



Electronically Submitted to tmullen@naic.org

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TO: The NAIC Market Conduct Regulation Modernization (D) Working Group ("Working Group")

Re: Exposure Question on Market Data and Scanning

On behalf of our members, the Insured Retirement Institute (IRI)¹ appreciates the opportunity to comment on the exposure question regarding whether technology can be used to improve market regulation related to advertising, marketing, and sales. IRI supports the Working Group's efforts to enhance market conduct regulation and consumer protection. We solicited input² from our member companies on the Industry Discussion Questions (the "Discussion Questions") shared by the Working Group, and there is strong member consensus around three themes that run through each section of the Discussion Questions: the need for standardized definitions, templates, and data layouts; more consistent and predictable timelines and examination procedures; and greater transparency into complaint coding, confirmation status, and examination reasoning. As such, we are providing more specific details on each topic area below, beginning with a broader issue for consideration by the Working Group.

A Foundational Consideration: Supporting the Use of Modern Technology in a Manner Consistent with Both Regulatory Requirements and Their Underlying Intent

Our members still report that certain regulations and examination standards may not be updated to reflect modern insurance operations. As a result, insurers are hesitant to rely on electronic delivery and digital data transfer, even where those methods are more efficient and create a better experience, out of concern that examiners will treat paper-based compliance as the only acceptable approach. A concrete example is the "duty to notify" requirement under the Life Insurance and Annuities Replacement Model Regulation (Model #613), which is frequently interpreted to require physical mailing of carrier-to-carrier notices even though the underlying

¹ The Insured Retirement Institute (IRI) is the leading association for the entire supply chain of insured retirement strategies, including life insurers, asset managers, and distributors such as broker-dealers, banks and marketing organizations. IRI members account for more than 95 percent of annuity assets in the U.S., include the top 10 distributors of annuities ranked by assets under management, and are represented by financial professionals serving millions of Americans. IRI champions retirement security for all through leadership in advocacy, awareness, research, and the advancement of digital solutions within a collaborative industry community.

² Please note that that responses to several of these questions are highly fact-specific and depend on variables such as company size, issue complexity, and internal processes. Accordingly, timelines and data production capabilities may vary significantly across companies and circumstances, and do not necessarily lend themselves to uniform or definitive responses.

replacement transaction may be processed entirely through digital channels and the receiving carrier is already informed before a mailed notice could arrive. As such, a carrier should be able to satisfy the duty to notify by electronic means, such as email, rather than only by physical mail. Second, where the existing carrier itself transmits the data that effectuates the replacement, that data transmission should be recognized as satisfying the duty to notify, because the receiving carrier receives the relevant information as part of the transfer itself. Additionally, given that this is a carrier-to-carrier process, it does not impact consumer protections. While this is a discrete example raised by our members, there may be other instances where similar allowances would be appropriate³. As such, IRI urges the Working Group to consider incorporating language into the Market Conduct Examination Guidelines that affirmatively recognizes that electronically delivered communications, the digital transmission of data, and digitally maintained records satisfy existing regulatory requirements because:

- Electronic processes meet the spirit of the regulation and of the Uniform Electronic Transactions Act (UETA) (as adopted by states) by ensuring relevant parties receive timely, accurate information more reliably than physical mail;
- Electronic processes provide a more reliable audit trail: digital transactions generate a time-stamped (with IP address and location), system-maintained record of what was sent, when it was sent, and that it was received, which improves the integrity of the notification process;
- Electronic processes produce more accurate information by reducing the transcription errors, delays, and version-control issues inherent in paper-based workflows; and
- Electronic processes are more secure: encrypted transmission with access controls provides substantially stronger protection for sensitive consumer and contract information than physical mail or fax.

IRI recommends that the Working Group explore an avenue to provide guidance or update the Market Conduct Examination Guidelines to confirm that electronic delivery and the digital transmission of data satisfy existing regulatory requirements. Establishing a consistent standard now will prevent inconsistent examiner-by-examiner interpretations and give insurers the confidence to commit to a modern digital compliance infrastructure.

³ For example, according to members, some examiners have been reluctant to accept system-generated date stamps as sufficient evidence of a document's receipt or transaction date, indicating a preference for manually stamped paper records. Similarly, examination expectations sometimes assume that all documents comprising a policy file reside in a single location, whereas those records are increasingly maintained across distributed cloud storage, so assembling a complete policy file can require additional time. Recognizing system-generated date stamps and distributed digital recordkeeping as reliable would help align these expectations with modern operations.

1. Market Conduct Data (Collection & Analysis)

IRI members strongly support uniform data standards, including data definitions, standard style guides, common data models, and clear transmission specifications adopted consistently across states. The operational benefit would be significant: standardization allows insurers to build one repeatable compliance process rather than recreating state-specific data extracts, field mappings, and quality-control routines for each examination. As it stands currently, a significant amount of exam data file requests and/or requested data elements within files require a manual data pull, which is more costly and time-consuming for insurers and regulators⁴.

Any new standard should be phased in and tested before required use, with clear specifications, examples, and validation rules so implementation does not create additional manual rework. Consistent state adoption would be important, but we understand the potential challenges to making this happen.

The data elements generating the most friction are those requiring judgment-based classification or varying in definition across products, systems, or states: complaint reason codes, confirmed/not-confirmed status, claim disposition codes, denial reasons, replacement indicators, and date-based timeliness calculations. Providing MCAS reporting by resident state while providing examination data by issue state is a persistent reconciliation burden. Additionally, data elements that are duplicative, irrelevant⁵, inconsistently defined, rarely used by regulators, or not tied to predictive oversight should be reviewed for revision or removal.

In addition, the Working Group may want to consider the work being advanced through *IRI's Digital First for Annuities* (DFA) initiative, which is facilitating more consistent and efficient communication between industry participants when they send and receive data. This initiative is helping drive the industry towards a “common language” through promoting the standardization of data and a build-once-use-many approach that can be implemented across industry participants.

If such an approach were considered by the Working Group, it could reduce friction in data requests and support a more streamlined and efficient communication and data transmission process for market conduct requests that aligns with the other data requests across the

⁴ Examples of data that commonly require a manual pull include: scan dates for paperwork received, or application dates, maintained in administrative systems; beneficiary information stored on secondary systems; claims paid following a Social Security Death Master File (DMF) match; surrender value, which is not retained across all systems and requires manual review of net versus gross pay; and agent licensing and appointment information, which is complicated by differing administrative systems and varying state tracking methods.

⁵ For example, examiners sometimes request lapse dates in connection with annuity exams.

industry. This would also help alleviate pain points related to the retrieval, transmission, and analysis of data for both industry participants and regulators, as information would be standardized and widely understood, making it easier to interpret, implement and use.

2. Examination Handbook & Processes

A standardized pre-exam package (something that would be more feasible to produce in a shorter time period) should be limited to data that already exists in a reportable format: complaint logs, complaint trend dashboards, basic policy and claim inventory summaries, existing monitoring summaries, organizational contacts, prior examination status, and standard policies and procedures. Items requiring longer lead times include custom historical extracts, transaction-level claim files, legacy system data, third-party administrator data, and vendor-administered platform data. Additional time is also needed for data requiring custom programming, vendor extraction, or historical reconstruction.

Companies do look at conduct-related risk indicators such as complaint volume and rate trends, confirmed complaint patterns, and escalation trends. Our members shared that any indicators, however, should be evaluated in context: complaint trends relative to block size, for example. A tiered, transparent risk model drawing on MCAS results, prior exam findings, remediation history, and business volume should drive examination scope, with low-risk areas (such as closed or smaller blocks of business) receiving targeted reviews and higher-risk areas receiving deeper examination.

The examination practices generating the most unnecessary burden are duplicative requests, changing or overly broad scopes (i.e. multiple business lines, simultaneous exams of multiple of a company's insurers, multi-year exam scope), inconsistent definitions and/or interpretations of state requirements, short deadlines for complex data, and multiple states asking the same questions separately. For pre-exam requirements, it would be helpful for regulators to identify the transactions, populations, and products they intend to examine at the outset and request that information up front, rather than over the course of the exam. Because IT and other business resources are typically mobilized at the start of an exam, calling on those same teams again months later for information that could have been collected at the outset adds avoidable time and cost.

A critical burden is often timing: data requests frequently arrive when the same teams are supporting MCAS submissions, statutory reporting, year-end close, financial exams, or simultaneous market conduct exams from multiple states. Coordinating request timing, allowing rolling productions, and providing reasonable extensions would materially improve response quality.

Additionally, inconsistent sample sizes skew error ratios, and larger sets of files take more time to produce. Determining a set number of sample files for review and implementing that consistently would also help minimize production time. We would also recommend using one sample set to evaluate multiple transactions.

Consistency in the use of the Market Regulation Handbook remains uneven across and within states, both by state regulators and the third-party companies hired to perform exams; the NAIC could publish consistency notes and training materials available to both examiners and industry so that insurers can rely on common expectations across jurisdictions. Uniform examiner training could also be helpful to reduce examiner-to-examiner divergence, and training as to the role of the Interstate Compact would be especially useful. Greater transparency into examination reasoning, including its scope and rationale (such as the statutes or regulations underlying an inquiry and the basis for any criticism, so that insurers can respond accordingly), helps insurers direct the right resources, enables more focused productions, and supports faster remediation. Additionally, shorter, more efficient exams allow insurers to provide more accurate, timely information, and to conduct remediation swiftly, rather than waiting months or years for exam feedback/findings, and any subsequent resolution. IRI members would generally support secure data rooms with role-based access, request tracking, and confirmation of receipt, provided confidentiality, data security, retention, and access-control expectations are clearly defined and followed.

3. Interstate Collaboration

State-to-state variation in definitions, production timelines, data layouts, portals, confidentiality expectations, complaint coding, and follow-up request formats can create operational challenges through manual work, separate quality-control processes, and longer timeframes to respond. The NAIC could consider publishing consistency notes, FAQs, examples, or cross-state interpretation guidance that insurers can rely on when designing compliance programs, and/or consider leveraging the DFA standards, DFA data definitions, and DFA Style Guide to standardize data. This could help create a more efficient communication and data transmission process across the industry for market conduct requests across multiple states.

For multi-state examinations, IRI members support a coordinated one-ask framework: a single lead state, coordinated request list, data specification, production calendar, and response repository, with participating states avoiding separate follow-up requests. The lead-state model currently used in multi-state examinations is broadly viewed as an appropriate structure. Standardization should cover exam request templates, complaint coding definitions, MCAS data definitions, production file layouts, certification language, confidentiality markings, due-date calculations, and remediation plan templates. Such

standardization would then make it easier to achieve uniform examiner training and more consistent use of the Market Regulation Handbook. Regulators should also receive feedback from industry throughout any rollout of a revamped multi-state exam framework to ensure both regulator and insurer obligations are met and so both parties are clear on expectations and receive the information needed for a successful exam.

Insurers generally already remediate issues identified in one state on a broader basis; regulators can reinforce this by recognizing voluntary self-remediation and treating timely proactive remediation as a mitigating factor.

4. Other Entity Oversight

Insurers can generally provide governance frameworks, model or tool inventories, due diligence summaries, monitoring reports, validation summaries, policies and procedures, contract forms, licensure information, administration statistics and escalation records. Materials that are more burdensome or infeasible to provide include vendor proprietary information, source code, trade secrets, third-party confidential data, large data requests from across multiple third-party administrators, and model architecture not owned by the insurer. Regulators should focus on the insurer's governance, oversight, and controls, particularly where a risk-based model of oversight is employed and audits are routinely conducted, rather than requiring unrestricted access to vendor proprietary materials and should define minimum documentation expectations, such as allowing summaries or attestations where detailed documentation is unavailable, while recognizing contractual and confidentiality limits. The primary practical challenge is turnaround time; proactive communication about data sources and realistic production timelines can lead to workable outcomes. IRI members would also encourage removal of the requirement for onsite third-party administrator audits/examinations for those states that may still require it, as technology has made remote examinations practical and more efficient.

5. Corrective Actions, Communications & Enforcement

A tiered corrective action framework could begin with informal clarification or written feedback for minor technical or isolated issues and escalate proportionally, through corrective action plans, targeted remediation, enhanced monitoring, and formal enforcement, based on severity, recurrence, consumer harm, and the insurer's response. Greater transparency into what statutes/regulations/interpretations are relied upon and how fines are calculated would help insurers understand regulator concern and focus, evaluate internal risk and scope remediation appropriately.

Inconsistent treatment of self-reporting and fines was also a significant concern raised by our members. Regulators routinely encourage self-reporting, but the practical experience does

not always match the rhetoric as companies that self-report can face fines and remediation requirements that companies resolving issues internally avoid. This undermines the incentive for proactive disclosure. Greater consistency around treatment of proactive remediation and corrective action and cooperation as mitigating factors in enforcement proceedings would be helpful for our members. Additionally, verification artifacts for completed remediation can include before-and-after metrics, audit trails, revised procedures, training records, system-change evidence, quality-control reports, consumer communications where applicable, and evidence of sustained post-remediation improvement. Greater latitude on remediation timetables would likewise be helpful, as some findings cannot be remediated until a final consent order is received, and certain states impose a very short timeline after receipt within which to remediate. A rolling remediation schedule when/where appropriate with routine updates provided to regulators would also be something industry would support.

6. Consumer Complaints

Overall, our members reported that more alignment around complaint coding, closure notifications, standardized categories, regulator review and response timeframes would be helpful. Standardization of complaint coding definitions was consistently mentioned as a priority recommendation. Uniform definitions, examples, and coding criteria would be helpful for the following: confirmed, not confirmed, justified, unjustified, resolved, closed, complaint reason, disposition, line of business, allegation category, complainant (whether by Annuitant/Owner/Complainant), state (whether by issue state/complaint submission state, resident state, or state with regulatory jurisdiction) and company error. Further, standardization of complaint log formats would facilitate reporting and analysis of complaint data for regulators and insurers. Some states also classify lost policy inquiries as complaints, which can artificially inflate complaint counts where no service failure or consumer harm is alleged; this is an issue that should be addressed in any uniform coding standard. Also, many states do not inform companies which complaints have been confirmed, and no explanation is provided when a determination is made. The absence of feedback on confirmed complaint determinations limits companies' ability to understand the regulatory standard and design processes to meet it.

Response timeline inconsistency is one of the more operationally burdensome aspects of the current complaint framework, with deadlines ranging from seven days in some states to three weeks in others. Short deadlines force resource reallocation that increases the risk of incomplete responses. Our members recommend standardized response periods across states, with a standardized extension request process. This includes standardization around when the complaint response clock starts and the calculation of uniform response timeframes using either business or calendar days, but not both. The requirement of whether

and when an acknowledgment letter is needed should also be standardized, if one is required at all.

Documentation requirements should also be proportionate to the complaint and should only request what is necessary to facilitate a specific complaint's resolution. Enclosure page limits and portal upload limitations should be addressed and communicated, and more standardization across portals would be helpful. For example, status visibility with confirmation status, closure notifications, secure document exchange, due date tracking, and downloadable records with receipt confirmation would meaningfully reduce operational burden, rather than providing access only to a sole individual within the company. Portal access also should accommodate team sign-on credentials and email-based verification; individual employee cell phone registration requirements create operational and privacy challenges. Further, there should be self-service capabilities for insurers with portals, as requiring state administrators to add or remove access leads to delays. It is important, however, to ensure that any standardization across state portals appropriately includes uniform confidentiality standards addressing privileged material, trade secrets, proprietary business information, and consumer personal data.

In conclusion, IRI recommends that the Working Group focus on three themes across all the topics:

1. **Standardization.** Uniform national definitions, templates, data definitions and standard style guides, and response time requirements across market conduct data, examinations, complaints, and multi-state requests. Definitions and consistency are the foundational priorities. State adoption, however, is the key challenge and the Working Group should develop a concrete strategy for driving this.
2. **Consistency.** Predictable timelines, complaint handling requirements, examination procedures, and corrective action frameworks, including consistent self-reporting principles, uniform complaint response deadlines, standardized portal requirements, and published examiner training and consistency notes. Equally important is consistency in how data itself is defined, formatted, and exchanged: when data elements share standardized definitions, layouts, and transmission specifications across the industry, regulators can obtain the data they want more easily and more quickly, and insurers can respond through a single, repeatable process rather than building bespoke, state-by-state extracts for each request.
3. **Transparency.** Visibility into complaint coding and confirmation status, validation logic, examination reasoning, and fine calculation, supporting faster remediation, reducing unnecessary burden, and building constructive regulatory relationships that produce better consumer outcomes.

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Cutting across all three priorities is the need to align regulations and examination standards with modern digital processes. Clear guidance recognizing electronic delivery, digital transmission of data and digital record-keeping as fully compliant with existing requirements (combined with targeted updates where express statutory language requires physical delivery) would deliver immediate efficiency gains and strengthen consumer protection. IRI and its members appreciate the Working Group's efforts and look forward to continued engagement. Please do not hesitate to reach out with any questions or if there is anything else with which we can assist.

Sincerely,

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