ▶ Rate increases requests ranging from 10% to 90%
- ▶ Consumers range from small group to very large group of consumers that are impacted by increases.

STOLI Summary

- ▶ Policies purchased by investors with no insurable interest in the insured
- ▶ Lack of insurable interest results in “wagering on human life”—bad public policy



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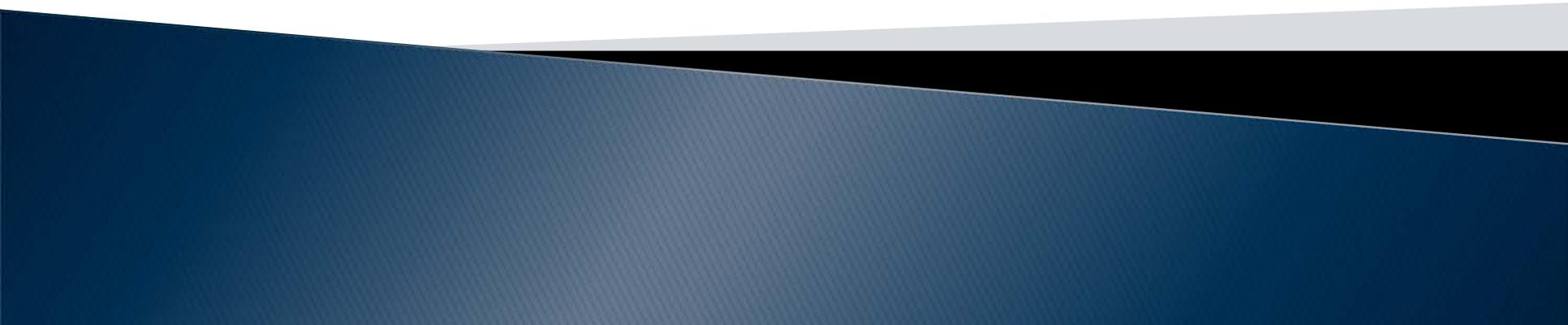
STOA Summary

- ▶ Investors offer an individual a fee for use of their identity as the annuitant
 - Individuals targeted are usually in extremely poor health
 - Individual may or may not realize or understand that they have agreed to be part of an annuity transaction



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Thank you for your time.





Consumer Assistance Division

Presented by David Zimmerman,
Director
North Dakota Insurance Department

Organizational Changes

Previously

Consumer Protection – P & C	Consumer Protection - L & H
<ul style="list-style-type: none"> Property & Casualty Investigation 	<ul style="list-style-type: none"> Actuary
<ul style="list-style-type: none"> Actuary 	<ul style="list-style-type: none"> Life & Health Investigation
	<ul style="list-style-type: none"> Rate & Form Filing
	<ul style="list-style-type: none"> Hotline & State Health Insurance Counseling

New Divisions

Product Filing Division	Consumer Assistance Division
<ul style="list-style-type: none"> Property & Casualty; Rate and Form Filing 	<ul style="list-style-type: none"> Property & Casualty Investigation
<ul style="list-style-type: none"> Life & Health; Rate and Form Filing 	<ul style="list-style-type: none"> Life & Health Investigation
<ul style="list-style-type: none"> Actuary 	<ul style="list-style-type: none"> Hotline
	<ul style="list-style-type: none"> State Health Insurance Counseling (SHIC)
	<ul style="list-style-type: none"> Prescription Connection



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Consumer Assistance Division (CAD)

- ▶ Supports the NDID Mission:
 - *“ ... to protect the public good by fairly and effectively administering the laws of North Dakota. We are committed to vigorous consumer protection efforts while fostering a strong, competitive marketplace that provide consumers with choices and access to high-quality insurance products and services at competitive prices. In pursuit of our mission, we will treat all of our constituencies with the highest ethical standards and respect they deserve.”*
- ▶ CAD serves as the “front door” of the NDID & focuses on assisting and educating consumers who have insurance issues that fall within its four functional areas
 - P&C, L&H, SHIC, Prescription Connection



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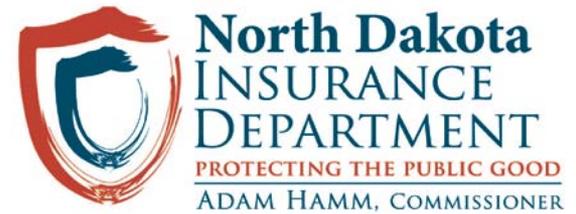
1701 South 12th Street, Bismarck Consumer Assistance Center



- Convenient: drive up to the door
- Accessible parking
- No steps
- Access to assistance for Medicare, Prescription Connection, Property & Casualty, and Life & Health insurance issues



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Complaints 2011

- ▶ Company Complaints Received=197
- ▶ Agent Complaints Received=17

2011 Company Complaint Details

Type	Complaints Closed	Relief*
Auto	75	\$66,118.78
Fire, Allied/CMP	5	\$59,309.39
Homeowners	53	\$69,706.60
Life/annuity	13	\$18,449.45
Accident/health	28	\$40,551.65
Liability	12	\$44,694.00
Miscellaneous	11	\$52,052.74
Total	197	\$1,150,882.61

Company Complaints – Trend

Year	Closed Complaints	Relief*
2001	379	\$376,501.52
2002	378	\$829,627.21
2003	310	\$867,895.37
2004	278	\$373,651.94
2005	220	\$437,139.32
2006	205	\$434,564.99
2007	201	\$422,665.85
2008	241	\$521,251.11
2009	236	\$656,361.44
2010	211	\$565,938.69
2011	197	\$1,150,882.61
Total	3,033	\$7,222,362.49

2011 Agent Complaint Details

Type	Complaints Closed	Relief*
Auto	2	0
Fire, Allied/CMP	0	0
Homeowners	0	0
Life/annuity	6	\$104,000.00
Accident/health	6	\$783.00
Liability	1	0
Miscellaneous	2	0
Total	17	\$104,783.00

Agent Complaints – Trend

Year	Closed Complaints	Relief*
2001	52	\$4,589.82
2002	51	\$22,447.20
2003	56	\$14,093.10
2004	33	\$55,730.99
2005	44	\$386,861.77
2006	25	\$26,365.65
2007	32	\$32,647.98
2008	34	\$44,778.30
2009	28	\$34,294.31
2010	24	0
2011	17	\$104,783.00
Total	458	\$779,051.75

Hotline—Consumer Assistance

- ▶ Walk-ins to the department=122
- ▶ Phone calls received and made=8,604

SHIC/Prescription Connection

- ▶ 2011 SHIC contacts=10,529
- ▶ PC has helped 7,529 people since beginning

Part D 2012 Enrollment

- ▶ Oct. 15–Dec. 7: can enroll or change Part D and Medicare Advantage plans
- ▶ Premiums, deductibles & **formularies** change every year, so it's important to review plans
- ▶ Jan. 1–Feb. 15: Medicare Advantage policyholders can only use this period to disenroll and enroll in original Medicare



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Part D Cost Sharing for 2013

Part D Benefit Parameters	CY 2012	CY 2013
Defined Standard Benefit		
Deductible	\$320	\$325
Initial Coverage Limit (Pre-Donut Hole)	\$2,930	\$2,970
Out-of-Pocket Threshold (To enter catastrophic phase)	\$4,700	\$4,750
Minimum Cost-sharing for Generic Drugs (Catastrophic Phase)	\$2.60	\$2.65
Minimum Cost-sharing for Brand Name Drugs (Catastrophic Phase)	\$6.50	\$6.60
Donut Hole Discounts (Brand Name / Generic)	50% / 14%	52.5% / 21%



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Increased Medicare Product Workload

- ▶ Since January 1, 2011 the baby boomers began to turn 65 (1946–1964)
 - Every day > 10,000 turn 65
 - This rate is expected to continue for the next ~ 17 years
- ▶ 2010 Census—65 & older 13% of population
 - Anticipated that this will increase to > 20%

Are They Ready For Retirement?

- ▶ ~ 3 out of 4 people start taking Social Security at age 62
 - Those born prior to 1959 – 25% deduction
 - Those born after 1959 – 30% deduction
- ▶ 35% of people over 65 rely almost entirely on Social Security payments

PROHIBITED AGENT/BROKER BEHAVIOR	APPROPRIATE AGENT/BROKER BEHAVIOR
Can't state that they are from Medicare or use "Medicare" in a misleading manner. For example, they can't state that they are endorsed by Medicare, are calling on behalf of Medicare, or that Medicare asked them to call or see the beneficiary	May call someone with Medicare who has expressly given permission. The permission applies only to the plan or agent/broker the person that requested contact from, for the duration of that transaction, and for the scope of products
Can't solicit potential enrollees door-to-door	Can call their own clients to discuss new plan options
Can't send unwanted emails, text messages, or leave voicemails	May call or visit someone with Medicare who attended a sales event if the person gave permission
Can't approach people with Medicare in common areas (i.e. parking lots, hallways, lobbies, sidewalks)	May initiate a phone call to confirm an appointment. Scope of the appointment may be changed with appropriate documentation
Can't conduct sales activities in healthcare settings except in common areas. Improper areas include waiting rooms, exam rooms, hospital patient rooms, dialysis centers and pharmacy counter areas	Can conduct sales activities in common areas of healthcare settings. Appropriate common areas include hospital or nursing home cafeterias, community or recreational rooms, and conference rooms
Can't make unwanted calls, including contacting people with Medicare under the guise of selling a non-Medicare Advantage (MA) or non-Prescription Drug Plan (PDP) product and allow the conversation to turn to MA or PDP. For example, an agent/broker can't begin by selling a Supplement & then offer an MA or PDP	Must secure a signed "scope of appointment", prior to the appointment. For example, provided that the person has completed the scope of appointment form following a marketing/sales event, the future appointment may take place immediately after marketing/sales meeting
Can't provide meals to potential enrollees at sales presentation	May provide refreshments and light snacks to potential enrollees at sales presentations
Can't conduct marketing or sales activities at an educational event (such as discuss plan benefits)	May schedule appointments with people who live in long term care facilities upon request
Can't market non-health related products (such as annuities and life insurance) to potential enrollees during MA or PDP sales activities or presentations	May leave cards behind for clients to give to their friend or family. The "referred" person has to contact the agent/broker directly
Can't offer gifts to potential enrollees of more than \$15. If a gift is offered it must be made available to all potential enrollees even if they do not enroll in a plan	May make sales presentations to groups of people without documenting scope of appointment with each individual since such documentation is only required for personal/individual sales events