TENTATIVE GENERAL SCHEDULE
NCOIL SPRING MEETING
MARCH 3 – 5, 2017

As of February 10, 2017, and Subject to Change

New Orleans Downtown Marriott
New Orleans, Louisiana

NCOIL SPRING MEETING
New Orleans, Louisiana
March 3-5, 2017
TENTATIVE SCHEDULE

FRIDAY, MARCH 3RD

Registration *Exhibits Open: 8:00 a.m. – 5:30 p.m.*	7:00 a.m.	-	5:30 p.m.
Welcome Breakfast	8:30 a.m.	-	10:00 a.m.
Special Executive Committee Session	10:00 a.m.	-	10:45 a.m.
Health, Long Term Care & Health Retirement Issues Committee	11:00 a.m.	-	12:30 p.m.
Griffith Foundation Legislator Luncheon	12:30 p.m.	-	1:45 p.m.
Legislative Micro Meetings	1:45 p.m.	-	2:15 p.m.
General Session	2:15 p.m.	-	3:30 p.m.
Networking Break	3:30 p.m.	-	3:45 p.m.
NCOIL–NAIC Dialogue	3:45 p.m.	-	5:00 p.m.
IEC Board Meeting	5:15 p.m.	-	5:45 p.m.
NCOIL Reception at the World War II Museum	5:30 p.m.	-	7:30 p.m.

SATURDAY, MARCH 4TH

Registration *Exhibits Open: 8:15 a.m. – 2:15 p.m.*	7:00 a.m.	-	2:15 p.m.

Financial Services & Investment Products Committee	8:15 a.m.	-	9:45 a.m.
General Session: Address by State Attorney General on Cybersecurity	9:45 a.m.	-	11:00 a.m.
Workers Compensation Committee	11:00 a.m.	-	12:00 p.m.
Luncheon	12:00 p.m.	-	1:15 p.m.
Life Insurance & Financial Planning Committee	1:15 p.m.	-	2:15 p.m.

SUNDAY, MARCH 5TH

Registration *Exhibits Open: 8:00 a.m. – 11:30 a.m.*	7:00 a.m.	-	11:00 a.m.
Property and Casualty Committee	8:00 a.m.	-	9:30 a.m.
Joint State-Federal Relations and International Insurance Issues Committee	9:30 a.m.	-	10:45 a.m.
Business Planning Committee and Executive Committee	10:45 a.m.	-	11:30 a.m.

FRIDAY, MARCH 3, 2017

Welcome Breakfast
March 3, 2017
8:30 a.m. – 10:00 a.m.

1. President Welcome
2. New member welcome
3. Professor Robert F. Williams Presentation on the automatic incorporation of private regulatory work product into State law
4. Adjournment

Special Executive Committee Session
March 3, 2017
10:00 a.m. – 10:45 a.m.

1. Preliminary Consideration of Model Act to Support State Regulation of Insurance Through More Informed Policymaking
2. Adjournment

Health, Long Term Care & Health Retirement Issues Committee
March 3, 2017
11:00 a.m. – 12:30 p.m.

**Call to order/roll call/approval of November 19, 2016 committee meeting minutes and January 27, 2017 interim committee minutes*

1. Network adequacy/provider directories/balance billing discussion
2. Discussion on value based insurance design
3. Discussion on ACA repeal/reform efforts
    a. Medicaid reform
    b. Marketplace Exchanges
    c. High-risk pools
4. Re-adoption of Model Laws
    a. Healthcare Balance Billing Disclosure Model Act
    b. Model Act Banning Fee Schedules for Uncovered Dental Services
    c. Patient Safety Model Act
    d. Rental Network Contract Arrangements Model Act
5. Adjournment

Griffith Foundation Educator Luncheon
March 3, 2017
12:30 p.m. – 1:45 p.m.

Legislative Micro Meetings
March 3, 2017
1:45 p.m. – 2:15 p.m.

General Session
The prospects of Financial Regulatory Restructuring and Legislative Reform in the Trump Administration and the 115th Congress
March 3, 2017
2:15 p.m. – 3:30 p.m.

Networking Break
March 3, 2017
3:30 p.m. – 3:45 p.m.

NCOIL – NAIC Dialogue
March 3, 2017
3:45 p.m. – 5:00 p.m.

**Call to order/roll call/approval of November 17, 2016 minutes*

1. NAIC Incorporation by Reference
2. Update on NAIC Insurance Data Security Model Law
3. Update on NAIC Unclaimed Property Model
4. Discussion on future of ACA and Dodd-Frank
    a. NAIC stance on elimination of FIO
5. Adjournment

IEC Board Meeting
March 3, 2017
5:15 p.m. – 5:45 p.m.

Taste of Louisiana Reception
March 3, 2017
6:00 p.m. – 7:00 p.m.

SATURDAY, MARCH 4, 2017

Financial Services & Investment Products Committee
March 4, 2017
8:15 a.m. – 9:45 a.m.

**Call to order/roll call/approval of November 17, 2016 committee meeting minutes*

1. Update on NAIC Insurance Data Security Model Law
2. Discussion of Resolution in Support of an Exemption for Community Banks from Onerous and Unnecessary Regulations
3. Discussion on New York and other State cybersecurity efforts
4. Federal cybersecurity developments
5. Adjournment

General Session: Address by State Attorney General on Cybersecurity
March 4, 2017
9:45 a.m. – 11:00 a.m.

Workers Compensation Committee
March 4, 2017
11:00 a.m. – 12:00 p.m.

**Call to order/roll call/approval of November 19, 2016 committee meeting minutes*

1. Presentation on Workers compensation premium fraud
2. Discussion on Florida workers compensation reform and its impact on other States
3. Discussion on Louisiana workers compensation system
4. Adjournment

Luncheon
March 4, 2017
12:00 p.m. – 1:15 p.m.

Life Insurance & Financial Planning Committee
March 4, 2017
1:15 p.m. – 2:15 p.m.

**Call to order/roll call/approval of November 18, 2016 committee meeting minutes*

1. Update on DOL Fiduciary Rule
2. Discussion on use of Big Data in Life Insurance Underwriting
3. Update on IIPRC Developments

4. Update on NAIC Unclaimed Property Model
5. Update on NAIC lost life insurance policy locator
6. Re-adoption of Model Laws:
    a. Insurance Compliance Self-Evaluative Privilege Model Act
    b. Secondary Addressee Model Act
7. Adjournment

SUNDAY, MARCH 5, 2017

Property & Casualty Committee
March 5, 2017
8:00 a.m. – 9:30 a.m.

**Call to order/roll call/approval of November 17, 2016 committee meeting minutes*

1. Detailed Discussion/Consideration of amended Limited Lines Travel Insurance Model Law
2. Discussion on Asbestos Claim Transparency Model Law
3. Rebates, Referrals and Rewards – What's OK and what's not?
4. Discussion on the use of Big Data and Autonomous Vehicles
5. Adjournment

Joint State-Federal Relations and International Insurance Issues Committee
March 5, 2017
9:30 a.m. – 10:45 a.m.

**Call to order/roll call/approval of November 18, 2016 joint committee meeting minutes*

1. Discussion on impact of Covered Agreement
    a. EU Equivalence and Solvency II
    b. H.R. 5143 update
2. Discussion on IAIS Initiatives
    a. International capital standards
3. FIO/FACI Activity
4. Discussion on new TRIA rules
5. Update on NCOIL Brussels Initiative
6. Proposed Resolution Encouraging FIO to Create a New Proposal for the Study of Auto Insurance Affordability in Accordance with Title V of Dodd-Frank
7. Adjournment

Business Planning Committee and Executive Committee
March 5, 2017
10:45 a.m.– 11:30 a.m.

**Call to order/roll call/approval of November 20, 2016 committee meeting minutes*

1. 2019 meeting locations
2. Recruitment of new member states
3. Administration
    a. Meeting Report
    b. Receipt of Financials
4. Consideration of Model Act to Support State Regulation of Insurance Through More Informed Policymaking
5. Re-adoption of Model Laws
    c. Healthcare Balance Billing Disclosure Model Act
    d. Model Act Banning Fee Schedules for Uncovered Dental Services
    e. Patient Safety Model Act
    f. Rental Network Contract Arrangements Model Act
    g. Insurance Compliance Self-Evaluative Privilege Model Act
    h. Secondary Addressee Model Act
6. Non-controversial calendar
    i. Committee Reports
7. Other Sessions
    j. Griffith Foundation Legislator Luncheon
    k. Featured Speakers
8. Any other business
9. Adjournment

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)
Healthcare Balance Billing Disclosure Model Act

Adopted by the NCOIL Executive Committee on March 6, 2011, and by the Health, Long-Term Care & Health Retirement Issues Committee on March 5, 2011.
Sponsored for discussion by Sen. Ann Cummings (VT) and Rep. Charles Kleckley (LA)

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Section 1. Purpose

The purpose of this Act is to provide transparency, accountability, and disclosure by healthcare facilities, facility-based providers, and health benefit plans regarding billing practices, notice of network benefits, and financial responsibilities in the delivery of non-emergency medical care.

Section 2. Definitions

A. "Balance billing" means the practice by a provider, who is not a participating provider in an enrollee's health plan network, of charging the enrollee the difference between the provider's fee and the sum of what the enrollee's health benefit plan pays and what the enrollee is required to pay in applicable deductibles, co-payments, coinsurance or other cost-sharing amounts as required by the health benefit plan.

Drafting Note: States should review their regulation of billing and payment practices for network and non-network providers.

B. "Enrollee" means an individual who is eligible to receive non-emergency medical care through a health benefit plan.

C. "Emergency medical care" includes any healthcare services provided in a healthcare facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. placing the patient's health in serious jeopardy;

2. serious impairment to bodily functions; or

3. serious dysfunction of any bodily organ or part.

D. "Facility-based provider" means an individual or group of healthcare providers:

1. to whom the facility has granted clinical privileges; and

2. who provides services to patients treated at the facility under those clinical privileges.

E. "Healthcare facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing non-emergency medical care, which is licensed by [Insert State Department of Health Services].

F. "Healthcare provider" means an individual who is licensed to provide and provides non-emergency medical care.

G. "Provider network" means all of the physicians and health care providers who have contracted to provide health care services to the enrollees of a health benefit plan. This includes a network operated by or that contracts with a health maintenance organization; a preferred provider organization; or another entity that issues a health benefit plan, including an insurance company.

Section 3. Applicability

A. This Act applies to any health benefit plan that:

1. provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(a) an insurance company;

(b) a group hospital service corporation operating under [Insert Applicable State Statute];

(c) a fraternal benefit society operating under [Insert Applicable State Statute];

(d) a stipulated premium company operating under [Insert Applicable State Statute];

(e) a health maintenance organization operating under [Insert Applicable State Statute];

(f) a multiple employer welfare arrangement that holds a certificate of authority under [Insert Applicable State Statute];

(g) an approved nonprofit health corporation that holds a certificate of authority under [Insert Applicable State Statute]; or

(h) an entity not authorized under this code or another insurance law of this state that contracts directly for non-emergency medical care on a risk-sharing basis, including a capitation basis; or

2. provides health and accident coverage through a risk pool created under [Insert Applicable State Statute].

B. This Act applies to a person to whom a health benefit plan contracts to:

1. process or pay claims;

2. obtain the services of physicians or other providers to provide non-emergency medical care to enrollees; or

3. issue verifications or pre-authorizations.

C. The Act applies to all healthcare facilities and facility-based providers that are providing medical care to patients, except for those providing care in Section 3(D).

D. This Act does not apply to:

1. Medicaid managed care programs operated under [Insert Applicable State Statute];

2. Medicaid programs operated under [Insert Applicable State Statute];

3. the state child health plan operated under [Insert Applicable State Statute];

4. Medicare;

5. emergency medical care as defined under Subsection 2(C) of this Act;

6. care as provided in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA); or

7. “excepted benefit” products as defined under 42 U.S.C. 300gg-91(c).

Section 4. Facility Disclosure

A. Each healthcare facility shall develop, implement, and enforce written policies for the billing of nonemergency medical care. The policies must address:

1. the providing of a conspicuous written disclosure to a consumer at the time the consumer is first treated on a non-emergency basis at the facility, at pre-admission, or first receives non-emergency or post-stabilization services at the facility that:

(a) provides confirmation whether the facility is a participating provider under the consumer's third-party payor coverage on the date services are to be rendered based on the information received from the consumer at the time the confirmation is provided; and

(b) informs consumers that if a facility-based provider who provides services to the consumer while the consumer is in the facility is not a participating provider with the same third-party payors as the facility, then the consumer may be billed for medical services for the amount unpaid by the consumer's health benefit plan.

2. the requirement that a facility provide a list, on request, to a consumer to be admitted to or who is expected to receive services from the facility, that contains the name and contact information for each facility-based provider or facility-based provider group that has been granted medical staff privileges to provide medical services at the facility; and

3. if the facility operates a website that includes a listing of physicians who have been granted medical staff privileges to provide medical services at the facility, the posting on the facility’s website of a list that contains the name and contact information for each facility-based provider or facility-based provider group that has been granted medical staff privileges to provide medical services at the facility and the updating of the list in any calendar quarter in which there are any changes to the list.

Section 5. Facility-Based Provider Disclosure

A. If a facility-based provider bills a patient treated at the facility for non-emergency medical care who is covered by a health benefit plan described in Section 3 that does not have a contract with the facility-based provider, requesting payment on the balance of the provider’s charge that is not related to co-pays, coinsurance payments, or deductible payments and is not covered by the health benefits plan, the facility-based provider shall send a billing statement that:

1. contains an itemized listing of the non-emergency medical care provided along with the dates the services and supplies were provided;

2. contains a conspicuous, plain-language explanation that:

(a) the facility-based provider is not within the health plan provider network; and

(b) the health benefit plan has paid a rate, as determined by the health benefit plan, which is below the facility-based provider billed amount;

3. contains a telephone number to call to discuss the statement, provide an explanation of any acronyms, abbreviations, and numbers used on the statement, or discuss any payment issues;

4. contains a statement that the patient may call to discuss alternative payment arrangements;

5. contains a notice that the patient may file complaints with the [Insert State Medical Board] and includes the [Insert State Medical Board] mailing address and complaint telephone number; and

6. for billing statements that total an amount greater than $200, over any applicable copayments or deductibles, states, in plain language, that if the patient finalizes a payment plan agreement within 30 days of receiving the first billing statement that includes all insurance payments and reflects the final amount owed by the enrollee or six months after the receipt of medical treatment, whichever occurs first and substantially complies with the agreement, the facility-based provider may not furnish adverse information to a consumer reporting agency regarding an amount owed by the patient for the receipt of medical treatment.

B. A patient may be considered by the facility-based provider to be out of substantial compliance with the payment plan agreement if payments in compliance with the agreement have not been made for a period of 45 days.

Drafting Note: States may wish to consider using an existing mediation process or establishing a mediation process to manage disputes that may arise regarding balance bills.

Section 6. Health Benefit Plan Disclosure

A. Each health benefit plan that reimburses healthcare through a provider network shall provide notice to its enrollees that:

1. a facility-based provider or other healthcare provider may not be included in the health benefit plan's provider network; and

2. a healthcare provider described by Section 6A(1) may balance bill the enrollee for amounts not paid by the health benefit plan.

B. 1. The health benefit plan shall provide the disclosure in writing to each enrollee:

(a) in any materials sent to the enrollee in conjunction with issuance or renewal of the plan's insurance policy or evidence of coverage;

(b) in an explanation of payment summary provided to the enrollee or in any other analogous document that describes the enrollee's benefits under the plan; and

(c) conspicuously displayed on any health benefit plan website that an enrollee is reasonably expected to access.

2. The commissioner by rule may prescribe specific requirements for the disclosure required under B(1). The form of the disclosure must be substantially as follows:

NOTICE: "IF YOU HAVE RECEIVED NON-EMERGENCY MEDICAL CARE IN A FACILITY THAT IS IN YOUR HEALTH PLAN'S NETWORK, BUT THE CARE IS DELIVERED BY A PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO IS NOT IN THAT NETWORK, YOU MAY BE RESPONSIBLE FOR PAYING SOME OR ALL OF THAT PHYSICIAN'S OR PROVIDER'S FEE THAT IS NOT COVERED BY YOUR HEALTH INSURANCE."

C. A health benefit plan must clearly identify healthcare facility-based providers who participate in the health benefit plan's provider network. Facility-based providers identified under this subsection must be identified in a separate and conspicuous manner in any provider network directory or website directory.

Drafting note: States may wish to consider amending their health plan network adequacy statutes to require that plans contract with an adequate number of facility-based providers at each in-network health care facility to serve their enrollees.

D. Along with any explanation of benefits sent to an enrollee that contains a remark code indicating a payment made to a non-network physician has been paid at the health benefit plan's allowable or usual and customary amount, a health benefit plan must also include the number for the department's consumer protection division for complaints regarding payment.

E. A health benefit plan shall provide to an insured by electronic or written correspondence, upon
request for a healthcare service or supply but no later than 48 hours after pre-certification, information on:

1. whether a facility-based provider or other healthcare provider is a participating provider in the insurer's preferred provider network;

2. whether proposed non-emergency medical care is covered by the health insurance policy;

3. what the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and

4. if applicable, coinsurance amounts owed based on the provider's contracted rate for in-network services or the insurer's usual and customary payment rate for out-of-network services.

Section 7. Penalties

A. The commissioner may take disciplinary action against a health benefit plan issuer that violates this Act, in accordance with *[Insert Applicable State Statute].*

B. A violation of this Act by a facility or a facility-based provider is grounds for disciplinary action and imposition of an administrative penalty by the *[Insert State Medical Board or Appropriate State Authority].*

Drafting Note: States should review administrative laws to ensure that appropriate notice, opportunity to cure, and other relevant administrative law provisions that may be applicable are appropriately incorporated into this model.

Section 8. Severability

If any section, paragraph, sentence, clause, phrase, or any part of this Act passed is declared invalid, the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected and shall remain in full force and effect.

Section 9. Effective Date

This Act shall take effect on [*insert months*] following enactment of the bill.

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)
Model Act Banning Fee Schedules for Uncovered Dental Services

Adopted by the NCOIL Executive Committee on November 21, 2010, and by the NCOIL Health, Long-Term Care & Health Retirement Issues Committee on November 20, 2010.

Section I. Summary
This Act would prohibit a dental insurance plan from requiring a dentist who provides services to its subscribers to accept a fee set by the plan for any services except covered services.

Section II. Definitions
A. "Covered services" means dental care services for which a reimbursement is available under an enrollee's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

B. "Dental plan" shall include any policy of insurance which is issued by a health care service contractor which provides for coverage of dental services not in connection with a medical plan.

Section III. Contracts With Providers For Dental Services
A. No contract of any health care service contractor that covers any dental services, and no contract or participating provider agreement with a dentist may require, directly or indirectly, that a dentist who is a participating provider provide services to an enrolled participant at a fee set by, or at a fee subject to the approval of, the health care service contractor unless the dental services are covered services.

Drafting Note: Concerns exist that dental plans may react by adopting a strategy of covering all services at a nominal or de minimus fee. Such a strategy by dental benefit plans, to adopt or impose a deductible, co-payment, co-insurances or any other requirement in such a way as to provide de minimus reimbursement and avoid the impact of this model bill is contrary to the spirit and intent of this model legislation. States should consider setting a threshold of what payment would constitute; for example, "50 percent of the dentists' prevailing fee, administered consistently with policies traditionally governing covered services."
B. A health care service contractor or other person providing third party administrator services shall not make available any providers in its dentist network to a plan that sets dental fees for any services except covered services.

Section IV. Penalties
Penalties provided for in [Insert Applicable State Statute Concerning Dental Plan Contracts] shall apply to any violation of this Act. Section V. Severability If any section, clause, or provision of this chapter shall be held either unconstitutional or ineffective in whole or in part to the extent that it is not unconstitutional or ineffective, it shall be valid and effective and no other section, clause or provision shall on account thereof be termed invalid or ineffective.

Section VI. Effective Date
This Act shall take effect immediately.

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
Patient Safety Model Act

Readopted by the NCOIL Health, Long-Term Care & Health Retirement Issues Committee on March 5, 2011, and Executive Committee on March 6, 2011. Adopted by the NCOIL Property-Casualty and Health Insurance Committees on November 18, 2005, and Executive Committee on November 19, 2005.

Sponsored by Rep. George Keiser (ND) and Assem. Nancy Calhoun (NY)

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[1] Based on Texas House Bill 1614, enacted during the 2003-2004 session.

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Purpose.

The purpose of this Act is to establish programs to:

A. promote public accountability through the detection of statewide trends in the occurrence of certain medical errors by:

1. requiring hospitals, ambulatory surgical centers, and mental hospitals to report errors
2. providing the public with access to statewide summaries of the reports 3. requiring hospitals, ambulatory surgical centers, and mental hospitals to implement risk-reduction strategies

B. require reporting of hospital infection statistics in order to improve patient safety

[Drafting Note: A further purpose of the Act is to reduce the rising medical liability insurance premiums that are charged to medical professionals and that reflect, in part, the costs of medical errors.]

Short Title.

This act may be called the Patient Safety Model Act.

Part I. Patient Safety Program.

Section A. Hospitals

Subpart 1. Duties of Department

(a) The department shall develop a patient safety program for hospitals. The program must:

[2] Based on a combination of New York State chapter amendments 284 and 239 (2005).

(1) be administered by the hospital licensing program within the department

(2) serve as an information clearinghouse for hospitals concerning best practices and quality improvement strategies

(b) The department shall group hospitals by size for the reports required by this Part as follows:

(1) less than 50 beds

(2) 50 to 99 beds

(3) 100 to 199 beds

(4) 200 to 399 beds

(5) 400 beds or more

(c) The department shall combine two or more categories described by Subsection (b) if the number of hospitals in any category falls below 40.

Subpart 2. Annual report

(a) On renewal of a license under this chapter, a hospital shall submit to the department an annual report that lists the number and frequency of occurrences at the hospital or at an outpatient facility owned or operated by the hospital of each of the following events during the preceding year:

(1) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient

(2) a perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams

(3) the suicide of a patient in a setting in which the patient received care 24 hours a day

(4) the abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant

(5) the sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility

(6) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities

(7) a surgical procedure on the wrong patient or on the wrong body part of a patient

(8) a foreign object accidentally left in a patient during a procedure

(9) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended

(b) The department may not require the annual report to include any information other than the number of occurrences of each event listed in Subsection (a) of this section.

Section B. Ambulatory Surgical Centers

Subpart 1. Duties of department

The department shall develop a patient safety program for ambulatory surgical centers. The program must:

(a) be administered by the ambulatory surgical center licensing program within the department

(b) serve as an information clearinghouse for ambulatory surgical centers concerning best and quality improvement strategies

Subpart 2. Annual report

(a) On renewal of a license under this chapter, an ambulatory surgical center shall submit to the department an annual report that lists the number and frequency of occurrences at the center or at an outpatient facility owned or operated by the center of each of the following events during the preceding year:

(1) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient

(2) the suicide of a patient

(3) the sexual assault of a patient during treatment or while the patient was on the premises of the center or facility

(4) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities

(5) a surgical procedure on the wrong patient or on the wrong body part of a patient

(6) a foreign object accidentally left in a patient during a procedure

(7) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended

(b) The department may not require the annual report to include any information other than the number of occurrences of each event listed in Subsection (a).

Section C. Mental Hospitals

Subpart 1. Duties of department

The department shall develop a patient safety program for mental hospitals licensed by the department. The program must:

(a) be administered by the licensing program within the department

(b) serve as an information clearinghouse for hospitals concerning best practices and quality improvement strategies

Subpart 2. Annual report

(a) On renewal of a license under this chapter, a mental hospital shall submit to the department an annual report that lists the number and frequency of occurrences at the hospital or at an outpatient facility owned or operated by the hospital of each of the following events during the preceding year:

(1) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient

(2) the suicide of a patient in a setting in which the patient received care 24 hours a day 5

(3) the sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility

(4) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities

(5) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended

(b) The department may not require the annual report to include any information other than the number of occurrences of each event listed in Subsection (a) of this section.

Section D. General Requirements

Subpart 1. Root cause analysis and action plan

(a) In this section, "root cause analysis" means the process that identifies basic or causal factors underlying a variation in performance leading to an event listed in Subparts 2 of Sections A, B, or C and that:

(1) focuses primarily on systems and processes

(2) progresses from special causes in clinical processes to common causes in organizational processes

(3) identifies potential improvements in processes or systems

(b) Not later than the 45th day after the date a hospital, ambulatory surgical center, or mental hospital becomes aware of an event listed in Subparts 2 of Sections A, B, or C, the facility shall:

(1) conduct a root cause analysis of the event

(2) develop an action plan that identifies strategies to reduce the risk of a similar event occurring in the future

(c) The department may review a root cause analysis or action plan related to an event listed in Subparts 2 of Sections A, B, or C during a survey, inspection, or investigation of a hospital, ambulatory surgical center, or mental hospital.

(d) The department may not require a root cause analysis or action plan to be submitted to the department.

(e) The department or an employee or agent of the department may not in any form, format, or manner remove, copy, reproduce, redact, or dictate from all or any part of a root cause analysis or action plan.

Subpart 2. Annual department summary

(a) The department annually shall compile and make available to the public a summary of the events reported by mental hospitals as required by Subpart 2 of Sections A, B, or C of this part. The summary shall identify events by specific hospital, ambulatory surgical center, or mental hospital but shall not directly or indirectly identify:

(1) an individual, or

(2) a specific reported event or the circumstances or individuals surrounding the event

Subpart 3. Best practices report and department summary

(a) A hospital, ambulatory surgical center, or mental hospital shall provide to the department at least one report of best practices and safety measures related to a reported event.

(b) A hospital, ambulatory surgical center, or mental hospital may provide to the department a report of other best practices and the safety measures that are effective in improving patient safety.

(c) The department by rule may prescribe the form and format of a best practices report. The department may not require a best practices report to exceed one page in length. The department shall accept, in lieu of a report in the form and format prescribed by the department, a copy of a report submitted by a hospital, ambulatory surgical center, or mental hospital to a patient safety organization.

(d) The department periodically shall:

(1) review the best practices reports

(2) compile a summary of the best practices reports determined by the department to be effective and recommended as best practices

(3) make the summary available to the public by posting it on the Department's Web site and distributing its availability to interested parties as widely as practical

(e) The summary shall identify best practices by specific hospital, ambulatory surgical center, or mental hospital but shall not directly or indirectly identify:

(1) an individual, or

(2) a specific reported event or the circumstances or individuals surrounding the event

Subpart 4. Confidentiality

The provisions of this section regarding the confidentiality of information or materials compiled or reported by a hospital, ambulatory surgical center, or mental hospital in compliance with or as authorized under this part do not restrict access, to the extent authorized by law, by the patient or the patient's legally authorized representative to records of the patient's medical diagnosis or treatment or to other primary health records.

Subpart 5. Report to legislature

(a) Not later than [insert practical date], the commissioner of public health shall: (1) evaluate the patient safety program established under Subpart 3 and

(2) report the results of the evaluation and make recommendations to the legislature

(b) The commissioner of public health shall conduct the evaluation in consultation with hospitals, ambulatory surgical centers, or mental hospitals licensed under [insert reference to licensing statute].

(c) The evaluation must address:

(1) the degree to which the department was able to detect statewide trends in errors based on the types and numbers of events reported

(2) the degree to which the statewide summaries of events compiled by the department were accessed by the public

(3) the effectiveness of the department's best practices summary in improving patient care
(4) the impact of national studies on the effectiveness of state or federal systems of reporting medical errors
(5) the Department shall publicize the report and its availability as widely as practical to interested parties, including, but not limited to, hospitals, providers, media organizations, health insurers, health maintenance organizations, purchasers of health insurance, organized labor, consumer or patient advocacy groups, and individual consumers. The annual report shall be made available to any person upon request.

Subpart 6. Gifts, grants, and donations
The department may accept and administer a gift, grant, or donation from any source to carry out the purposes of this part.

Subpart 7. Whistleblower Protection
(a) No employer shall take retaliatory action against any employee because the employee does any of the following:
(1) Discloses or threatens to disclose to any person or entity any activity, policy, practice, procedure, action, or failure to act of the employer or agent of the employer that the employee reasonably believes is a violation of any law or that the employee reasonably believes constitutes improper quality of patient care
(2) Provides information to, or testifies before, any public body conducting an investigation, a hearing, or an inquiry that involves allegations that the employer has violated any law or has engaged in behavior constituting improper quality of patient care
(3) Objects to or refuses to participate in any activity, policy, or practice of the employer or agent that the employee reasonably believes is in violation of a law or constitutes improper quality of patient care
(b) Subdivisions (a)(1) and (3) of this section shall not apply unless an employee first reports the alleged violation of law or improper quality of patient care to the employer, supervisor, or other person designated by the employer to address reports by employees of improper quality of patient care, and the employer has had a reasonable opportunity to address the violation. The employer shall address the violation under its compliance plan, if one exists. The employee shall not be required to make 8 a report under this Subsection if the employee reasonably believes that doing so would be futile because making the report would not result in appropriate action to address the violation.

Subpart 8. Administrative penalty
(a) The department may assess an administrative penalty against a person who violates this part or a rule adopted under this part.
(b) The penalty may not exceed $1,000 for each violation. Each day of a continuing violation constitutes a separate violation.

(c) In determining the amount of an administrative penalty assessed under this section, the department shall consider:

(1) the seriousness of the violation

(2) the history of previous violations

(3) the amount necessary to deter future violations

(4) efforts made to correct the violation

(5) any hazard posed to the public health and safety by the violation

(6) any other matters that justice may require

(d) All proceedings for the assessment of an administrative penalty under this Subpart are considered to be contested cases under [insert reference to state administrative procedure act].

Subpart 9. Notice; request for hearing

(a) If, after investigation of a possible violation and the facts surrounding that possible violation, the department determines that a violation has occurred, the department shall give written notice of the violation to the person alleged to have committed the violation. The notice shall include:

(1) a brief summary of the alleged violation

(2) a statement of the amount of the proposed penalty based on the factors set forth in Subpart 8(c) of this section

(3) a statement of the person's right to a hearing on the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty

(b) Not later than the 20th day after the date on which the notice is received, the person notified may accept the determination of the department made under this section, including the proposed penalty, or make a written request for a hearing on that determination.

(c) If the person notified of the violation accepts the determination of the department, the commissioner of public health or the commissioner's designee shall issue an order approving the determination and ordering that the person pay the proposed penalty.

Subpart 10. Hearing; order

(a) If the person notified fails to respond in a timely manner to the notice 9 under Subpart 9(b) of this section, or if the person requests a hearing, the department shall:

(1) set a hearing

(2) give written notice of the hearing to the person

(3) designate a hearings examiner to conduct the hearing

(b) The hearings examiner shall make findings of fact and conclusions of law and shall promptly issue to the commissioner of public health or the commissioner's designee a proposal for decision as to the occurrence of the violation and a recommendation as to the amount of the proposed penalty if a penalty is determined to be warranted.

(c) Based on the findings of fact and conclusions of law and the recommendations of the hearings examiner, the commissioner of public health or the commissioner's designee by

order may find that a violation has occurred and may assess a penalty or may find that no violation has occurred.

Subpart 11. Notice and payment of administrative penalty; judicial review; refund

(a) The department shall give notice of the order under Subpart 12(c) to the person notified. The notice must include:

(1) separate statements of the findings of fact and conclusions of law

(2) the amount of any penalty assessed

(3) a statement of the right of the person to judicial review of the order

(b) Not later than the 30th day after the date on which the decision is final as provided by [insert reference to state administrative procedure code], the person shall either:

(1) pay the penalty

(2) pay the penalty and file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty, or

(3) without paying the penalty, file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty

(c) Within the 30-day period, a person who acts under Subsection (b)(3) of this section may:

(1) stay enforcement of the penalty by:

(i) paying the penalty to the court for placement in an escrow account, or

(ii) giving to the court a supersedeas bond that is approved by the court for the amount of the penalty and that is effective until all judicial review of the order is final, or

(2) request the court to stay enforcement of the penalty by:

(i) filing with the court a sworn affidavit of the person stating that the person is financially unable to pay the amount of the penalty and is financially unable to give the supersedeas bond and

(ii) giving a copy of the affidavit to the department by certified mail

(d) If the department receives a copy of an affidavit under Subsection (c)(2) of 10 this Subpart, the department may file with the court, within five days after the date the copy is received, a contest to the affidavit. The court shall hold a hearing on the facts alleged in the affidavit as soon as practicable and shall stay the enforcement of the penalty on finding that the alleged facts are true. The person who files an affidavit has the burden of proving that the person is financially unable to pay the penalty and to give a supersedeas bond.

(e) If the person does not pay the penalty and the enforcement of the penalty is not stayed, the department may refer the matter to the attorney general for collection of the penalty.

(f) Judicial review of the order:

(1) is instituted by filing a petition as provided by [insert reference to state administrative procedure code], and

(2) is under the substantial evidence rule

(g) If the court sustains the occurrence of the violation, the court may uphold or reduce the amount of the penalty and order the person to pay the full or reduced amount of the penalty. If the court does not sustain the occurrence of the violation, the court shall order that no penalty is owed.

(h) When the judgment of the court becomes final, the court shall proceed under this Subsection. If the person paid the amount of the penalty under Subsection (b)(2) of this Subpart and if that amount is reduced or is not upheld by the court, the court shall order that the department pay the appropriate amount plus accrued interest to the person. The rate of the interest is the rate charged on loans to depository institutions by the New York Federal Reserve Bank, and the interest shall be paid for the period beginning on the date the penalty was paid and ending on the date the penalty is remitted. If the person paid the penalty under Subsection (c)(1)(i) or gave a supersedeas bond under Subsection (c)(1)(ii) and if the amount of the penalty is not upheld by the court, the court shall order the release of the escrow account or bond. If the person paid the penalty under Subsection (c)(1)(i) and the amount of the penalty is reduced, the court shall order that the amount of the penalty be paid to the department from the escrow account and that the remainder of the account be released. If the person gave a supersedeas bond and if the amount of the penalty is reduced, the court shall order the release of the bond after the person pays the amount.

Subpart 12. Expiration

Unless continued in existence, this part expires *[four years after the effective date of this act].*

Subpart 13. Effective dates

[State may want to consider amount of time necessary for entities to comply with the provisions of this act.]

<u>Part II. Hospital Infections Disclosure.</u>

Section A. Definitions

For purposes of this act:

1. "Department" means the Department of _____ *[State may have several possible agencies to collect the data. These could be the state hospital licensing agency, state health care data collection agency, or state public health agency. This would minimize the state's cost to implement the bill, as the hospital-acquired infection data can be gathered in the course of collecting other patient data.]*
2. "Hospital" means an acute care health care facility licensed under the Hospital Licensing Act *[insert a cross-reference and/or citation to the definition of "acute care hospital" in your state hospital licensing law. You may also consider including hospital-affiliated and freestanding outpatient surgical centers.]*
3. "Hospital-acquired infection" means a localized or systemic condition (a) that results from adverse reaction to the presence of an infectious agent(s) or its toxin(s) as determined by clinical examination and (b) that was not present or incubating at the time of admission to the hospital unless the infection was related to a previous admission to the same facility.

Section B. Hospital Reports

1.(a) Each hospital shall maintain a program capable of identifying and tracking hospital acquired infections for the purpose of public reporting under this section and quality improvement.

(b) Such programs shall have the capacity to identify the following elements: the specific infectious agents or toxins and site of each infection; the clinical department or unit within the facility where the patient first became infected; and the patient's diagnoses and any relevant specific surgical, medical or diagnostic procedure performed during the current admission.

(c) The department shall establish guidelines, definitions, criteria, standards and coding for hospital identification, tracking and reporting of hospital acquired infections that shall be consistent with the recommendations of recognized centers of expertise in the identification and prevention of hospital acquired infections including, but not limited to the National Health Care Safety Network of the Centers for Disease Control and Prevention or its successor. The department shall solicit and consider public comment prior to such establishment.

(d) Hospitals initially shall be required to identify, track and report hospital acquired infections that occur in critical care units to include surgical wound infections, central line related bloodstream infections, and ventilator associated pneumonia.

(e) Subsequent to the initial requirements identified in paragraph (d) of this subdivision the department may, from time to time, require the tracking and reporting of other types of hospital acquired infections that occur in hospitals in consultation with technical advisors who are regionally or nationally recognized experts in the prevention, identification and control of hospital acquired infection and the public reporting of performance data.

2. Each hospital shall regularly report to the department the hospital infection data it has collected. The department shall establish data collection and analytical methodologies that meet accepted standards for validity and reliability. In no case shall the frequency of reporting be required to be more frequently than once every six months, and reports shall be submitted not more than 60 days after the close of the reporting period.

3. The commissioner shall establish a state-wide database of all reported hospital acquired infection information for the purpose of supporting quality improvement and infection control activities in hospitals. The database shall be organized so that consumers, hospitals, healthcare professionals, purchasers and payers may compare individual hospital experience with that of other individual hospitals as well as regional and state-wide averages and, where available, national data.

4. (a) Subject to paragraph (c) of this subdivision, on or before [choose date] of each year the commissioner shall submit a report to the governor and the legislature, which shall simultaneously be published in its entirety on the department's Web site, that includes, but is not limited to, hospital acquired infection rates adjusted for the potential differences in risk factors for each reporting hospital, an analysis of trends in the prevention and control of hospital acquired infection rates in hospitals across the state, regional and, if available, national comparisons for the purpose of comparing individual

hospital performance, and a narrative describing lessons for safety and quality improvement that can be learned from leadership hospitals and programs.

(b) The commissioner shall consult with technical advisors who have regionally or nationally acknowledged expertise in the prevention and control of hospital acquired infection and infectious disease in order to develop the adjustment for potential differences in risk factors to be used for public reporting.

(c) (i) No later than one year subsequent to the effective date of this act, the department shall establish a hospital acquired infection reporting system capable of receiving electronically transmitted reports from hospitals. Hospitals shall begin to submit such reports as directed by the commissioner but in no case later than six months subsequent to the establishment of such reporting system.

(ii) The first year of data submission under this section shall be considered the "pilot phase" of the statewide hospital acquired infection reporting system. The purpose of the pilot phase is to ensure, by various means, including any audit process referred to in Subdivision 6 of this section, the completeness and accuracy of hospital acquired infection reporting by hospitals. For data reported during the pilot phase, hospital identifiers shall be encrypted by the department in any and all public databases and reports. The department shall provide each hospital with an encryption key for that hospital only to permit access to its own performance data for internal quality improvement purposes.

(iii) No later than 180 days after the conclusion of the pilot phase, the department shall issue a report to hospitals assessing the overall accuracy of the data submitted in the pilot phase and provide guidance for improving the 13 accuracy of hospital acquired infection reporting. The department shall issue a report to the governor and the legislature assessing the overall completeness and accuracy of the data submitted by hospitals during the pilot phase and make recommendations for the improvement or modification of hospital acquired infection data reporting based on the pilot phase, as well as share lessons learned in prevention of hospital acquired infections. No hospital- identifiable data shall be included in the pilot phase report, but aggregate or otherwise de-identified data may be included.

(iv) After the pilot phase is completed, all data submitted under this section and compiled in the statewide hospital acquired infection database established herein and all public reports derived therefrom shall include hospital identifiers.

5. Subject to Subdivision 4 of this section, a summary table, in a format designed to be easily understood by lay consumers, that includes individual facility hospital acquired infection rates adjusted for potential differences in risk factors and comparisons with regional and/or state averages shall be developed and posted on the department's Web site. The commissioner shall consult with consumer and patient advocates and representatives of reporting facilities for the purpose of ensuring that such summary table report format is easily understandable by the public, and clearly and accurately portrays comparative hospital performance in the prevention and control of hospital acquired infections.

6. To assure the accuracy of the self-reported hospital acquired infection data and to assure that public reporting fairly reflects what actually is occurring in each hospital, the department shall develop and implement an audit process.
7. For the purpose of ensuring that hospitals have the resources needed for ongoing staff education and training in hospital acquired infection prevention and control, the department may make such grants to hospitals within amounts appropriated therefor.

Section C. Privacy

(1) The provisions of this section regarding the confidentiality of information or materials compiled or reported by a hospital in compliance with or as authorized under this part do not restrict access, to the extent authorized by law, by the patient or the patient's legally authorized representative to records of the patient's medical diagnosis or treatment or to other primary health records.

(2) It is the expressed intent of the Legislature that a patient's right of confidentiality shall not be violated in any manner. Patient social security numbers and any other information that could be used to identify an individual patient shall not be released notwithstanding any other provision of law.

Section D. Whistleblower Protection

(a) No employer shall take retaliatory action against any employee because the employee does any of the following:

(1) Discloses or threatens to disclose to any person or entity any activity, policy, practice, procedure, action, or failure to act of the employer or agent of the employer that the employee reasonably believes is a violation of any law or 14 that the employee reasonably believes constitutes improper quality of patient care

(2) Provides information to, or testifies before, any public body conducting an investigation, a hearing, or an inquiry that involves allegations that the employer has violated any law or has engaged in behavior constituting improper quality of patient care

(3) Objects to or refuses to participate in any activity, policy, or practice of the employer or agent that the employee reasonably believes is in violation of a law or constitutes improper quality of patient care

(b) Subdivisions (a)(1) and (3) of this section shall not apply unless an employee first reports the alleged violation of law or improper quality of patient care to the employer, supervisor, or other person designated by the employer to address reports by employees of improper quality of patient care, and the employer has had a reasonable opportunity to address the violation. The employer shall address the violation under its compliance plan, if one exists. The employee shall not be required to make a report under this Subsection if the employee reasonably believes that doing so would be futile because making the report would not result in appropriate action to address the violation.

Section E. Penalties

A determination that a hospital has violated the provisions of this Act may result in any of the following:

1. termination of licensure or other sanctions relating to licensure under the Hospital Licensing Act *[insert name and citation of state hospital licensing act].*
2. a civil penalty of up to $1,000 per day per violation for each day the hospital is in violation of the Act

Section F. Regulatory oversight

The Department shall be responsible for ensuring compliance with this Act as a condition of licensure under the Hospital Licensing Act and shall enforce such compliance according to the provisions of the Hospital Licensing Act. *[insert name and citation of state hospital licensing act].*

Section G. Amendments

The Hospital Licensing Act is amended as follows: *[Amend state hospital licensing act to add that violations of the Infections Disclosure Act are grounds for license termination or sanctions under the state licensing act.]*

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
RENTAL NETWORK CONTRACT ARRANGEMENTS MODEL ACT

Adopted by the NCOIL Executive Committee on November 23, 2008, and by the Health, Long-Term Care, and Health Retirement Issues Committee on November 21, 2008.

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Section I. Definitions

For purposes of this Act, the following definitions shall apply:

A. "Contracting entity" means any person or entity that enters into direct contracts with providers for the delivery of health care services in the ordinary course of business.

B. "Covered individual" means an individual who is covered under a health insurance plan.

C. "Direct notification" is a written or electronic communication from a contracting entity to a provider documenting third party access to a provider network.

D. "Health care services" means services for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.

E. 1. "Health insurance plan" means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise.
2. "Health insurance plan" shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance; coverage issued as

a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; coverage similar to the foregoing as specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits; dental or vision benefits; benefits for long-term care, nursing home care, home health care, or community-based 2 care; specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or such other similar, limited benefits as are specified in regulations; Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or other similar limited benefit supplemental coverages.

F. 1. "Provider" means a physician, a physician organization, or a physician hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts.

2. "Provider" does not include a physician organization or physician hospital organization that leases or rents the physician organization's or physician hospital organization's network to a third party.

G. "Provider network contract" means a contract between a contracting entity and a provider specifying the rights and responsibilities of the contracting entity and provider for the delivery of and payment for health care services to covered individuals.

H. "Third party" means an organization that enters into a contract with a contracting entity or with another third party to gain access to a provider network contract.

Section II. Scope

A. This Act does not apply to provider network contracts for services provided to Medicaid, Medicare, or State Children's Health Insurance Program (SCHIP) beneficiaries.

B. This Act does not apply in circumstances where access to the provider network contract is granted to an entity operating under the same brand licensee program as the contracting entity.

C. This Act does not apply to a contract between a contracting entity and a discount medical plan organization.

Drafting Note: Each state will determine whether this legislation should apply to self-funded employer-sponsored health insurance plans and/or third-party administrators operating on their behalf (as regulated under the Employee Retirement Income Security Act of 1974 [ERISA]).

Section III. Registration

A. Any person that commences business as a contracting entity shall register with the (Appropriate State Agency) within 30 days of commencing business in this State unless such person is licensed by the (Appropriate State Agency) as an insurer. Upon passage of this Act, each person, not licensed by the (Appropriate State Agency) as a contracting entity shall register with the (Appropriate State Agency) within 90 days of the effective date of this Act.

1. Registration shall consist of the submission of the following information:

(a) the official name of the contracting entity, including any d/b/a designations used in this state;

(b) the mailing address and main telephone number for the contracting entity's main headquarters; and

(c) the name and telephone number of the contracting entity's representative who shall serve as the primary contact with the Department.

2. The information required by this Section shall be submitted in written or electronic format, as prescribed by the (Appropriate State Agency).

3. The (Appropriate State Agency) may collect a reasonable fee for the purpose of administering the registration process.

Section IV. Contracting Entity Rights and Responsibilities

A. A contracting entity may not grant access to a provider's health care services and contractual discounts pursuant to a provider network contract unless:

1. the provider network contract specifically states that the contracting entity may enter into an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities under the provider network contract as if the third party were the contracting entity; and

2. the third party accessing the provider network contract is contractually obligated to comply with all applicable terms, limitations, and conditions of the provider network contract.

B. A contracting entity that grants access to a provider's health care services and contractual discounts pursuant to a provider network contract shall:

1. identify and provide to the provider, upon request at the time a provider network contract is entered into with a provider, a written or electronic list of all third parties known at the time of contracting, to which the contracting entity has or will grant access

to the provider's health care services and contractual discounts pursuant to a provider network contract;

2. maintain an internet website or other readily available mechanism, such as a toll-free telephone number, through which a provider may obtain a listing, updated at least every 90 days, of the third parties to which the contracting entity or another third party has executed contracts to grant access to such provider's health care services and contractual discounts pursuant to a provider network contract;

3. provide the third party with sufficient information regarding the provider network contract to enable the third party to comply with all relevant terms, limitations, and conditions of the provider network contract;

4. require that the third party who contracts with the contracting entity to gain access to the provider network contract identify the source of the contractual discount taken by the third party on each remittance advice (RA) or explanation of payment (EOP) form furnished to a health care provider when such discount is pursuant to the contracting entity's provider network contract; and

5. (a) notify the third party who contracts with the contracting entity to gain access to the provider network contract of the termination of the provider network contract no later than (insert number) days prior to the effective date of the final termination of the provider network contract; and

(b) require those that are by contract eligible to claim the right to access a provider's discounted rate to cease claiming entitlement to those rates or other contracted rights or obligations for services rendered after termination of the provider network contract.

(c) The notice required under subsection IV(B)(5)(a) can be provided through any reasonable means, including but not limited to: written notice, electronic communication, or an update to electronic database or other provider listing.

C. Subject to any applicable continuity of care requirements, agreements, or contractual provisions:

1. a third party's right to access a provider's health care services and contractual discounts pursuant to a provider network contract shall terminate on the date the provider network contract is terminated;

2. claims for health care services performed after the termination date of the provider network contract are not eligible for processing and payment in accordance with the provider network contract; and

3. claims for health care services performed before the termination date of the provider network contract, but processed after the termination date, are eligible for processing and payment in accordance with the provider network contract.

D. 1. All information made available to provider in accordance with the requirements of this Act shall be confidential and shall not be disclosed to any person or entity not involved in the provider's practice or the administration thereof without the prior written consent of the contracting entity.

2. Nothing contained in this Act shall be construed to prohibit a contracting entity from requiring the provider to execute a reasonable confidentiality agreement to ensure that confidential or proprietary information disclosed by the contracting entity is not used for any purpose other than the provider's direct practice management or billing activities.

Section V. Third Party Rights and Responsibilities

A. A third party, having itself been granted access to a provider's health care services and contractual discounts pursuant to a provider network contract, that subsequently grants access to another third party is obligated to comply with the rights and responsibilities imposed on contracting entities under Sections IV and VI of this Act.

B. A third party that enters into a contract with another third party to access a provider's health care services and contractual discounts pursuant a provider network contract is obligated to comply with the rights and responsibilities imposed on third parties under Section V of this Act.

C. 1. A third party will inform the contracting entity and providers under the contracting entity's provider network contract of the location of a website, toll-free number, or other readily available mechanism, to identify the name of the person or entity to which the third party subsequently grants access to the provider's health care services and contractual discounts pursuant to the provider network contract.

2. The website will be updated on a routine basis as additional persons or entities are granted access. The website shall be updated to reflect all current persons and entities with access every 90 days. Upon request, a contracting entity shall make access information available to a provider via telephone or through direct notification.

Section VI. Unauthorized Access to Provider Network Contracts

A. It is an unfair insurance practice for the purposes of (insert applicable reference to state insurance code unfair trade practices section) to knowingly access or utilize a provider's contractual discount pursuant to a provider network contract without a contractual relationship with the provider, contracting entity, or third party, as specified in this Act.

B. Contracting entities and third parties are obligated to comply with Sections IV(B)(2) or V(C)(1) and (2) concerning the services referenced on a remittance advice (RA) or explanation of payment (EOP). A provider may refuse the discount taken on the RA or EOP if the discount is taken without a contractual basis or in violation of these sections. However, an error in the RA or EOP may be corrected within 30 days following notice by the provider.

C. A contracting entity may not lease, rent, or otherwise grant to a third party, access to a provider network contract unless the third party accessing the health care contract is:

1. a payer or third party administrator or another entity that administers or processes claims on behalf of the payer;

2. a preferred provider organization or preferred provider network, including a physician organization or physician-hospital organization; or

3. an entity engaged in the electronic claims transport between the contracting entity and the payer that does not provide access to the provider's services and discount to any other third party.

Section VII. Enforcement
Enforcement of this model will follow that of *(insert applicable reference to state insurance code unfair trade practices section).*

Section VIII. Effective Date
This Act shall be effective *(insert date).*

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INSURANCE COMPLIANCE SELF-EVALUATIVE PRIVILEGE MODEL ACT

Adopted by the NCOIL Life Insurance Committee on February 28, 1998, and by the Executive Committee on March 1, 1998. Readopted by the Executive Committee on July 13, 2001, February 27, 2004, July 22, 2006, and February 26, 2012.

Section 1. Insurance compliance self-evaluative privilege.

(a) To encourage insurance companies and persons conducting activities regulated under this Code, both to conduct voluntary internal audits of their compliance programs and management systems and to assess and improve compliance with State and federal statutes, rules, and orders, an insurance compliance self-evaluative privilege is recognized to protect the confidentiality of communication relating to voluntary internal compliance audits. The Legislature hereby finds and declares that protection of insurance consumers is enhanced by companies' voluntary compliance with this State's insurance and other laws and that the public will benefit from incentives to identify and remedy insurance and other compliance problems. It is further declared that limited expansion of the protection against disclosure will encourage voluntary compliance and improve insurance market conduct quality and that the voluntary provisions of this Section will not inhibit the exercise of the regulatory authority by those entrusted with protecting insurance consumers.

*Drafting Note: An insurance compliance self-evaluative audit is not intended to replace a market conduct examination by regulators.**

(b) (1) Except as provided in subsections (c) and (d) of this section, an insurance compliance selfevaluative audit document is privileged information and is not discoverable, or admissible as evidence in any legal action in any civil, criminal, or administrative proceeding. The privilege created herein is a matter of substantive law of this State and is not merely a procedural matter governing civil or criminal procedures in the courts of this State.

Drafting Note: An alternative to this approach would be to include subsection (b) in the exception clause which would allow a regulator to discover (gain access to) the work product of a self-evaluative audit.

(2) If any company, person, or entity performs or directs the performance of an insurance compliance audit, an officer, employee or agent involved with the insurance compliance audit, or any consultant who is hired for the purpose of performing the

insurance compliance audit, may not be examined in any civil, criminal, or administrative proceeding as to the insurance compliance audit or any insurance compliance self-evaluative audit document, as defined in this Section. This subsection (b)(2) does not apply if the privilege set forth in subsection (b)(1) of this Section is determined under subsection (c) or (d) not to apply.

(3) A company may voluntarily submit, in connection with examinations conducted under this Article, an insurance compliance self-evaluative audit document to the Commissioner, or his or her designee, as a confidential document under Section [ ] of this Code without waiving the privilege set forth in this Section to which the company would otherwise be entitled; provided, however, that the provisions in Section [ ] permitting the Commissioner to make confidential documents public pursuant to Section [ ] and access to the National Association of Insurance Commissioners shall not apply to the insurance compliance self-evaluative audit document so voluntarily submitted. To the extent that the Commissioner has the authority to compel the disclosure of an insurance compliance self-evaluative audit document under other provisions of applicable law, any such report furnished to the Commissioner shall not be provided to any other persons or entities and shall be accorded the same confidentiality and other protections as provided above for voluntarily submitted documents. Any use of an insurance compliance self-evaluative audit document furnished as a result of a request of the Commissioner under a claim of authority to compel disclosure shall be limited to determining whether or not any disclosed defects in an insurers' policies and procedures or inappropriate treatment of customers has been remedied or that an appropriate plan for their remedy is in place.

(i) A company's insurance compliance self-evaluative audit document submitted to the Commissioner shall remain subject to all applicable statutory or common law privileges including, but not limited to, the work product doctrine, attorney-client privilege, or the subsequent remedial measures exclusion.

(ii) Any compliance self-evaluative audit document so submitted and in the possession of the Commissioner shall remain the property of the company and shall not be subject to any disclosure or production under [state's Freedom of Information Act or sunshine law(s).]

(4) Disclosure of an insurance compliance self-evaluative audit document to a governmental agency, whether voluntary or pursuant to compulsion of law, shall not constitute a waiver of the privilege set forth in subsection (b)(1) of this section with respect to any other persons or any other governmental agencies.

(c) (1) The privilege set forth in subsection (b) of this Section does not apply to the extent that it is expressly waived by the company that prepared or caused to be prepared the insurance compliance self-evaluative audit document.

(2) In a civil or administrative proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege set forth in subsection (b) of this Section is asserted, if the court determines one of the following:

(A) the privilege is asserted for a fraudulent purpose; or

(B) the material is not subject to the privilege.

(3) In a criminal proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege described in subsection (b) of this Section is asserted, if the court determines one of the following:

(A) the privilege is asserted for a fraudulent purpose;

(B) the material is not subject to the privilege; or

(C) the material contains evidence relevant to commission of a criminal offense under this Code, and all three of the following factors are present:

(i) the Commissioner, State's Attorney, or Attorney General has a compelling need for the information; and

(ii) the information is not otherwise available; and

(iii) the Commissioner, State's Attorney, or Attorney General is unable to obtain the substantial equivalent of the information by any other means without incurring unreasonable cost and delay.

(d) (1) Within 30 days after the Commissioner, State's Attorney, or Attorney General serves on an 3 insurer a written request by certified mail for disclosure of an insurance compliance self-evaluative audit document under this subsection, the company that prepared or caused the document to be prepared may file with the appropriate court a petition requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Section or subject to disclosure. The court has jurisdiction over a petition filed by a company under this subsection requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged or subject to disclosure. Failure by the company to file a petition waives the privilege for this request only.

(2) A company asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall include in its request for an in camera hearing all of the information set forth in subsection (d)(5) of this Section.

(3) Upon the filing of a petition under this subsection, the court shall issue an order scheduling, within 45 days after the filing of the petition, an in camera hearing to determine whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Section or subject to disclosure.

(4) The court, after an in camera review, may require disclosure of material for which the privilege in subsection (b) of this Section is asserted if the court determines, based upon its in camera review, that any one of the conditions set forth in subsection (c)(2)(A) and (B) is applicable as to a civil or administrative proceeding or that any one of the conditions set forth in subsection (c)(3)(A) through (C) is applicable as to a criminal proceeding. Upon making such a determination, the court may only compel the disclosure of those portions of an insurance compliance self-evaluative audit document relevant to issues in dispute in the underlying proceeding. Any compelled disclosure will not be considered to be a public document or be deemed to be a waiver of the privilege for any other civil, criminal, or administrative proceeding. A party unsuccessfully opposing disclosure may apply to the court for an appropriate order protecting the document from further disclosure.

(5) A company asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection (d) shall provide to the Commissioner, State's Attorney, or Attorney General, as the case may be, at the time of filing any objection to the disclosure, all of the following information:

(A) The date of the insurance compliance self-evaluative audit document.

(B) The identity of the entity conducting the audit.

(C) The general nature of the activities covered by the insurance compliance audit.

(D) An identification of the portions of the insurance compliance self-evaluative audit document for which the privilege is being asserted.

(e) (1) A company asserting the insurance compliance self-evaluative privilege set forth in subsection (b) of this Section has the burden of demonstrating the applicability of the privilege. Once a company has established the applicability of the privilege, the party seeking disclosure under subsection (c)(2)(A) of this Section has the burden of proving that the privilege is asserted for a fraudulent purpose. The Commissioner, State's Attorney, or Attorney General seeking disclosure under subsection (c)(3) of this Section has the burden of proving the elements set forth in subsection (c)(3) of this Section.

(2) The parties may at any time stipulate in proceedings under subsections (c) or (d) of this Section to entry of an order directing that specific information contained in an insurance compliance self- evaluative audit document is or is not subject to the privilege

provided under subsection (b) of this Section. Any such stipulation may be limited to the instant proceeding and, absent specific 4 language to the contrary, shall not be applicable to any other proceeding.

(f) The privilege set forth in subsection (b) of this Section shall not extend to any of the following:

(1) documents, communications, data, reports, or other information expressly required to be collected, developed, maintained, or reported to a regulatory agency pursuant to this Code, or other federal or State law;

(2) information obtained by observation or monitoring by any regulatory agency; or

(3) information obtained from a source independent of the insurance compliance audit

(g) As used in this Section:

(1) “Insurance compliance audit” means a voluntary, internal evaluation, review, assessment, audit, or investigation for the purpose of identifying or preventing noncompliance with, or promoting compliance with laws, regulations, orders, or industry or professional standards, which is conducted by or on behalf of a company licensed or regulated under this Code, or which involves an activity regulated under this Code.

(2) “Insurance compliance self-evaluative audit document” means documents prepared as a result of or in connection with an insurance compliance audit. An insurance compliance self-evaluative audit document may include a written response to the findings of an insurance compliance audit. An insurance compliance self-evaluative audit document may include, but is not limited to, as applicable, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer-generated or electronically recorded information, phone records, maps, charts, graphs, and surveys, provided this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit. An insurance compliance self-evaluative audit document also includes, but is not limited to, any of the following:

(A) an insurance compliance audit report prepared by an auditor, who may be an employee of the company or an independent contractor, which may include the scope of the audit, the information gained in the audit, and conclusions and recommendations, with exhibits and appendices;

(B) memoranda and documents analyzing portions or all of the insurance compliance audit report and discussing potential implementation issues;

(C) an implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing future noncompliance; or

(D) analytic data generated in the course of conducting the insurance compliance audit.

(3) “Company” has the same meaning as provided in [Reference specific state code].

(h) The insurance compliance self-evaluative privilege created by this legislation shall apply to all litigation or administrative proceedings pending at the effective date of this legislation.

(i) Nothing in this Section nor the release of any self-evaluative audit document hereunder shall limit, waive, or abrogate the scope or nature of any statutory or common law privilege including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

(j) Effective Date. This bill shall become effective immediately upon its passage by the Legislature and approval by the Governor.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

SECONDARY ADDRESSEE MODEL ACT

Adopted by the NCOIL Life Insurance Committee on November 17, 1996, and by the NCOIL Executive Committee on November 20, 1996. Readopted by the NCOIL Executive Committee on July 12, 2001, February 27, 2004, July 22, 2006, and February 26, 2012.

Section 1. Secondary notice.

A. Except as provided herein, no individual contract for life insurance issued or issued for delivery in this state (one year after the effective date of this Act) covering a natural person 64 years of age or older, which has been in force for at least 1 year, shall be lapsed for nonpayment of premium unless, after expiration of the grace period and at least 21 days prior to the effective date of any such lapse, the insurer has mailed a notification of such impending lapse in coverage to the policyowner and to a specified secondary addressee if such addressee has been designated in writing by name and address by the policyowner.

B. An insurer issuing such a life insurance contract on or after (one year after the effective date of this Act) shall notify the applicant of the right to designate a secondary addressee at the time of application for the policy on a form provided by the insurer, and thereafter the policyowner has the right to designate a secondary addressee, in writing, by name and address, at any time the policy is in force, by submitting such written notice to the insurer.

C. For purposes of any life insurance policy which provides a grace period longer than 51 days for nonpayment of premiums, the notice of possible lapse in coverage as required by this section shall be mailed at least 21 days prior to the expiration of the grace period provided in such policies to the policyowner and to the secondary addressee.

D. This section shall not apply to life insurance contracts under which premiums are payable monthly or more frequently and regularly collected by a licensed agent, or paid by a credit card or any pre-authorized check processing or automatic debit service of a financial institution.

Section 2. This Act shall take effect upon becoming law.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

~~Limited Lines~~ Travel Insurance Model Act

Adopted by the NCOIL Property-Casualty Insurance Committee on November 16, 2012, and Executive Committee on November 18, 2012. ***Sponsored by Rep. Robert Damron (KY).***
****Amendments sponsored by Rep. Matt Lehman (IN)***

Drafting Note: This Travel Insurance Model Act is intended to be enacted as a standalone chapter of the insurance code with appropriate cross references to seamlessly incorporate provisions such as licensing and premium tax into the adopting state's existing statutory structure. Alternatively, sections such as the licensing and premium tax provisions that may fit into other sections of an adopting state's statutory structure could be pulled from the Model and incorporated into the sections of the adopting state's insurance code that address those topics.

Section 1. Short Title

This Act shall be known as the "~~Limited Lines~~ Travel Insurance Model Act."

Section 2. Scope and Purposes

A. The purpose of this Act is to promote the public welfare by creating a comprehensive legal framework within which Travel Insurance may be sold in this state through the establishment of clear regulatory obligations for those involved in the development and distribution of Travel Insurance, preserving the unique aspects of Travel Protection Plans, and protecting and benefiting consumers by encouraging fair and effective competition within the market.

B. The requirements of this Act shall apply to Travel Insurance, whether or not provided as part of a Travel Protection Plan, where policies and certificates are delivered or issued for delivery in this state. It shall not be applicable to Cancellation Fee Waivers and Travel Assistance Services, except as expressly provided herein.

C. All other applicable provisions of this state's insurance laws shall continue to apply to Travel Insurance except that the specific provisions of this Act shall supersede any general provisions of law that would otherwise be applicable to Travel Insurance. In the case of any conflict between the provisions of this Act and any other provisions of the insurance laws of this state, the provisions of this Act shall prevail.

Section ~~2~~3. Definitions

As used in this Act:

"Aggregator Site" means a website that provides access to information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping.

"Blanket Travel Insurance" means Travel Insurance issued to any Eligible Group providing coverage for specified circumstances and specific classes of persons defined in the policy and issued to a policyholder and not by specifically naming the persons covered, by certificate or otherwise, although a statement of the coverage provided may be given, or required by policy to be given, to eligible persons.

"CancellationFee Waiver" means a contractual agreement between a supplier of travel arrangements or travel services and its customer to waive some or all of the non-refundable cancellation fee or penalty provisions of the underlying travel contract between the supplier and customer. A CancellationFee Waiver is not insurance.

"Commissioner" means the commissioner of insurance of this state.

> **Drafting Note:** Insert the title of the state's chief insurance regulatory official wherever the term "Commissioner" appears.

"Eligible Group" means any of the following:

a. Any entity engaged in the business of providing travel or travel services, including but not limited to: tour operators, lodging providers, vacation property owners, hotels and resorts, travel clubs, property managers, cultural exchange programs, and common carriers of passengers, including but not limited to airlines, cruise lines, railroads, steamship companies, and public bus carriers;

b. Any college, school, or other institution of learning covering students, teachers or employees defined by reference to specified hazards incident to activities or operations of the institution of learning;

c. Any employer covering any group of employees, contractors, dependents or guests, defined by reference to specified hazards incident to activities or operations of the employer;

d. Any sports team, camp, or sponsor thereof covering participants, members, campers, employees, officials, supervisors, or volunteers;

e. Any religious, charitable, recreational, educational, or civic organization or branch thereof covering any group of members, participants, or volunteers defined by reference to specified hazards incident to any activity or activities or operations sponsored or supervised by or on the premises of such organization or branch;

f. Any financial institution or financial institution vendor, or parent holding company, trustee, or agent of or designated by one or more financial institution or financial institution vendor, under which accountholders, credit card holders, debtors, guarantors, or purchasers are insured;

g. Any incorporated or unincorporated association, including labor unions, having a common interest, constitution and bylaws, and organized and maintained in good faith for purposes other than obtaining insurance for members or participants of such association;

h. Any trust or the trustees of a fund established, created or maintained for the benefit of members or customers of one or more associations meeting the above requirements;

i. Any entertainment production company covering any group of participants, volunteers, audience members, contestants, or workers;

j. Any newspaper or other publisher covering its journalists and carriers;

k. Any volunteer fire department or any first aid, civil defense or other such volunteer group, or agency having jurisdiction thereof, covering all or any group of the members, participants or volunteers of such fire department or first aid, civil defense or other group; or

l. Any other group where the Commissioner has determined that the members are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, and that issuance of the policy would not be contrary to the best interests of the public.

"Group Travel Insurance" means Travel Insurance issued to any Eligible Group.

~~A.~~ "Limited Lines Travel Insurance Producer" means a~~:~~ (i) licensed managing general agent or third party administrator, (ii) licensed insurance producer, including a limited lines producer, or (iii) Travel Administrator.

~~1. Licensed managing general underwriter,~~
~~2. Licensed managing general agent or third party administrator, or~~
~~3. Licensed insurance [producer/agent] designated by an insurer as the travel insurance supervising entity as set forth in Section 6 below.~~

~~B.~~ "Offer and disseminate" means providing general information, including a description of the coverage and price, as well as processing the application, collecting premiums, and performing other non-licensable activities permitted by the state.

"Travel Administrator" means a person who directly or indirectly underwrites, collects charges, collateral or premiums from, or adjusts or settles claims on residents of this state, in connection with Travel Insurance, except that a person shall not be considered a Travel Administrator if that

person's only actions that would otherwise cause it to be considered a Travel Administrator are among the following:

a. a person working for a Travel Administrator to the extent that the person's activities are subject to the supervision and control of the Travel Administrator;

b. an insurance producer selling insurance or engaged in administrative and claims related activities within the scope of the producer's license;

c. a Travel Retailer offering and disseminating Travel Insurance and registered under the license of a Limited Lines Travel Insurance Producer in accordance with this Act;

d. an individual adjusting or settling claims in the normal course of that individual's practice or employment as an attorney at law and who does not collect charges or premiums in connection with insurance coverage; or

e. a business entity that is affiliated with a licensed insurer while acting as a Travel Administrator for the direct and assumed insurance business of an affiliated insurer.

"Travel Assistance Services" means non-insurance services that may be distributed by Limited Lines Travel Insurance Producers or other entities, and for which there is no indemnification for the Travel Protection Plan customer based on a fortuitous event, nor any transfer or shifting of risk that would constitute the business of insurance. Travel Assistance Services include, but are not limited to: security advisories; destination information; vaccination and immunization information services; travel reservation services; entertainment; activity and event planning; translation assistance; emergency messaging; international legal and medical referrals; medical case monitoring; coordination of transportation arrangements; emergency cash transfer assistance; medical prescription replacement assistance; passport and travel document replacement assistance; lost luggage assistance; concierge services; and any other service that is furnished in connection with planned travel that is not related to the adjudication of a Travel Insurance claim, unless otherwise approved by the Commissioner in a Travel Insurance filing. Travel Assistance Services are not insurance and not related to insurance.

~~C.~~ "Travel Insurance" means insurance coverage for personal risks incident to planned travel, including but not limited to:

1. interruption or cancellation of trip or event;
2. loss of baggage or personal effects;
3. damages to accommodations or rental vehicles; or
4. sickness, accident, disability or death occurring during travel.

Travel insurance does not include major medical plans, which provide comprehensive medical protection for travelers with trips lasting six (6) months or longer, including for example, those working overseas as an ex-patriot or military personnel being deployed.

"Travel Protection Plans" means plans that provide one or more of the following: Travel Insurance, Travel Assistance Services, and CancellationFee Waivers.

~~D.~~ "Travel Retailer" means a business entity that makes, arranges or offers travel services and may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a Limited Lines Travel Insurance Producer.

> **Drafting Note:** States that have recently adopted Travel Insurance producer licensing and registration laws or regulations may refer to the applicable definitions adopted therein rather than restating them in this section.

~~Section 3. Requirements~~ Section 4. Licensing and Registration

A. The Commissioner may issue to an individual or business entity that has filed with the Commissioner an application for such limited license in a form and manner prescribed by the Commissioner, a Limited Lines Travel Insurance Producer License, which authorizes the Limited Lines Travel Insurance Producer to sell, solicit or negotiate Travel Insurance through a licensed insurer.

~~A.~~B. A Travel Retailer may offer and disseminate Travel Insurance under a Limited Lines Travel Insurance Producer business entity ("licensed business entity") license only if the ~~Limited Lines Travel Insurance Producer complies with the~~ following conditions are met:

1. The Limited Lines Travel Insurance Producer or Travel Retailer provides to purchasers of travel insurance:

   a. A description of the material terms or the actual material terms of the insurance coverage;

   b. A description of the process for filing a claim;

   c. A description of the review or cancellation process for the travel insurance policy; and

   d. The identity and contact information of the insurer and Limited Lines Travel Insurance Producer.

2. At the time of licensure, the Limited Lines Travel Insurance Producer shall establish and maintain a register on a form prescribed by the [insert commissioner] of each Travel Retailer that offers Travel Insurance on the Limited Lines Travel Insurance Producer's behalf. The register shall be maintained and updated by the limited lines travel insurance producer and shall include the name, address, and contact information of the Travel Retailer and an officer or person who directs or controls the Travel Retailer's operations, and the Travel Retailer's
Federal ~~Employment~~ Tax Identification Number. The Limited Lines Travel Insurance Producer shall submit such register to the state insurance department upon reasonable

request. The Limited Lines Travel Insurance Producer shall also certify that the Travel Retailer registered complies with 18 USC 1033.

3. The Limited Lines Travel Insurance Producer has designated one of its employees who is a licensed individual producer as the person (a "Designated Responsible Producer" or "DRP") responsible for the Limited Lines Travel Insurance Producer's compliance with the travel insurance laws, rules and regulations of the state.

4. The DRP, president, secretary, treasurer, and any other officer or person who directs or controls the Limited Lines Travel Insurance Producer's insurance operations comply with the fingerprinting requirements applicable to insurance producers in the resident state of the Limited Lines Travel Insurance Producer.

5. The Limited Lines Travel Insurance Producer has paid all applicable insurance producer licensing fees as set forth in applicable state law.

6. The Limited Lines Travel Insurance Producer requires each employee and authorized representative of the Travel Retailer whose duties include offering and disseminating Travel Insurance to receive a program of instruction or training, which may be subject to review by the commissioner. The training material shall, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

7. Limited Lines Travel Insurance Producers, and those registered under their licenses, are exempt from the examination requirements under *[cite applicable state code section]*, and the pre-licensing and continuing education requirements of *[cite applicable state code section]*.

~~B~~C. Any Travel Retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that:

1. Provide the identity and contact information of the insurer and the Limited Lines Travel Insurance Producer;

2. Explain that the purchase of travel insurance is not required in order to purchase any other product or service from the Travel Retailer; and

3. Explain that an unlicensed Travel Retailer is permitted to provide general information about the insurance offered by the Travel Retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the Travel Retailer or to evaluate the adequacy of the customer's existing insurance coverage;

~~C~~D. A Travel Retailer's employee or authorized representative, who is not licensed as an insurance producer may not:

1. Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

2. Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

3. Hold himself or itself out as a licensed insurer, licensed producer, or insurance expert.

E. Notwithstanding any other provision in law, a Travel Retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating Travel Insurance on behalf of and under the direction of a Limited Lines Travel Insurance Producer meeting the conditions stated in this Act, is authorized to do so and receive related compensation, upon registration by the Limited Lines Travel Insurance Producer as described in Sub-section (B)(2) above.

F. Responsibility**:** As the insurer designee, the Limited Lines Travel Insurance Producer is responsible for the acts of the Travel Retailer and shall use reasonable means to ensure compliance by the Travel Retailer with this Act.

Drafting Note: States that have already implemented a licensing and registration law or regulation consistent with the NCOIL Limited Lines Travel Insurance Model Act and NAIC Uniform Licensing Standard 34 (Limited Lines Travel Insurance Standard) may choose to cross-reference that law or regulation instead of using the language set forth in this Section. States that have not yet implemented such a law or regulation with respect to Travel Insurance may choose to incorporate this Section under their existing producer licensing laws.

Section 5. Premium Tax

A. A travel insurer shall pay premium tax, as provided in [cross-reference to the state's existing premium tax provision] on Travel Insurance Premiums paid by any of the following:

1. an individual policyholder who is a resident of this state;
2. a certificate-holder who is a resident of this state who elects coverage under a Group Travel Insurance policy; or
3. an Eligible Group policyholder that is resident in, or has its principal place of business in, this state that purchases a Blanket Travel Insurance policy.

B. An insurer shall obtain and maintain documentation necessary to determine the state to which premium tax should be reported based on information provided by the policyholder or certificate-holder, as applicable.

Section 6. Competitive Market

A. A competitive market is presumed to exist for Travel Insurance unless the Commissioner, after hearing, determines that a reasonable degree of competition does not exist in the market and the Commissioner issues a ruling to that effect. Such ruling shall expire no later than one

year after issue unless the Commissioner renews the ruling after hearing and a finding as to the continued lack of a reasonable degree of competition.

B. In determining whether a reasonable degree of competition exists, the Commissioner shall consider relevant tests of workable competition pertaining to market structure, market performance, and market conduct, and the practical opportunities available to consumers in the market to acquire pricing and other consumer information and to compare and obtain insurance from competing insurers. The tests for determining whether a competitive market exists shall include one or all of the following:

1. The size and number of firms actively engaged in the market;
2. Market shares and changes in market shares of firms;
3. Ease of entry and exit from a given market;
4. Underwriting restrictions;
5. Whether profitability for companies generally in the market segment is unreasonably high;
6. The availability of consumer information concerning the product and sales outlets or other sales mechanisms; and
7. Efforts of insurers to provide consumer information.

C. The determination of competition involves the interaction of the various tests and the weight given to specific tests depends upon the particular situation and pattern of test results.

Drafting Note: States that have existing competitive market provisions in statute may choose to cross-reference those provisions instead of using the language in this section.

Section 7. Forms and Rates

A. Notwithstanding any other provision of the [insurance code], Travel Insurance shall be classified and filed for purposes of rates and forms under an inland marine line of insurance.

Drafting Note: For consistency, states may wish to update their statutory definition of inland marine to include travel insurance as defined in this Act. .

B. All Travel Insurance policies, certificates of insurance, endorsements, riders and rates delivered, issued for delivery, or charged in this state shall be filed with the Commissioner before being used. No policy, certificate of insurance, or endorsement shall be issued until the expiration of thirty (30) days after it has been filed, unless the Commissioner shall have given prior written approval.

Drafting note: This subsection is for those states that have form and/or rate filing requirements.

C. Eligibility and underwriting standards for Travel Insurance may be developed and provided based on Travel Protection Plans designed for individual or identified marketing or distribution channels, and the Travel Insurance offered as part of the Travel Protection Plan

may be offered as individual Travel Insurance, Group Travel Insurance, or Blanket Travel Insurance.

D. Rates filed subject to this Section shall be made in accordance with the following provisions:

1. Rates shall not be excessive, inadequate or unfairly discriminatory.

a. Excessive rates.

i. A rate in a competitive market is not excessive.
ii. A rate in a noncompetitive market is excessive if it is likely to produce a profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered.

b. Inadequate Rates. A rate is not inadequate unless such rate is clearly insufficient to sustain projected losses, expenses and special assessments in the class of business to which it applies and the use of such rate has or, if continued, will have the effect of substantially lessening competition or the tendency to create monopoly in any market.

c. Unfairly Discriminatory Rates. Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory if it is averaged broadly among persons insured under single insurance plans, whether offered on an individual, Group, or Blanket Travel Insurance policy.

2. In determining whether rates comply with the excessiveness standard upon a finding of a noncompetitive market under subparagraph 1(a)(ii), the inadequacy standards under subparagraph 1(b), or the unfair discrimination standard under subparagraph 1(c), the following criteria shall apply:

a. Due consideration shall be given to past and prospective loss experience within and outside this state; to the conflagration and catastrophe hazards; to a reasonable margin for profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers; to past and prospective expenses both countrywide and those specifically applicable to this state; and to provisions for special assessments and to all other relevant factors within and outside the state.

b. Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. No risk

classification, however, may be based upon race, creed, national origin or the religion of the insured.

c. The expense provisions included in the rates to be used by an insurer shall reflect the operating methods of the insurer and its anticipated expenses.

d. The rates may contain provision for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of the profit, consideration shall be given to all investment income attributable to the line of insurance.

Drafting Note: States that have form and rate requirements may choose to cross-reference their existing rate making provisions instead of using the language in this section.

Section 8. Travel Protection Plans

Travel Protection Plans may be offered for one price in this state if:

A. There is no finding by the Commissioner, pursuant to Section 6 [or cross-reference to the state's other competitive market provisions], that the Travel Insurance market in the state is non-competitive or that the Travel Protection Plan restricts competition by either significantly decreasing output or efficiency in the market or that a travel insurer or Travel Retailer is exerting sufficient market power in providing Travel Insurance or Travel Protection Plans such that competition is adversely impacted or that the Travel Protection Plan would exact burdensome terms that would not exist in a competitive market;

B. The Travel Insurance, Travel Assistance Services and CancellationFee Waivers are clearly delineated in the Travel Protection Plan's fulfillment materials. The fulfillment materials shall include the Travel Insurance disclosures required under state law and the contact information for persons providing Travel Assistance Services and Cancellation Fee Waivers, as applicable; and

C. The Travel Protection Plan clearly discloses to the consumer at or prior to the time of purchase and fulfillment that it includes Travel Insurance, Travel Assistance Services and Cancellation Fee Waivers, as applicable, and provides an opportunity for the consumer to obtain additional information regarding the features and pricing of each.

Section 9. Sales Practices

A. All persons offering Travel Insurance to residents of this state are subject to the Unfair Trade Practices Act at [*insert reference to state UTPA law*], except as otherwise provided in this Section. In the event of a conflict between this Act and other provisions of the [insurance code] regarding the sale and marketing of Travel Insurance and Travel Protection Plans, the provisions of this Act shall control.

B. Illusory Travel Insurance. Offering or selling a Travel Insurance policy that could never result in payment of any claims for any insured under the policy is an unfair trade practice

under [*insert reference to state UTPA law*].

C. Marketing.

1. All documents provided to consumers prior to the purchase of Travel Insurance, including but not limited to sales materials, advertising materials, and marketing materials, shall be consistent with all Travel Insurance policy documents, including but not limited to, forms, endorsements, policies, rate filings and certificates of insurance.

2. Travel Insurance policies or certificates that contain pre-existing condition exclusions must clearly disclose the exclusion in the coverage's fulfillment materials.

3. Policyholders or certificateholders shall have a minimum of ten (10) days from the date of purchase to review and cancel the policy or certificate for a full refund of the Travel Protection Plan price, unless the insured has either started the covered trip or has filed a claim under the Travel Insurance coverage.

4. The company shall disclose in the policy fulfillment and documentation whether the Travel Insurance is primary or secondary to other applicable coverage.

5. Where Travel Insurance is marketed directly to a consumer through an insurer's website or by others through an Aggregator Site, it shall not be an unfair trade practice or other violation of law where an accurate summary or short description of coverage is provided on the web page, so long as the consumer has access to the full provisions of the policy through electronic means.

D. Opt out. Unless otherwise permitted by state or federal law, no person offering Travel Insurance or Travel Protection Plans on an individual or Group basis may do so using negative option or opt-out, which would require a consumer to take an affirmative action to deselect coverage such as unchecking a box on an electronic form when they purchase a trip.

E. It shall not be an unfair trade practice to include Blanket Travel Insurance coverage with the purchase of a trip, provided the coverage is not marketed as free.

Section 10. Travel Administrators

A. Notwithstanding any other provisions of the [insurance code], no person shall act or represent itself as a Travel Administrator in this state unless that person:

1. is a licensed producer for property insurance in this state with an inland marine line of authority;

2. holds a valid managing general agent (MGA) license in this state; or

3. holds a valid third -party administrator (TPA) license in this state.

B. A Travel Administrator and its employees are exempt from the licensing requirements of [reference to adjuster licensing act].

Section 11. Registration

A Travel Retailer whose insurance-related activities, and those of its employees, are limited to offering and disseminating Travel Insurance on behalf of and under the direction of a Limited Lines Travel Insurance Producer meeting the conditions stated in this Act, is authorized to do so and receive related compensation, upon registration by the Limited Lines Travel Insurance Producer as described in Section ~~3(A)~~4(B)(2) above.

Section ~~5~~ 12. Policy

Travel insurance may be provided under an individual policy or under a group or master policy.

Section ~~7~~ 13. Enforcement

~~The Limited Lines Travel Insurance Producer and any Travel Retailer offering and disseminating travel insurance under the Limited Lines Travel Insurance Producer License shall be subject to the [insert statutory code citations for (i) the applicable unfair trade practices provisions of the insurance code and (ii) enforcement provisions applicable to insurance producers generally].~~

A. The Commissioner may conduct investigations or examinations of travel insurers, Limited Lines Travel Insurance Producers, Travel Retailers, and Travel Administrators to enforce the provisions of this Act to protect resident Travel Insurance consumers.

B. The Commissioner may take action, following notice and a hearing, necessary or appropriate to enforce the provisions of this Act, Commissioner's orders, and state statutes to protect consumers of Travel Insurance in this state, pursuant to Section [*insert reference to state notice/hearings/court actions law*].

C. A person found in violation of this Act or orders or regulations of the Commissioner may be assessed a civil or administrative penalty not to exceed $10,000 per type of violation.

Drafting Note: It is recommended that states review the enforcement procedures in their insurance laws and administrative procedure laws and ensure that enforcement authority under this Section is designated to the proper official(s).

Section 14. Regulations

The Commissioner may promulgate regulations to implement the provisions of this Act.

Section ~~8.~~ 15. Effective Date

This Act shall take effect 90 days after enactment.

Atlantic Corporate Center
2317 Route 34, Suite 2B
Manasquan, NJ 08736
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

Model Act to Support State Regulation of Insurance Through More Informed Policymaking

To be considered by the NCOIL Executive Committee on March 3, 2017

****Sponsored by Asm. Ken Cooley, CA***

Preamble:

The purpose of this Law is to secure more informed legislative oversight of the insurance industry. Under the McCarran-Ferguson Act, 10 U.S.C. § 1011, primary responsibility for setting insurance regulatory policy rests with the States. In order to regulate a large, sophisticated industry in interstate commerce, the States must work together to, among other things, develop model insurance legislation. Most such model laws, however, are written not by legislators but rather by executive branch officials, through the National Association of Insurance Commissioners (NAIC).

State insurance commissioners act at NAIC in large part operating under a delegation of authority from the states' legislative branch, but without oversight of state legislators. Although technically NAIC models must be passed in the States, in reality, the most important models are mandated under the NAIC accreditation system.

NAIC, a fully funded 501(c)(3), generates almost all of its approximately $100 million budget from funds generated through its members' status as government regulators. Today that funding base has diversified to include assessments of licensees mandated to use NAIC's services by insurance commissioners, but a key original funding source that allowed NAIC to grow to where it is today was NAIC bylaws-required assessments of member States.

Due to the fact that State legislators must be educated about the complexities of insurance public policy, and be kept abreast of developments and trends in insurance markets and regulation in order to be able to work together as lawmakers to draft appropriate national model legislation, State Legislators specializing in insurance-related issues organized the National Conference of Insurance Legislators (NCOIL) in 1969. State insurance budgets should ensure that both NAIC and the NCOIL are properly supported to ensure the purposes set forth in this Preamble.

Section 1. Purpose

The purpose of this Act is to amend a State's insurance code provision analogous to Section 3(C) of the State's adoption of the NAIC Model Law on Examinations to require that State insurance budgets ensure that both NAIC and NCOIL are properly supported to ensure that insurance public policymakers are properly educated on the issues before them.

Section 2. Budget Appropriation for NAIC & NCOIL

The State insurance code provision analogous to Section 3(C) of the State's adoption of the NAIC Model Law on Examinations is amended as follows:

(C)

(i) In lieu of an examination under this Act of a foreign or alien insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, such reports may only be accepted if (1), the insurance department was at the time of the examination accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program or (2) the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(ii) The Department of Insurance shall annually in its budget seek appropriation for and fund its annual member assessment required under Article II of the National Association of Insurance Commissioners' bylaws.

(iii) The Department of Insurance shall annually in its budget seek appropriation for and fund memberships and associated travel and other reasonable expenses necessary for the chairmen and ranking members of the House and Senate insurance committees of jurisdiction to fully participate in the National Conference of Insurance Legislators.

Section 3. Effective Date

This Act shall take effect _____

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Manasquan, NJ 08736
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

PROPOSED RESOLUTION ENCOURAGING THE FEDERAL INSURANCE OFFICE (FIO) TO CREATE A NEW PROPOSAL FOR THE STUDY OF AUTO INSURANCE AFFORDABILITY IN ACCORDANCE WITH TITLE V OF THE DODD-FRANK ACT

To be considered by the NCOIL State-Federal Relations Committee on Friday, March 3, 2017
Sponsored by Sen. Dan "Blade" Morrish

WHEREAS, Title V of the Dodd-Frank Act authorized FIO to monitor the extent to which "traditionally underserved" communities and consumers, minorities, and low-income and moderate-income (LMI) persons have access to "affordable" auto insurance; and

WHEREAS, the law also required the FIO to consider all publicly available data before issuing a data call of the private insurance industry; and

WHEREAS, the auto insurance rating laws remain within the sole jurisdiction of the states under the McCarran-Ferguson Act; and

WHEREAS, as regulated by the states, auto insurance rates are not to be excessive, inadequate, or unfairly discriminatory; and

WHEREAS, neither state law nor federal law require auto insurance rates to be "affordable" since affordability is a result of two factors, income or the ability to pay that auto insurers have no control over and the cost-based price; and

WHEREAS, the FIO has created an affordability index to facilitate the study and called for private auto insurance industry data; and

WHEREAS, the FIO did not adequately consider the sufficiency of publicly available data to facilitate the study; and

WHEREAS, the definition of "affordability" and the index is inappropriate for the additional following reasons:

- It fails to account for or even acknowledge the concept of consumer choice, including the well-established fact that residual market populations have been greatly reduced, providing substantial evidence of universal affordability and availability;

- It fails to consider and evaluate the multiplicity of exogenous factors that influence auto insurance pricing and consumption, including the clear stagnation of income or the ability to pay factor and the cost drivers for the pricing; and
- It inappropriately implies that one single measure is a reasonable proxy for whether auto insurance is “affordable”;

BE IT NOW THEREFORE RESOLVED, that the National Conference of Insurance Legislators (NCOIL) calls upon the FIO to act as follows to ensure consistency with state law and in accordance with congressional mandates that the regulation of auto insurance rates is left to the states:

- Either increase the 2% threshold or abandon the new formula in order to create a new index that incorporates the aforementioned facts and factors;
- Acknowledge that the two variables, income level and costs, must be considered and that the stagnation of income has had a serious impact on the affordability of insurance;
- Attribute the decrease in the auto insurance residual market populations to the universal affordability and availability of auto insurance;
- Acquiesce to the state regulation of insurance rates to prevent inadequacy, excessiveness, and unfair discrimination; and

Confirm in the study or in writing now that the FIO affordability index will not be used in any fashion or forum to undermine, impair or supersede the state regulation of insurance rates as being inadequate, excessive, or unfairly discriminatory.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE & HEALTH RETIREMENT ISSUES COMMITTEE
INTERIM MEETING
JANUARY 27, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care & Health Retirement Issues Committee held an interim meeting via phone conference on Friday, January 27, 2017 at 3:00 p.m.

Asm. Kevin Cahill of New York, Chair of the Committee, called into the conference and presided.

Other members of the Committee present were:

Rep. Bart Rowland, KY
Rep. Don Flanders, NH
Sen. Neil, Breslin, NY
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Glen Mulready, OK

Other legislators present:

Asm. Ken Cooley, CA
Sen. Dorsey Ridley, KY
Rep. Greg Kromer, LA
Rep. Justin Hill, MO
Rep. Marguerite Quinn, PA

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

DISCUSSION ON IMPACT OF AFFORDABLE CARE ACT (ACA) REPEAL/REFORM

Asm. Cahill began by stating that it is important to note that at this time, it is hard to know what will happen regarding any efforts to repeal and/or replace the ACA. However, NCOIL, as a group of bi-partisan State legislators, is uniquely qualified to offer help to Congress and the Trump Administration as they consider their options. Asm. Cahill then summarized some of the recent actions of the Trump Administration aimed toward the ACA such as the Executive Order and the suspension of ACA-related advertising. Asm. Cahill stated the goal of the interim committee call is to try and arrive at "principles on healthcare reform," to share with Congress and the Trump Administration - similar to what NCOIL did in 2009 - and to encourage NCOIL legislators to reach out to their Congressional members to offer NCOIL's assistance in helping with any ACA repeal/reform efforts.

Asm. Cahill noted that in New York, repealing ACA without replacement could result in approximately a $3.5 billion loss in federal Medicaid funding, $600 million of which is county aid. Asm. Cahill further noted that hundreds of thousands of people qualify for Medicaid and federal subsidies under the ACA; if ACA is repealed without replacement, some will remain on the roll while some may not. Asm. Cahill also noted that his district could lose approximately $6 million in federal funding and approximately 45,000 people would lose health insurance coverage.

Asm. Cahill then discussed some of the statistics in a report from the Center for State Budget and Policy Priorities and The Urban Institute. That report contained State-by-State data of the number of people who would lose coverage and the loss of related federal funding if last year's failed reconciliation bill, H.R. 3762, were used as the basis for ACA repeal without replacement. Asm. Cahill noted the following State data: Missouri would lose $1.2 billion in federal marketplace spending and 504,000 people would lose coverage; Arkansas would lose $194 million in federal marketplace spending and 361,000 people would lose coverage; Kentucky would lose $259 million in federal marketplace spending and 486,000 people would lose coverage; Alaska would lose $171 million in federal marketplace spending and 62,000 people would lose coverage; Pennsylvania would lose $1.9 billion in federal marketplace spending and 956,000 people would lose coverage; Louisiana would lose $366 million in federal marketplace spending and 558,000 people would lose coverage; North Dakota would lose $54 million in federal marketplace spending and 69,000 people would lose coverage. (Note – those state statistics are for 2019).

Sen. Hackett noted that 700,000 people signed up for Medicaid expansion in Ohio and stated that there are big questions facing State budgets if there is an ACA repeal without replacement. Rep. Mulready asked how the abovementioned numbers were arrived at and what specific portions of the ACA were repealed to arrive at those numbers. Will Melofchik, Legislative Director for NCOIL Support Services, stated that the numbers were arrived at using last year's reconciliation bill, H.R. 3762, which removed, without replacement: individual tax penalties for not keeping qualifying health coverage; tax penalties for employers that do not offer qualifying health coverage; premium tax credits; cost-sharing subsidies; transitional reinsurance program; Medicaid expansion; and other taxes specified in the ACA. Chris Condeluci of CC Law and Policy then stated that it is extremely important to note that the numbers projected in all reports using H.R. 3762 are hypothetical in nature because we not know what the specific ACA repeal/reform legislation will look like. Mr. Condeluci stated, however, that Congress is aware that if it does not come up with a proper plan, the numbers stated could become a reality.

Asm. Cahill then asked, as a bi-partisan group of State legislators, what can NCOIL do to assist Congress and the Trump Administration as they work on ACA repeal/reform legislation. Asm. Cooley stated that the general conversation requires disciplined thinking and it is important to convey what the ripple effects of ACA repeal/reform legislation could have on the States. Asm. Cooley noted that any communications with Congress should note the State budgetary impacts of such legislation, how risk-pools will be effected, and the consequences that the entire health care industry could face. Asm. Cooley also noted that it is important to have America's Health Insurance Plans (AHIP) be involved. Mr. Condeluci stated that a good idea might be to formulate answers to the questions that House Majority Leader Kevin McCarthy, Senate HELP Committee Chairman Lamar Alexander, and members of the Senate Finance Committee sent to State Governors and Insurance Commissioners requesting their feedback on how best to implement changes to the ACA. Mr. Condeluci noted that he has heard talk in D.C. that States will be encouraged to use 1332 and 1115 waivers. Asm. Cahill stated that he is leaning towards thinking that the waiver process should be more flexible, but with more flexibility there will of course be substantial changes – will there be a finite amount of dollars from the federal government to States as opposed to a "relative" amount of dollars? Asm. Cahill urged all to review the letters mentioned and to think of responses.

Asm. Cahill then asked Commissioner Tom Considine, NCOIL CEO, what did NCOIL agree upon in its 2009 "Principles on Healthcare Reform" which were sponsored by Sen. Seward. Cmsr. Considine then paraphrased the principles, which are:

General 1) NCOIL supports healthcare reform that would provide consumers with access to affordable coverage and quality care. 2) NCOIL believes that the states, acting as laboratories of democracy, are appropriate venues for reform. 3) NCOIL supports examination of the impacts on other lines of insurance, including workers' comp and auto.

State/Federal 4) NCOIL opposes any preemption of state regulatory authority and subsequent insurance consumer protections. 5) NCOIL opposes any attempt to repeal the insurance antitrust exemption under the McCarran-Ferguson Act of 1945. 6) NCOIL questions the federal government's health insurance reform track record, including ERISA, which hinders a state's authority to make health insurance market changes. 7) NCOIL is on record as opposing federally directed interstate health insurance sales because of domicile state shopping and cherry picking risks, but supports states' ability to enter freely into compacts with neighboring states. 8) NCOIL believes that healthcare reform should include greater cooperation and coordination among the Justice Department, U.S. Department of Health and Human Services (HHS), state insurance regulators, law enforcement, and private insurers to combat healthcare fraud.

Cost Implications 9) NCOIL believes that any meaningful reform should not increase the cost of healthcare. 10) NCOIL opposes any new unfunded federal mandates. 11) NCOIL opposes any federal reform that adds to state Medicaid costs. 12) NCOIL is on record as supporting efforts to provide federal funding for innovative state insurance reform programs. 13) NCOIL supports pilot projects that allow willing states to experiment with medical malpractice cost controls.

Asm. Cahill noted that the context in which we view those principles are different now – we've had about 5 full years of the ACA and it is engrained in States' budgets. Sen. Hackett stated that he does not object to coming up with principles but noted that there are going to be disagreements during the process and noted that the ACA broke down in Ohio. Asm. Cahill stated that he thinks drafting a set of Principles is a good place for NCOIL to start. Asm. Cooley and Sen. Seward agreed.

Asm. Cahill asked AHIP for their stance on the validity of the claim that health plan providers will leave the market if a repeal/reform solution is not clarified. Dianne Bricker of AHIP stated that AHIP believes that whatever the repeal/reform legislation looks like there will be a need to extend the deadline for submitting health plans for review. Asm. Cahill asked if the deadline remained being May, will there still be a full array of products available? Ms. Bricker stated that it would be very difficult to do so. Rep. Hill stated that he believes that there will be huge rate increases issued in an effort to pressure repeal/reform action to materialize. Rep. Hill also stated that he is supportive of expediting 1332 waivers to come up with some flexibility. Ms. Bricker stated that AHIP is supportive of State flexibility and noted that if the May deadline remains, it will discourage some plans. Cmsr. Considine stated that he had a conversation with a large health plan provider recently who stated that if things remain this uncertain going forward, "we will play nowhere."

Mr. Condeluci stated that it is important that everyone know that the frustrations and concerns that have been stated during the call are well known in D.C. and that there are steps being taken to improve the regulatory environment, part of which is to extend the deadline for health plan review. Mr. Condeluci stated that he has heard of contemporaneous action occurring: extending 1332 waivers to States and improving the regulatory environment. Asm. Cahill asked if 1332 waivers will be used for States to have blanket authority to run their health care systems. Mr.

Condeluci stated that he is not sure about it being used for blanket authority, but he has heard that the Trump Administration wants maximum flexibility for States to implement their health care systems and the issue of whether the Administration wants a 1332 waiver to encompass such blanket authority comes down to whether it wants to circumvent the statute as it is currently written.

Asm. Cahill stated that after the minutes for this interim committee call are drafted, they should be circulated and then everyone can communicate via e-mail to suggest what the Principles should look like. Asm. Cahill then announced the Health Committee Model Laws that are up for re-adoption at the upcoming Spring Meeting in New Orleans and asked if anyone had any comments on them – no comments were received.

An unidentified person then asked if there will be an NCOIL Model Act on Air Ambulances introduced in New Orleans. Asm. Cahill stated that there will not be a Model Act introduced but it is expected that the NCOIL President will appoint an Air Ambulance Task Force by then.

ADJOURNMENT

There being no further business, the Committee adjourned at 4:00 p.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & INVESTMENT PRODUCTS COMMITTEE AND CYBERSECURITY TASK FORCE
LAS VEGAS, NEVADA
NOVEMBER 17, 2016
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Financial Services & Investment Products Committee and Cybersecurity Task Force met at the Paris Hotel on Thursday, November 17, 2016, at 1:00 p.m.

Senator Bob Hackett of Ohio, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR
Rep. Joseph Fischer, KY
Rep. Bart Rowland, KY
Tommy Thompson, KY
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Sen. David O'Connell, ND
Rep. Bill Botzow, VT Rep.
Sen. Mike Hall, WV

Members of the Cybersecurity Task Force present were:

Sen. Jason Rapert, AR
Rep. Joseph Fischer, KY
Rep. Steve Riggs, KY (Chair)
Rep. George Keiser, ND
Sen. Bob Hackett, OH
Rep. Marguerite Quinn, PA
Rep. Bill Botzow, VT

Other legislators present were:

Asm. Ken Cooley, CA

Also in attendance were:
Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 15, 2016, meeting in Portland, Oregon.

RETIREMENT SECURITY – WORK AND SAVE

Sarah Gill, Senior Legislative Representative from AARP spoke first. Ms. Gill stated that 50% of all households are currently at risk of having a financially insecure retirement. That number has steadily risen – in 1983, 1 in 3 households were at risk. Ms. Gill stated that it is important to note that financial insecurity is not the inability to visit grandchildren but rather the inability to pay things such as an electric bill and rent. Ms. Gill noted that 33% of all households do not have access to an IRA or other type of retirement product. Having access to such a product through an employer is important because of behavioral economics – people are 15 times more likely to

save just by having access to payroll deduction plans at work. That number jumps to 18 times more likely when an employer uses automatic enrollment.

Ms. Gill stated that if you make more than $80,000 per year, you have a 3 out of 4 chance of having access to a retirement plan at work. If you have make less than $20,000 per year, you don't have a good chance of having the same access. However, your social security replacement ratio will be much higher. Therefore, it's the folks in the middle that are "squeezed" because their social security replacement rate is not high and they are less likely to have access to a retirement plan at work. A social security replacement ratio is a person's social security income after retirement, divided by his or her gross income before retirement. Ms. Gill further stated that while those 25 years and younger are less likely to have access to a retirement plan at work, the scary part is that those that are 40-64 years old struggle to have access as well.

Ms. Gill then offered some solution to these problems: availability, automatic enrollment, ease of investment, automatic escalation and lifetime income streams. Ms. Gill stated that she often gets asked if lower income individuals will actually use retirement products if offered and based on polling data, it is extremely important to them, even more so than higher income individuals. AARP's main solution to these problems is its Work 'n Save Program, the main concept being a public-private partnership that provides easy to use plug and play options that are cost effective and help make small businesses more competitive by making it easier for them to offer retirement plans. The program is paid for through participation fees. There is a huge precedent in States taking active roles in these types of arenas. Looking to 529 college saving plans, in 1998 the cumulative savings by American families for college in said plans at that point in time was only $2 billion but in 2015 the cumulative total saved reached more than $250 billion. That is the model to which AARP is looking when developing its Work 'N Save Program. Many States are working on these types of programs and it is important that States modify the program to meet their specific needs. Ms. Gill noted that polling data indicates that 80% of people, across party lines, think that small businesses should offer retirement savings plans.

John M. Huff, NAIC President and Director of the Missouri Department of Insurance stated that too many people are not planning for their retirement. Earlier this year, NAIC launched a retirement security initiative that is broken down into 3 components: consumer protection, education, and innovation. With consumer protection, NAIC staff is working with industries and State legislators to encourage State adoption of Model #275, Suitability and Annuity Transactions Model Regulation; updating Model #245, Annuity Disclosure Model Regulation and the Senior Certification Model Regulation, #278; and the Life Insurance Buyers Guide. Additionally, on November 21, 2016, NAIC is launching its life insurance policy locator – individuals can go to the NAIC website and see if there is an outstanding life insurance policy after a loved one passes away. With education, NAIC staff has launched a retirement security micro-site that has been very successful. And with innovation, particularly with long term care, NAIC has established the long term care innovation subgroup to help solve some of the problems facing that industry.

John Mangan, Regional Vice President of ACLI stated that ACLI has offered itself as a resource to all States that are looking to improve their retirement security systems. Mr. Mangan also noted that the interstate compact has helped innovate by offering more types of annuities and products to the marketplace – that type of innovation will help advance retirement security. Mr. Mangan noted that this is a huge issue and it involves everyone at every age, which means everyone needs to be at the table to help solve it.

Sen. Hackett stated that in Ohio some stated that the public sector shouldn't be involved in getting the private sector to develop these retirement systems. Mr. Mangan stated that ACLI believes offering more choice to consumers is the best route to take. Ms. Gill stated that the concerns in Ohio have been voiced in other States and that is why it is important to have the public and private sectors work together on these issues. Mr. Mangan stated that some things that State legislators can do to help solve these issues, perhaps using NCOIL as a vehicle to do so, is to discuss with Congress possible efforts to try and raise contribution limits, create a simplified 401k, and have multiple employer plans.

CONSIDERATION OF MODEL LAW CONCERNING IDENTITY THEFT AND MINORS

Rep. Riggs stated that this Model is necessary for situations where an adult of any age wants to apply for a credit card or other type of credit and finds out that his or her identity has been stolen as a youth, which has ruined their credit. Typically, parents have not been able to exercise a credit/security freeze for their children because they usually don't have credit in the first place and because of the way certain State laws are written. But now, several states have passed laws giving parents the right to request credit/security freeze protections for minors. In effect, parents can ask to have a credit record created, and then have it frozen. Accordingly, this Model, which is similar to the laws that States have adopted on this issue, allows credit reporting agencies to place a security freeze on a minor's credit report. Approximately 20 States have adopted legislation similar to this Model. Sen. Hackett noted that Ohio is currently working to introduce legislation on this issue.

Wes Bissett of the Independent Brokers and Agents of America, stated that IIABA believes that being able to place a security freeze on a credit report should be free. While the fees seem low, studies have shown that they can operate as a barrier to some. Additionally, most States allow fee exemptions for those that are victims of identity theft. Mr. Bissett recommended that Rep. Riggs' Model should be expanded to include all individuals, not just minors. Rep. Riggs stated that he believes the issue of charging fees should be left up to the individual States and the Model should not be amended to state that. Rep. Riggs also noted that the Model contains the identity theft provision that Mr. Bissett noted. Sen. Rapert expressed his support for the Model and seconded Rep. Riggs' motion to adopt the Model. Rep. Riggs then stated he is open to waiving the fee requirement. Rep. Keiser stated that he supports the Model as written. The committee then unanimously adopted the Model.

DISCUSSION OF REVISED DRAFT OF NAIC INSURANCE DATA SECURITY MODEL ACT

Director Huff stated that the NAIC Model essentially handles 3 areas: the front-end data security, the ongoing risk controls, and the back-end mitigation, investigation and notification requirements in the event of a breach. The Model is undergoing a 3rd round of revisions and NAIC is hopeful that the new draft will be issued soon so that the Model can be considered by the end of the year. However, while hoping to move quickly, the number one priority is to make sure all the language in the Model is appropriate. NAIC is willing to hold another conference call with NCOIL members to review the next draft.

Kate Kiernan of ACLI stated that ACLI is working closely with NAIC on the Model and that the current framework of having 47 different cyber-breach requirements has been difficult for those involved. ACLI is concerned about the cyber threats facing consumer and company data but is encouraged by the work NAIC has done thus far. Ms. Kiernan also stated that it is extremely cumbersome and dangerous for insurers to be subject to different cybersecurity standards. Additionally, ACLI would like to see the NAIC get this Model right for the insurance industry and then possibly get other industries on board.

Frank O'Brien of PCI stated that there are fewer things more important to the insurance industry than the safekeeping of consumers' data. If consumers don't think their information is being handled properly, insurers won't get the information they need. However, it is a delicate balance of meeting the legitimate expectations of consumers and the ability of companies to use the information appropriately. PCI has been working closely with NAIC on its Model but unfortunately the current draft of the Model has significant problems and PCI is unable to support it. PCI is looking forward to working with NAIC on the next draft.

Sen. Hackett questioned whether the insurance industry needs to be singled out in this area and also noted that some are worried about compliance costs. Director Huff stated that there needs to be a level of proportionality with regards to compliance costs. As to the insurance industry, Director Huff stated that the issue of singling out the insurance industry is an important one, but ultimately the industry is unique enough to have its own cyber requirements. Rep. Keiser complemented the NAIC's efforts on the Model but echoed Sen. Hackett's concerns about singling out the insurance industry. Rep. Keiser also stated that he is concerned with the model stating that it contains the "exclusive standards" for insurance industry. Rep. Keiser also stated he has other concerns with the Model such as defining vague terms like "reasonably foreseeable internal and external threats." Wes Bissett stated that IIABA is very concerned with the NAIC Model. Some examples include the obligation to investigate and to deliver breach notices at the company level is not imposed on the independent agent – IIABA believes each individual and entity subject to the Model should have their own independent obligations and if a breach occurs they can follow those obligations. Mr. O'Brien stated that the Model is designed to give the regulator some leeway because the cyber threats are constantly evolving. This is a classic public policy issue – there are equities that need to be balanced. Rep. Fischer stated that if the intent of the Model is to achieve uniformity with regard to cybersecurity and the insurance industry, section 2 of the Model does not further that goal – that section should simply state that the Model cannot be superseded.

RE-ADOPTION OF IDENTITY THEFT PROTECTION MODEL ACT

Upon a motion made and seconded the committee unanimously agreed to re-adopt the Identity Theft Protection Model Act.

ADJOURNMENT

There being no further business, the Committee adjourned at 2:30 p.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE AND RETIREMENT ISSUES COMMITTEE
LAS VEGAS, NEVADA
NOVEMBER 19, 2016
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care and Retirement Issues Committee met at the Paris Las Vegas Hotel on Saturday, November 19, 2016, at 1:45 p.m.

Assemblyman Kevin Cahill of New York, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR
Rep. Jeff Greer, KY
Sen. Dan "Blade" Morrish, LA
Rep. Ken Goike, MI
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Sen. David O'Connell, ND
Rep. Don Flanders, NH
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Bill Botzow, VT
Rep. Kathie Keenan, VT
Sen. Mike Hall, WV

Other legislators present were:

Rep. David Livingston, AZ
Asm. Ken Cooley, CA
Asm. Will Barclay, NY
Rep. Glen Mulready, OK

Also in attendance were:
Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 16, 2016, meeting in Portland, Oregon.

DISCUSSION OF PROPOSED MODEL REGARDING PRIVATE DISABILITY INCOME INSURANCE

Rep. Keiser introduced and made brief remarks on the Employer-Sponsored Group Disability Income Protection Model Act. Overall, the Model encourages employers to establish group disability income protection plans for their employees and to enroll eligible employees in those plans. Upon a motion made and seconded, the Committee unanimously passed the Model.

AIR AMBULANCE REGULATORY EFFORTS

Rep. Keiser stated that NCOIL needs to stay engaged on this issue and accordingly made a motion to recommend to the Executive Committee that a Task Force be formed to address this issue. Upon the motion being seconded, the Committee unanimously agreed to make such recommendation to the Executive Committee. Rep. Greer stated that he believes that at the

Spring Meeting in New Orleans he will have an Air Ambulance Model Act to introduce. Rep. Greer also stated that he supports the idea of an NCOIL Air Ambulance Task Force.

LONG TERM CARE ISSUES

Eric Cioppa, NAIC Secretary-Treasurer and Superintendent of the Maine Bureau of Insurance, stated that in Maine, despite the health insurance market being significantly larger than the long term care market, he spends as much time on long term care issues as he does health insurance issues. Supt. Cioppa stated that the long term care market is crying out for a private solution. The NAIC has created a Senior Issues Task Force and a Long Term Care Benefit Adjustment subgroup. The subgroup is looking at, among other things, partnership plans which are part of federal law. If you buy a plan that's partnership qualified, people can protect some of their assets. Many States have adopted such plans and one of the requirements for them is that the product being sold has to contain the consumer protections adopted by the NAIC – this will be discussed at the upcoming NAIC Fall Meeting. Supt. Cioppa further stated that the NAIC believes that there is a need for a private sector solution in the long term care industry. There is a tremendous strain on State Medicaid budgets and there needs to be a way for modestly priced and innovative products to be sold on the market. The NAIC has held several hearings to try and understand what the impediments are, both at the federal and state level.

Supt. Cioppa then spoke to the actuarial aspect of the long term care industry. The recognition of trying to sell a product for 20-30 years with a level premium is not working. Some of the actuarial underpinnings like establishing the interest rates at the beginning of a product life cycle don't seem to make sense anymore. The NAIC has a Health Actuarial Task Force and a Long Term Care Pricing subgroup is working on how to deal with rate increases for old closed-block businesses. Some rate increases are exceedingly high – over 50%. But at the same time when, you look at the generous benefits from old policies you can quickly recognize that there are solvency issues for those policies. For example, Penn-Treaty will be put into liquidation and it is a big insolvency with which guaranty funds will have to deal. There is a delicate balance with rate sufficiency and affordability for consumers. One of the things the NAIC has seen are "landing spots." Landing spots are essentially a more structured version of inflation protection reductions. Landing spots allow insureds to reduce their current inflation protection amounts to lower amounts in such a way as to offset the rate increase. The policyholder's current daily benefit keeps the inflation-based increase accrued to date and then begins inflating at a new, lower rate.

Bonnie Burns, Training and Policy Specialist at California Health Advocates, stated almost no one thinks that the problems facing the long term care industry can be solved solely by insurance. Ms. Burns stated that everyone will not be able to buy long term care insurance even if a new product is invented. States will have a risk to their Medicaid programs because younger retirees are not going to be able to buy long term care insurance at all because they are not like their parents – they are people who have less income, less assets, and more chronic illnesses. Unless we find a way to coordinate all of the public resources for long term care with private insurance, problems will continue. Consumers have their own risks with long term care products. Consumers did what they were told to do – buy an insurance product to pay for the care they need later in life but they are the ones facing the incredible rate increases. Ms. Burns stated that she appreciates landing spots, but if a person takes one of them and then later gets another rate increase, they may end up with a product in the end that is of very little value to them despite all the money they put into it over the years. Additionally, consumers face risk in understanding what they're buying. Some of the newer products are very complex because the industry has merged long term care insurance and annuity products. There is a real challenge for people to

continue to pay long term care premiums. For example, when women lose a spouse they lose a significant amount of income. Additionally, the industry cannot tell the difference between a voluntary lapse and a lapse that occurred from a death.

Burns continued to the use of benefits, which is another issue to think about. The person who actually deals with the benefits side of the policy will probably be a family member, who is probably not going to know anything about long term care at all. In many cases, the paperwork is so complicated that claims end up being denied and that often leads to lawsuits. In closing, consumer risk tends to fall under the radar screen because it is overshadowed by the risks facing the insurance companies and States through their Medicaid program.

Supt. Cioppa stated that consumer protection is extremely important. In Maine, several brochures were issued to notify consumers of their rights under these policies. In addition, a regulation was passed that makes clear that the burden for things such as whether a long term care facility is licensed or not falls on the insurer and not the consumer. However, inflation for a product for over 20-30 years is very expensive and it seems that the people that can afford these policies are people that can self-insure anyway. Supt. Cioppa proposed possibly working with NCOIL and/or the federal government on new solutions: is there a way to adjust 401(k)'s so that buying a long term care policy is a tax-free transaction? Can Medicare serve as a reinsurer for long term care? We have to think differently on these issues because when insurers first began selling these products, they didn't know how to accurately price the risk. But now they're better at it and its extremely expensive for consumers. Asm. Cahill asked if the changes to the industry can be done regulatorily or statutorily? Supt. Cioppa stated that at the State level he thinks it can be done regulatorily.

Ms. Burns noted that when we first began thinking of long term care insurance the main issue was the catastrophic cost of a nursing home. But today, nursing home care has been replaced in many cases by assisted living. People can be kept at home at very high levels of efficiency if they have the right tools and care. Costco sells a computerized surveillance system to monitor the outside of your home. If you turn that inside you can monitor those inside your home and connect that information electronically to the adult child's cell phone. Taking that further and thinking of all the technology we have, adult children can work full-time and simultaneously know how their parent is doing. If you then add to that "care management" and "care coordination" you can have people available at certain points in the day who can check on the parent. Ms. Burns stated that you would be amazed at how efficient and cost-effective this would be. This is something for State legislators to think about.

Rep. Keiser asked Supt. Cioppa what is the scope and magnitude of the closures of companies like Penn Treaty on State guaranty funds. Supt. Cioppa stated that some of the costs will be placed on health insurers. NAIC is looking to perhaps prospectively modify State guaranty laws to reflect that long term care was not sold as a health product.
Rep. Mulready stated that not long ago, life insurance companies started allowing accelerated benefits - are there companies out there doing something similar with long term care? Supt. Cioppa stated that we are now seeing more hybrid products – a life product that has a long term care rider or an annuity product that has a long term care rider. Sen. Seward asked if there is a timetable to expect some ideas/solutions from the NAIC Task Forces and Working Groups? Supt. Cioppa stated the goal is to have policy recommendations ready at some point in 2017.

Asm. Cahill stated that due to time constraints, if any legislators or anyone in the audience has a question or statement, they can send the question to NCOIL staff and it will be added to these minutes.

NETWORK ADEQUACY STANDARDS/PROVIDER DIRECTORIES/BALANCE BILLING MODEL LAW DISCUSSION

Asm. Cahill noted that a side-by-side comparison of all the Models that deal with network adequacy standards, provider directories and balance billing will be completed by AHIP before the Spring Meeting in New Orleans.

Dean Cameron, Director of the Idaho Department of Insurance stated that the issue of network adequacy standards is very difficult. The reality is that the Affordable Care Act has changed the dynamics of the relationship between providers and carriers. Idaho has seen a consolidation of providers where physicians have been bought up or joining and participating with large hospital network groups. Additionally, particular provider entities such as dialysis companies have been bought up and owned by 1 or 2 entities. That has made the negotiation for contracts even more heightened. One thing is clear, networks are becoming narrower as carriers are struggling to figure out how to lower prices as regulators and legislators are pushing them to have those lower prices. Provider groups on the other hand are demanding exclusivity in order to offer those carrier prices.

In 2013, the NAIC acknowledged that changes needed to be made with network adequacy standards. After an extensive comment and review period, the NAIC developed the Health Benefit Plan Network Access and Adequacy Model Act. Dir. Cameron stated that he is proud of the work that went into it but it is far from perfect. Of major conflict is the issue of balance billing and in his opinion, the balance billing provisions don't go far enough to protect consumers. Both Dir. Cameron and Supt. Cioppa stated that the issue of network adequacy standards is problematic and is not going away anytime soon.

Sen. Seward stated that his Model focuses on providing protection for patients. The Model, among other things: establishes new network adequacy standards; improves the disclosure requirements for insurers, health care providers and hospitals; provides an appeal process for out of network referral denials; seeks to protect patients from unexpected medical bills from out of network providers; and addresses the problem of consumers choosing policies that allow them go out of network but the reimbursement benefits are woefully inadequate. Sen. Seward stated that AHIP's comparison of all the Models will be very helpful towards drafting a comprehensive price of legislation on the issues discussed today.

UPDATES Commissioner Tom Considine, NCOIL CEO, provided brief updates. Cmsr. Considine noted that after a series of correspondence with the U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services in which NCOIL expressed concern over regulations that would prevent consumers from having Health Savings Accounts (HSA's), they amended their 2017 standard plan offerings to provide an option for HSA's. Cmsr. Considine further noted that NCOIL had commented on a Tri-Agency (DOL, HHS, Treasury) Notice of Proposed Rulemaking (NPRM) that dealt with among other things, excepted benefits, short-term medical insurance and specified diseases or illnesses. Overall, NCOIL noted that the NPRM encroached upon issues that have traditionally been within the state-insurance regulatory arena. Cmsr. Considine noted that the agencies decided to not issue regulations regarding specified diseases and illnesses but did decide to proceed with short term medical product regulation. Cmsr. Considine further noted that given the recent ruling by the D.C. Circuit in Central United Life, Inc. v. Burwell, it was surprising to see the agencies proceed with rulemaking. No one has filed a lawsuit yet because there is thought that the regulations might be repealed during the 90-day lookback period by the Trump Administration.

Asm. Cahill closed with proposing that a teleconference be held between now and the Spring conference in New Orleans to discuss whether NCOIL wants to offer comments to Congress and relevant regulatory agencies about the future of the ACA. Rep. Keiser agreed and requested that the recommendation be sent to the Executive Committee. Rep. Keiser also requested that the teleconference be held in December.

ADJOURNMENT

There being no further business, the Committee adjourned at 3:00 p.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
STATE-FEDERAL RELATIONS COMMITTEE AND INTERNATIONAL INSURANCE ISSUES COMMITTEE
LAS VEGAS, NEVADA
NOVEMBER 18, 2016
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) State-Federal Relations Committee and International Insurance Issues Committee met jointly at the Paris Las Vegas Hotel on Friday, November 18, 2016, at 9:15 a.m.

Senator Dan "Blade" Morrish of Louisiana, Chair of the International Insurance Issues Committee, presided.

Other members of the Committees present were:

Sen. Jason Rapert, AR
Rep. Steve Riggs, KY
Sen. Dan "Blade" Morrish, LA
Rep. Michael Webber, MI
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Sen. David O'Connell, ND
Rep. Don Flanders, ND
Sen. Neil Breslin, NY
Sen. James Seward, NY
Rep. Bill Botzow, VT
Rep. Richard Smith, GA

Other legislators present were:

Rep. David Livingston, AZ
Sen. Travis Holdman, IN
Sen. John Shickel, KY
Rep. Ken Goike, MI
Rep. Lana Theis, MI
Rep. Lewis Moore, OK
Rep. Marguerite Quinn, PA

Also in attendance were:
Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 16, 2016, meeting in Portland, Oregon.

H.R. 5143 UPDATE/RECAP OF D.C. FLY-IN

Commissioner Tom Considine, NCOIL CEO, provided a brief recap of the D.C. Fly-In that occurred on September 7, 2016: NCOIL Secretary Sen. Jason Rapert of Arkansas, Asm. Will Barclay of NY, Sen. Bob Hackett of OH, Sen. Mike Hall of WV, Rep. Joseph Fischer of KY, Rep. Marguerite Quinn of PA, and NCOIL Vice President Steve Riggs of KY met and educated members of Congress and their staff about the importance of the state-based regulation of insurance and legislation such as H.R. 5143 and S. 1086. The aforementioned legislators also met with Rep. Blaine Luetkemeyer, sponsor of H.R. 5143, and his staff. The legislators also used the meetings as an opportunity to discuss the problems facing the air ambulance industry.

Somewhat surprisingly, many were not aware of the issue but found it troubling and were open to looking into it. Overall, the fly-in was a tremendous success.

John Huff, NAIC President and Director of the Missouri Department of Insurance, then provided an update on H.R. 5143. Dir. Huff stated that NAIC is supportive of H.R. 5143 and stressed that the United States insurance regulatory system is the most competitive and successful in the world. Dir. Huff stressed that any changes to that system should be at home by those who are accountable to policyholders. International insurance standard meetings are currently closed to the public and only include international regulators – that is very problematic. NAIC applauds the work that Rep. Luetkemyer has done with H.R. 5143. That piece of legislation, along with S. 1086, will go a long way towards bringing transparency to the international standard setting process and ensuring that such international standard setters comply with the relevant domestic standard setting system. Dir. Huff noted that such legislation is a bi-partisan effort and that NAIC is looking forward to seeing the legislation advance. Sen. Hackett stated that during the D.C. fly-in he heard some concerns that the process of discussing regulatory changes with U.S. regulators and legislators after they are agreed to during international meetings is very time-consuming – is there any way to speed up that process? Dir. Huff stated that making the international meetings transparent and open to U.S. regulators and legislators would solve that problem. Dir. Huff further stated that involving the people subject to change is a better process as opposed to forcing change and waiting on people to adapt. This is particularly important when dealing with international capital standards – NAIC is not yet convinced that additional capital needs to be held at a group level just to meet international standards.

CONTINUED DISCUSSION REGARDING COVERED AGREEMENTS AND EU EQUIVALENCE

David Mattax, Commissioner of the Texas Department of Insurance stated that if a jurisdiction is not found to be “equivalent,” it can result in that jurisdiction being subject to more stringent regulatory requirements for that jurisdiction’s companies doing business in the European Union (EU). This has the result of either imposing the Solvency II upon jurisdictions or placing jurisdictions at a competitive disadvantage to its own industry. Some European countries have already begun imposing restrictions on U.S. companies such as branching requirements. Last year, the EU granted the U.S. provisional equivalence to the U.S. group solvency regime which largely benefited EU insurers. Fundamentally, that means the EU has imposed solvency requirements on its members which require additional capital. When you tie up additional capital, that restricts the ability of markets and companies to grow. By granting provisional equivalence, what the EU has said is, for a European company, for your business in the U.S., you may use U.S. statutory reserve principles but for your business in the EU you have to comply with Solvency II. What the EU has told American companies is, because you’re not equivalent, for both your European and American businesses you have to use Solvency II. That is a fundamental disadvantage for American companies. To address that, FIO entered into “covered agreement” negotiations. Cmsr. Mattax stated that it is difficult to see how the recent election will impact such negotiations and that it is up to State legislators, regulators, and the insurance industry to analyze a covered agreement, if enacted, and to tell Congress if it is a good deal for America. Rep. Moore asked whether a covered agreement/equivalence discussions will impact American companies competing in America or American companies competing in Europe? Cmsr. Mattax stated principally it will affect American companies competing in Europe and the main point is that for those companies to get a fair deal, they will have to give something up during negotiations. It is then important for the companies not competing in Europe to not be adversely affected by the negotiations.

Rep. Moore asked if the idea of a compact, quarterbacked by NCOIL, been considered to ensure that States are briefed and aware of this issue? Cmsr. Mattax stated that such an idea has already been executed by expanding NAIC Model Acts such as the Credit for Reinsurance Model Law and Regulation. Dir. Huff stated that one concern is that we currently have a lot of foreign reinsurance, particularly on the natural catastrophe side, which is good because it diversifies the risk if there is a significant event. But in very large measure, there is confidence that the credit risk of those foreign reinsurers is accounted for in the U.S. system by analyzing foreign reinsurers ability and willingness to pay. If that credit risk is diminished by a covered agreement, there are only two other places to place that credit risk: consumers, which we will not do, and U.S. insurers that buy that reinsurance which many people think is not a good option.

DISCUSSION OF BUILDING CODES

John Doak, Commissioner of the Oklahoma Insurance Department began a presentation titled: "Building Resilient Homes – A Better Way Forward." Natural disasters such as tornadoes and earthquakes are relevant across the entire country. Many towns are comprised of buildings that are very old. Cmsr. Doak stated that the theory is by strengthening building codes, there will be less damages for towns and cities to deal with. An example can be found in Moore, Oklahoma: wind load standard was raised to 135 mph from 90 mph; vertical load path throughout house and garage was strengthened; enhanced roof sheathing fasteners and fasteners schedules; narrowed spacing of roof framing; enhanced connections in the roof framing including the use of hurricane straps and strengthening of gable and walls and wall sheathing; and structural changes made to garages and wind rated garage doors. Those are minimal changes but they have a dramatic change. The estimated cost to meet new building codes is only $2 per square foot and in Cleveland County, OK, if all homes had been constructed to the new standards, the additional cost would have been less than 2% of the residential insured losses in that county.

Cmsr. Doak stated that in 2009, a new law went into effect that requires insurance companies to provide a premium discount, rate reduction, or other adjustment for individuals who build or retrofit their home to certain standards. The adjustments are based on the company's own actuarial analysis and the standards include the Insurance Institute for Business & Home Safety (IBHS) Fortified Home High Wind and Hail and Fortified Home Hurricane Standards. Cmsr. Doak noted that in Tulsa, OK, the first Habitat for Humanity home was built with the IBHS standards and hopefully that trend continues. Cmsr. Doak also noted that a recent University of Alabama study showed that switching from a conventional construction standard to a Fortified designation increases the value of a home by nearly 7%, holding all other variables constant. Cmsr. Doak stated that the plan in Oklahoma is to: introduce legislation similar to Alabama's that incorporates certain building standards into homeowners' insurance underwriting; work with realtors and Multiple Listing Service (MLS) to get resilient construction standards included in the MLS listing; and work with appraisers to determine if resilient construction can be a factor in home appraisals. Lastly, Cmsr. Doak welcomed all to the National Tornado Summit & Disaster Symposium in Oklahoma in February, 2017 to further discuss these important issues. Sen. Morrish asked if the Oklahoma building code enforcement will be on the State or county level. Cmsr. Doak stated that is something Oklahoma is still studying. Sen. Morrish also asked if the Oklahoma legislation will apply to only new construction? Cmsr. Doak stated for now, the legislation will probably be focused on only new construction but they are not sure yet. Rep. Keiser asked what are insurance companies saying about underwriting the standards/construction? Cmsr. Doak stated that interestingly the IBHS is funded by the insurance industry and that the industry is willing to discuss underwriting issues.

UPDATE ON EFFECT OF BREXIT ON U.S. INSURANCE MARKET

Dave Snyder of the Property Casualty Insurers Association of America (PCI) stated that Brexit's negative effects on stock markets were short-lived. However, a court decision has since been released that stated that the British Parliament had a right to make a decision on Bexit before the government could take the U.K. out of the EU – that is currently on appeal so there is a degree of uncertainty out there. If and when Brexit occurs, the U.S. may have to negotiate its trade agreements and other arrangements with the EU – the U.S. may have to separately negotiate them with the U.K.

Mr. Snyder then stressed that despite the benefits and success of the U.S. state-based system of insurance regulation, there have never been more challenges facing said system. For example, Dodd-Frank gave limited new roles to the U.S. Treasury and the Federal Reserve Board (FSB) to use in connection with the representatives of the States in international regulatory discussions. And unfortunately, the federal agencies have pressed the envelope of their authority and have frequently failed to support state-based regulation in international discussions that were often held behind closed doors, beyond the reach of governors, state legislators and even Congress.

Mr. Snyder noted that advocacy for state-based insurance regulation has been working and praised NCOIL's efforts. For example, the FSB announced that it would not follow international accounting and capital standards unless they make sense domestically. Mr. Snyder stressed, however, that such advocacy needs to continue. Mr. Snyder also noted that in a recent study sponsored by PCI and NAMIC found that if Solvency II capital standards were applied in the U.S., the average auto and homeowner insured would pay between $50-$100 per year per policy as a result of the increased capital standards that provide very little additional consumer protection. Mr. Snyder stated that Congress is responding to efforts like NCOIL's D.C. fly-in and that the efforts need to continue – the job is not done until legislation is enacted. Lastly, Mr. Snyder urged that the Committee pass Rep. Quinn's Resolution Reaffirming Support for the U.S. State-Based System of Insurance Regulation in Response to Recent Federal Encroachment. Rep. Keiser stated that with the U.K. out of the EU, the EU's capacity to make loans and/or give bailouts is significantly reduced – what impact on the banking industry would Brexit have? Mr. Snyder stated that the impact will certainly not be positive and that there are significant concerns that the EU will financially struggle in the wake of Brexit.

Dennis Burke of the Reinsurance Association of America stated that a number of European countries have closed their doors to American companies due to the issues of Solvency II, equivalence and covered agreements. Mr. Burke stated that he and his colleagues do not anticipate covered agreement negotiations being successful. Mr. Burke applauded NCOIL's consideration of a Brussels trip, and if that trip occurs, NCOIL should explicitly ask EU leaders for the U.S. to be deemed equivalent under Solvency II, something that the NAIC has never done. Mr. Snyder stated that an NCOIL trip to Brussels would be very helpful to deliver a clear message that the damage being done to the U.S. insurance regulatory system needs to stop.

NCOIL EFFORTS TO VISIT BRUSSELS

Sen. Holdman stated that many EU leaders are unaware that State legislators are the policymakers for the largest insurance market in the world and that NCOIL needs to educate them on how our system actually works. Notably, prior to speaking in Portland, Oregon, Dr. Nicholas Whyte stated that he had never spoken to a State legislator before. He stated that he found the Portland conference to be extremely educational for him as to how our system works. Dr. Whyte encouraged NCOIL to get involved with EU leaders. Sen. Holdman said he is hopeful

to have a Brussels trip set up by late Spring or early Summer 2017 and that support has already been offered to ensure the trip occurs.

CONSIDERATION OF RESOLUTION REAFFIRMING SUPPORT FOR THE U.S. STATE-BASED SYSTEM OF INSURANCE REGULATION IN RESPONSE TO RECENT FEDERAL ENCROACHMENT

Rep. Quinn, sponsor of the Resolution, stated that the Resolution is essentially a reaffirmation of NCOIL's main purpose: supporting the U.S. state-based system of insurance regulation. Rep. Quinn urged the committee to adopt the Resolution. Upon a motion made and seconded by Rep. Fischer, the Resolution was unanimously adopted.

RE-ADOPTION OF MODEL LAWS

Upon a motion made and seconded, the Company Licensing Modernization Model Act and the Market Conduct Surveillance Model Law were unanimously re-adopted.

ADJOURNMENT

There being no further business, the Committee adjourned at 10:30 a.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
LAS VEGAS, NEVADA
NOVEMBER 18, 2016
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the Paris Las Vegas Hotel on Friday, November 18, 2016 at 3:45 p.m.

Senator Mike Hall of West Virginia, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR
Rep. Martin Carbaugh, IN
Rep. Joseph Fischer, KY
Rep. Jim Gooch, KY
Rep. Jeff Greer, KY
Rep. Bart Rowland, KY
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Sen. David O'Connell, ND
Rep. Don Flanders, NH
Sen. Bob Hackett, OH
Sen. Roger Picard, RI
Rep. Bill Botzow, VT
Rep. Kathie Keenan, VT

Other legislators present:

Rep. Matt Lehman, IN
Rep. Marguerite Quinn, PA

Also in attendance were:
Commissioner Tom Considine, NCOIL Support Services, LLC
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 14, 2016 meeting in Portland, Oregon.

FOLLOW-UP DISCUSSION REGARDING DOL FIDUCIARY RULE/UPDATE ON LITIGATION

Tom Roberts, Esq., of Groom Law Group, provided a brief update on the litigation challenges facing the DOL Fiduciary Rule. Mr. Roberts stated that the Rule is probably the most sweeping revision to the laws effecting the sales of financial products. The rule makes anyone who is engaged in the process of selling a financial product, including an insurance contract, a fiduciary, and therefore requires them to comply with the "Best Interest Standard of Conduct." The "Best Interest Standard of Conduct" requires the salesman to make recommendations that are not only prudent and but without regard to his/her own financial interest. There were six separate cases challenging the Fiduciary Rule, the three most significant have been consolidated in the case in Texas: US Chamber of Commerce, the ACLI and the Indexed Annuity Leadership Council vs. the Department of Labor.
The three other cases were brought by groups that were affected by the way the rule treated the sale of fixed index annuity products: One case was the NAFA case brought in Washington DC the second being the Market Synergy Group vs. the DOL brought in Kansas. Both cases argue that the way the DOL treated sellers of fixed index annuity products was fundamentally unfair,

arbitrary, and capricious and requires them to comply with conditions that are virtually impossible to comply with. Another case was brought by Thrivent Financial for Lutherans which has embedded in its Articles of Incorporation an obligation to arbitrate claims and one element of the DOL Rule is that it prohibits arbitration clauses involving class action cases.

He went on to review the substantive claims underlying these cases. He continued by saying that the cases challenge the DOL's statutory authority to have enacted the rule, and what the department did was take a particular term that was in the ERISA statute of 1974 which stated that providers of "investment advice" are fiduciaries and they reinterpreted in a way that it captured virtually all sales people. One of the industries claims is that the department has taken a term that was well understood for more than 40 years and they reinterpreted it in a way that it was never meant to be interpreted. He went on to say that the cases have argued that the DOL has stretched its rulemaking authority to reach not only sales to employer based plans, plans that are subject to ERISA, but also tried to extend its reach to the IRA market and by trying to reach the IRA market, the litigants argue that the DOL is really acting well beyond their statutory boundaries. He continued by stating that there is a fundamental argument that Congress has been clear that it intends for securities to be regulated by the SEC and fixed annuity products to be regulated by the states - and now the DOL is coming in in a way that Congress never intended and is heavily regulating the sale of the fixed annuity products and fixed indexed annuity products and there are also very interesting claims about the fiduciary rule hampering commercial free speech in violation of the first amendment.

He continued by saying that procedural claims are what you would expect. There are claims that the Department acted arbitrarily and capriciously, particularly in regard to its treatment of fixed indexed annuity products – where at the last minute they took them out of the key exemptions. And there are also issues about the attention that was given to the costs of complying with the rule vs the societal benefits of applying the rule.

Mr. Roberts stated that there were three hearings which were held to date on the cases. He continued by saying that one of the cases had led to a published decision – the NAFA vs. Perez case, brought in the District of Columbia. The Judge issued a 92-page opinion in favor of the DOL. Judge Moss rejected all of the industry claims and stated that he thinks that when Congress chose to use term "Investment Advice" as a definition of what a fiduciary is, he believes it is a reasonable construction of that term to extend to all people who advise in the sale of investment products. Judge Moss found no problem with the Departments requirement as a condition of compliance that parties to a transaction enter into a private contract, a best interest contract, in which the seller of a financial product agrees with the buyer that any recommendation of the product would be in the buyers best interest. Mr. Roberts stated that the DOL required the parties to enter into a contract in an effort to create an enforcement right on the part of IRA holders as under current law they have no enforcement rights. By requiring parties to enter into a contract the DOL gives IRA's holders a basis to bring future class action claims against sellers of financial products.

Mr. Roberts then mentioned that yesterday at a hearing in the case brought by ACLI and others, Judge Lynn had a very different view in that she was more favorably disposed to the industry than Judge Moss had been in the DC case.

John Magnan from ACLI stated that their senior council was at the hearing and it was his understanding that the judge was trying to make the distinction between the consolidated case and the NAFA case. Mr. Mangan stated that they were encouraged by the tone of the questions asked by Judge Lynn about the private right of action and perhaps that this rule overstepped

Congress. Mr. Mangan stated that within the next 30 days Judge Lynn would be writing her opinion and that we would know pretty soon what her position is and whether she has a chance to stay this or not. Mr. Roberts added that if the DC circuit holds in favor of the Department and the 5th Circuit in Texas holds in favor of the industry, there would be a split and that split would most likely be headed to the US Supreme Court.

Mr. Roberts moved on to speak about President Elect Trump. Many members of the public, as well as the industry, were surprised with the result of the election but the industry was particularly surprised as they did not foresee the possibility of what a Trump administration might mean to the DOL Fiduciary Rule. He stated that the President Elect has a member of his economic team, Anthony Scaramucci, who stated that President-Elect Trump was going to repeal the Fiduciary Rule as soon as he gets into office. He added that, perhaps, President-Elect Trump, being a populous as he is widely regarded, might support the rule. He went on to say that most folks are expecting that when he takes office, he will delay the applicability of the rule and he can do that through an interim final rule making process without going to notice and comment and so right now there is a rule that is scheduled to become applicable on April 10, 2017 and the expectation is that it would get bumped some months down the road. He added that President-Elect Trump can also choose to change the rule by reopening the rule making process for public comment but he can't do that with a stroke of a pen and needs to be deliberate with the way he intends to proceed. Another thing he might do is to instruct his justice department not to defend the rule in litigation. He added that Congress could override a piece of rulemaking - you need 60 Senators to cut off a debate on an act of the nature. He concluded that it seems like we are heading toward a likely split through the two circuits.

Mr. Magnan added that there were so many moving parts and that he felt that the main issue all along is that the rule will have a detrimental effect on small investors and small employers access to retirement plans. He went on to say that they are working with the NAIC to strengthen state regulation of suitability. They are also looking at the regulatory possibilities that could exist under a new President – a delay in the operational date is something that seems possible. Sen. Keiser asked Mr. Roberts to explain the difference between Suitability and Best Interest Standard. Mr. Roberts stated that Suitability is the standard of conduct that governs the sale of securities by broker dealers. Under the Suitability standard, a broker dealer must make a recommendation of a product to his client that is suitable for meeting the clients needs. In other words, the client needs to be fitted with an appropriate product. That being said, the broker is permitted to recommend products that would generate compensation for him – that of course is the broker's business, the business of selling. The Best Interest Standard focuses on the compensation element of the recommendation. It states that the seller of a product must not only recommend a product that is suitable but must make a recommendation that is "without regard to the salespersons own financial interests." That is the crux of the debate – is it possible/feasible to take commission salespeople and say "you must sell products that are not only suitable but when you make a recommendation you must do so without regard to your financial interest."

Rep. Keiser asked that, hypothetically, if he is sold a product and it is front end loaded and it costs $20,000 and he gives the seller $100,000, he then has $80,000 going to work for him. There is another product that is 1% but he paid throughout so he invested $99,000 today vs. $80,000, he is going to make more money assuming they are on the investment pattern. Sen. Keiser stated that he could argue that the first product was not well suited to him and that suitability is part of the cost of that product – whether it is a commission or any other form of remuneration. Mr. Roberts responded by stating he agreed that the cost of services is an element of suitability and FINRA has brought regulatory action over the years to brokers who have recommended inappropriately costly products. Mr. Roberts stated that he struggles with

how one can reconcile the need to incentivize a sales force with a rule that says that the salesforce may not consider their own financial interests.

Sen. Hall asked doesn't a broker have to disclose, very clearly, in the documents given to a client what commissions is being paid under the new rule. Mr. Roberts responded by stating that under the new rule if you are proposing to sell a financial product and are hoping to earn a commission, you are a fiduciary with an impermissible conflict of interest. The rule says you are a fiduciary because you are recommending a product, you hope to earn a commission so, therefore, you are conflicted from proceeding unless you can fit into an exemption that the DOL has designed and the exemption that they hope to channel most selling activity through is called the "BIC (best interests contract) Exemption" which is very complex and has a number of disclosure elements in it.

Sen. Hall stated that, in other words, it requires the customer to ask for the disclosure and it is not ordinarily just given to them. Some companies, however, can ask their brokers to disclose if they want. The broker can choose the level of compensation that they could take and then disclose it. Mr. Roberts stated that what Sen. Hall stated was the law as it existed today. Under the DOL regime, that would cease to be the case because the BIC exemption requires that all salespeople who are customer facing be financially indifferent about what product they sell. They would be earning the same amount whether they sold a mutual fund, a fixed annuity or a variable annuity.

Sen. Hall asked that if you are in the managed money world, and you are not a commissioned sales person or you're not commission driven, don't you have a fiduciary standard already? Mr. Roberts said they are. Mr. Roberts went on to say that not all fiduciaries are equal in the eyes of the law. There are fiduciaries in the securities world who are registered under the Investment Advisors Act of 1940 and those fiduciaries are permitted to have conflicts provided that they disclose to their clients in writing what the conflicts are and the client authorizes the advice notwithstanding the conflicts. There are also ERISA fiduciaries - the legal ramifications are quite different than those under the securities law because under ERISA, it would be illegal for a fiduciary to proceed in the face of a conflict unless an exemption is available to relieve the conflict.

Sen. Rapert stated that he appreciated Mr. Roberts update and added that on Sunday there is a Resolution being considered by the Executive Committee that was passed out of this Committee at the last meeting to oppose the Fiduciary Rule. He asked if it is proper to say that, the most egregious thing about the Fiduciary Rule from the DOL is that they have not only have gone out of bounds on what would normally be their turf, but that it seems they have gone against all recommendation to slow down and take input from the SEC and Congress? Mr. Roberts responded by stating that that was a fair statement and that the DOL would argue with that and they would say that they have consulted with the SEC. Mr. Roberts agreed with Sen. Rapert's statement that the DOL has entered an area of rulemaking where they are fundamentally engaged in rules that would govern the distribution of financial products in a way that they have never done before.

Sen. Rapert stated to Sen. Hall that he received a letter on November 16th that was address to the executive committee, which will be provided to the executive committee, from the Financial Services Institute in Washington D.C. that represents nearly 20,000 independent financial advisors – they have added their voice to a list of other organizations that are involved in a lawsuit with the federal government, asking that the DOL listen to Congress and to slow down.

RECENT ACTIVITY SURROUNDING PRINCIPLE BASED RESERVING (PBR)

Eric Cioppa, Superintendent of the Maine Bureau of Insurance and Secretary-Treasurer of the NAIC, began by stating that in July of this year, PBR became effective by a super majority of states adopting the model legislation. PBR will become effective 1/1/17 with a three-year phase in period. He went on to say that what it does is moves us away from the old way that life insurers calculate reserves to contemplate the new complex products that are out there and modernizes how life insurers set reserves in the life insurance space. He added that one of the reasons why the NAIC has been so aggressive in pushing this is because the NAIC has been criticized for allowing a lot of captives that work around the reserves and it is hoped that by the implementation of PRB, it will eliminate the need for captives that are dealing with what they feel are redundant reserves with term-life and whole-life.

Supt. Cioppa stated that this is a complex area that will be new to everyone so what NAIC has done is set up what they call the “Valuation Analysis Working Group” which is going to be a subset of experts from the States. They are going to help states review their models, review what life insurers are doing on PBR and the NAIC has also hired three additional actuaries to review the models. He stated that this is a solvency issue and some insurers are going to reduce their reserves and some insurance will have to increase their reserves. They can use their own experience to help set their reserves. He did note that there were some exemptions. (i.e.- if you have less than three hundred million for an individual or six hundred million for a group, and an RBC of over 450% you would be exempt from PBR). He concluded by thanking the committee and the states for their implementation.

Kate Kiernan of ACLI stated that the threshold for enacting PBR was 42 states, 75% of premium volume and, to date, they have actually reached 46 states and 85.7% of the US Life Insurance market. She went on to say that they are awaiting some legislation in MA that has made it way out of the joint committee of financial services and they are hopeful that it will pass before the end of the year and the changes would go into effect as of January 1st. Ms. Kiernan stated that they were looking at Alaska, NY and Wyoming and that there has been some activity NY and the new superintendent of the Department of Financial Services has indicated that she is interested in moving forward with implementation. Ms. Kiernan stated that there was some movement in Alaska during their last legislative session but that it did not pass and they are hopeful that the other two states will be passing the legislation.

Nancy Bennett, Senior Life Fellow with the American Academy of Actuaries (ACA) stated that she cannot underestimate the importance of moving to this new regime. She went on to say that as exciting as PBR is, it does bring some challenges to both regulators and insurers. Consequently, there are some “guard rails” that were built into the methodology. She stated that PBR is a risk focused dynamic method for calculating reserves and will be used in the calculation for capital requirements as well. PBR has been in the making for 15+ years and it has taken so long because this idea had a lot of merit but there was also a lot of reluctance to move to this paradigm for calculating reserves. The framework first began with variable annuities which started back in the early 2000’s but what is in the valuation manual that has passed is really a hybrid between what could be described as a rule based approach or a pure PBR and economic based approach. It will have limited scope in terms of products and restraints in methodology. The PBR method by design is a dynamic method that is intended to change over time as things change over time subject to continuous review and improvement. If it is seen in 3, 4, or 5 years from now that the results are not as intended or desired, changes could be made from there.

She went on to say that it was important to remember why we are here and that it is because the current valuation methods have a lot of shortcomings. The current reserving has fundamentally been unchanged for 150 years and even though there are more complex products being offered, the reserving mythology was not keeping up with the changes. PBR modernizes the valuation framework so that it is consistent with the products and the benefits that are being desired by consumers and sold by insurance companies. It is more principle based/economically focused rather than a rigid rule. The current valuation process is formula based. With the principle based approach, we are moving more toward a more complex approach but instead of being based on a one size fits all formula, with prescribed one size fits all assumptions, it is a more model based calculation. It uses a model of an insurance companies' policies and therefore reflects all the risks the insurance company takes in selling those policies. It is based on the actual experience of that particular insurance company. As a dynamic approach, it reflects the current economic conditions so it doesn't just lock things in at issue.

There are several benefits that come with PBR for both regulators as well as consumers and insurers. One key issue is that it addresses/incorporates all of the risks the insurer takes on with issuing some of these policies. The previous one size fits all approach, although it was easy to calculate, had certain risks that were missing from calculating the reserve. The PBR approach addresses all the identifiable and material risks that an insurer takes on. The result of a PBR approach is that it right sizes the reserve. It was known that the existing reserve system produced redundant or over reserves for some products but for other products the reserve were not sufficient. The benefit to the consumer is that they are not being over charged because the insurer has to hold overly redundant or excessively conservative reserves. Moreover, the reserve and the reserve methodology is more consistent with how an insurance company manages its risk. You don't have the system where the insurance company goes off and calculates a regulatory requirement. You are able to leverage off the systems the insurance company uses to manage its risk with the systems that are used to calculate the required reserves. Also, one of the aspects of the PBR approach or, more specifically, the valuation manual, is that it simplified or facilitated an easier way for the reserve standards to be updated. In the current approach, if there was a new product that came out and it was identified that the reserve formula doesn't really address it, you would go through it and update it with an actuarial guideline or maybe a regulation that would update it and then it would have to pass through all the different states. With the valuation manual that is in place today, it is much simpler to make the changes to the valuation manual and then have that follow through in the different states. What it means is that the valuation standards will stay more up to date with changes of the product that are offered.

Most importantly, the principle based reserve does come with a minimum floor. It is recognized that with all the benefits of PBR, it is a new paradigm and there will be challenges. For regulators, we are looking at a system now that is based on a model, a very complex model of an insurance company's assets and the liability of the products that it holds. That is a much different approach of calculating a reserve than just a simple formula on a spreadsheet. Developing modeling expertise within the regulatory community will be essential to have a successful implementation of PBR. The regulators will also be getting much more information about a company's experience which is good, but that means that they will also be getting a lot more data and it will impose a data management challenge particularly at the beginning. The other item is that regulators like to have a system that allows them to compare reserves across companies, so right now because everything is so customized with PBR, it will take a little while to develop or have some industry wide benchmarks based on experience data.

Life insurers are also going to have some implementation challenges, notably, there is going to be more governance as well as more sophistication required in the valuation process and their ability to model. The reserves themselves will also be more volatile because they are not set as they will change from period to period therefore explaining that volatility and explaining those financials will take more time. PRB is a good thing but it is seen by some as a “brave new world”. It is important to understand that there are certain prescriptive and limiting elements that have been built into the system and it is understandable that there would be some discomfort among regulators and others that monitor or look or review the financials of an insurance company. Some of these prescriptive and limiting guardrails could be considered traditional guardrails. It is likely that some may go away once everyone gets more comfortable and some may remain permanent. PBR only applies to new policies issued after the first of the year and it will not have any effect on existing policies in place. The effect of PBR on a company’s processes and financial results will take several years to see how that will come into play. Reserves will also remain subject to an asset-adequacy analysis and an actuarial opinion.

In terms of the impact on PBR, because it is going to be phased in over a long period of time, it is difficult to predict. It would be fair to say that on the vast majority of policies there won’t be a great deal of impact. On whole life policies, you will see very little impact, on term insurance policies you will probably see a reduction in reserves and then on some universal life policies, you will see some reserves go down and some reserves go up. It is further anticipated that insurance companies will likely change their product design so, for those products, if left unchanged, would have seen a large increase in reserves but because of the PBR, it is likely that those products will be modified so that they do not see that big reserve increase.

PBR is a major paradigm shift and many people have been working on this for many years and while it comes with challenges, it really modernizes the valuation techniques. Sen. Keiser stated that when PBR was passed, a provision was put in that gave the commissioner the authority to exempt specialized and small companies from PBR. He then asked if the working group was going to establish baseline criteria that commissioners can use across the states for consistency for that exclusion? Supt. Cioppa stated that premiums thresholds were put in -- three hundred million for individual insurers and six hundred million for groups along with the 450 RBC requirement.

UPDATE ON NAIC UNCLAIMED PROPERTY MODEL

Supt. Cioppa stated that the NAIC established the Unclaimed Life Insurance Benefits Working Group - they completed their work on their model and they will be voting on it shortly. He stated that it is not intended to duplicate the good work that NCOIL has done. They looked at the model, kept a lot of the same features and added an 18 month look-back period for lapsed policies, a semi-annual look-back for lapsed policies as well as a number of other features. He stated that consumers are going to benefit from both models if they have any unclaimed life insurance policies. He stated that 19 states have a lost policy locator which was implemented and the NAIC is in the process of implementing one nationally that will help as well. Supt. Cioppa acknowledged that NAIC needs to communicate better with NCOIL when developing Models that NCOIL has already weighed in on.

John Mangan stated that a letter was written to the NAIC working group on October 25 outlining some of the ACLI’s remaining concerns with the draft NAIC model. He went on to state that the ACLI raised the question of whether the second model is necessary given the fact that there is an NCOIL model that they have supported and is in effect in 23 states and pending in a couple more states. Further, he added that he knows that the NCOIL model is an effective approach

and has resolved many of the issues that came up during some of their settlement conferences ACLI has had with some of their companies. Even in states that do not have the NCOIL model, they have started to modify their practices to in essence comply with it. The Uniform Law Commission has also updated it Uniform Unclaimed Property Act and it is consistent with what NCOIL put together. Mr. Mangan concluded by stating that they wanted to congratulate the NAIC on its lost policy locator service.

LIFE INSURANCE DISCLOSURES PROVIDED TO CONSUMERS

Kate Kiernan stated that currently there are comprehensive regulations protecting consumers' interests in annuity sales. From product development to advertising to sales, life insurers offering annuities must comply with state and federal laws and rules that help protect consumers' interest. On the State regulatory side, as insurance products, annuities are regulated by the insurance department and the laws and regulations include product and content marketing rules, sales practice requirements, and free-look provisions – if an annuity purchaser is not satisfied with the product, it can be returned to the insurance company for a full or partial refund depending on the type of annuity. Most "free look" periods last 10 days but rules vary from state to state.

Ms. Kiernan went through a few of the NAIC models: Annuity Disclosure Model Regulation; Variable Annuity Model Regulation; Suitability in Annuity Transactions Model Regulation; the use of Senior-Specific Certification and Professional Designations; and the Life Insurance and Annuities Replacement Model Regulation. There are two other models but not many states have adopted them and the NAIC is looking at whether they need to amend them: the Modified Guaranteed Annuity Model Regulation and the Annuity Non-Forfeited Model Regulation. Ms. Kiernan touched briefly on the federal laws and regulation stating that federal securities laws give the SEC authority to supervise securities including variable annuities. FINRA, a self-regulatory organization which the SEC oversees, sets rules that governs the sales practices of broker-dealers. There are a number of rules under both of those entities. Ms. Kiernan stated that two disclosure documents must be given to individuals at the time of an annuity application: NAIC Annuity Buyers' Guide and a Comprehensive Annuity Disclosure Document. The NAIC Buyers' Guide covers both fixed and variable deferred annuities. The fixed guide includes a separate section for Indexed Annuities. The Buyer's Guide covers a lot of information in easy to understand language and includes: The different types of annuities, how they work, how they accumulate and pay out, a description of fees, charges, adjustments and different options such as guaranteed living benefits, taxation of annuities; for variable annuities, how account values may change, and for index annuities, how different crediting rates work.

She stated that the NAIC Annuity Disclosure Model outlines a comprehensive list of elements that need to be in the disclosure document that is given to applicants. They include: information about the insurer, a description of the contract and benefits, the guaranteed and non-guaranteed elements of the contract, how interest is credited, the available benefit income options, how withdrawals and surrenders may reduce the contract value, death benefits, a summary of the tax status of the contract, the impact of riders such as guaranteed living benefits, fees, and how guaranteed and index rates are applied. She continued by adding that companies may provide prospective purchasers with illustrations governed by statutory law. If provided, they must include both the narrative and numeric portions and include how benefits may be calculated; and there are standards to ensure they are easy to understand and are not misleading. Sales of variable annuity products must be accompanied by a prospectus and on at least an annual basis, companies must provide contract holders with a report of the status of their annuity contracts including cash values, amounts credited, loan activity, etc. Ms. Kiernan added that

companies must make their annuity disclosure recordkeeping available to state regulators for market conduct purposes. She also stated that State adoption of the NAIC Suitability in Annuity Transactions Model Regulation, the NAIC Annuity Disclosure Model Regulation, Use of Senior-Specific Certifications has been robust and ACLI actively supports further state adoption of those models.

Tomasz Serbinowski, an Actuary from the Utah Insurance Department, stated that he went on to say that he is speaking for himself and not his employer. Mr. Serbinowski stated that Guaranteed Lifetime Withdrawal Benefits (GLWB's) and CDA's are very similar. GLWB's, offered typically with a variable annuity, allows you take a certain number of withdrawals without worrying about depleting your fund. CDA's have almost the same features but stands alone and could be offered to someone who has a 401 (k) and doesn't want to move the money to a variable annuity. This would afford them the opportunity to make safe withdrawals.

He proceeded by saying that what CDA's typically help you withdraw money from a 401(k) or a similar account. The insurers are not underwriting the life in this case but are underwriting the fund. They look at how risky the fund is. It will typically have restrictions on the fund and typically will define a benefit base that would be used to determine fees and allowable withdrawals, the purpose to make sure if your fund goes down before you start withdrawing, somehow the amount of money you can take out is specified upfront. He stated that more and more people face retirement without defined benefit plans. In the old paradigm, you typically retired with a pension and if you had a fund on the side it might be used to supplement. Today, when people retire with 401(k) and other assets you have to figure out how to manage withdrawals. Retirees have the risk of outliving their assets – known as longevity risk. CDA's major attraction is that it does not require anyone to turn over assets at once to the insurance company. There are other tools but they require you to take assets and turn them over on day 1 to the insurance company. People are reluctant to do that.

Mr. Serbinowski stated that the problem with whether consumer disclosures are adequate is that CDA's and GLWB's are insurance features – when you buy insurance consumers know they are spending money, not making money. Consumers buying homeowners insurance, auto insurance, health insurance, etc. generally view such products as an expense. Consumers don't expect to be financially be "better off" when they purchase insurance. However, current illustrations of GLWB's and CDA's may lead consumers to believe that such products are likely to increase their wealth. Consumers may not be able to gauge the level of fund performance under which they are better off with the insurance. Additionally, GLWB's and CDA's typically allow insurers to control the risk through changes to allowable funds and feel levels. Current illustrations also do not explicitly state the fees. In realty, over the first 10 years, fees may add up to a third of the initial investment. Under many scenarios, over the lifetime of the product, fees may exceed initial investment. Illustrations also do not differentiate between the fund depletion due to fees vs. market performance and longevity.

In response to a question of whether a CDA is likely to pay off, Mr. Serbinowski stated it depends on the allowable investments and fees charged – more aggressive investments will tend to increase the value to consumers but it may be limited by the insurer. Also, higher fees will tend to lower the value to the consumer. Mr. Serbinowski stated that showing cumulative fees and fund value in the absence of a CDA might improve consumer understanding of the product and enhanced disclosures may help consumers make informed decisions and lead them to alternative solutions. Enhanced disclosures may also result in changes to marketing practices.

Sen. Hall stated that Mr. Serbinowski was correct in that fees were not laid out as they were contained in the prospectus and asked if his suggestion was to see the fees laid out as he presented. Mr. Serbinowski stated that if he were to buy the product, he would like to see all fees but he is not an average consumer. Sen. Hall asked if Mr. Serbinowski felt the fees were fair in terms of the risk the company was taking on in hedging the position in case of a bad market. Mr. Serbinowski stated that they may very well be fair but he is not trying to say they are not fair. He is saying that if you look at it in a different way, maybe you would buy a different product.

Cmsr. Considine asked if there were any comparisons to see what is the impact on the consumer of instead of the percentage of the investment on a year by year basis, if the consumer paid a much larger upfront investment (on a $500,000 corpus, if they paid a $50,000 upfront) and there was no percent on a year by year basis, which of those scenarios is the consumer better off? Mr. Serbinowski stated that If you pay up front, it may be very risky to the insurance company. These products pose some very big challenges to the insurance company as well. Cmsr. Considine asked a question about the rate of the return being phantom - if the value goes down below a certain level, are you still charged as if it hit at a certain level. Mr. Serbinowski stated he was not sure if he understood the question but 2% is charged to the benefit base, not to the account value. Cmsr. Considine asked if he was correct in stating that the actual value in the account might be $200,000 but the consumer pays 2% on $400,000? Mr. Serbinowski said yes, that is how most operate.

ADJOURNMENT

There being no further business, the Committee adjourned at 5:22 pm.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE
LAS VEGAS, NEVADA
NOVEMBER 17, 2016
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at the Paris Las Vegas Hotel on Thursday, November 17, 2016 at 5:15 p.m.

Representative Steve Riggs of Kentucky, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR
Rep. Matt Lehman, IN
Rep. Joseph Fischer, KY
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Sen. Neil Breslin, NY
Sen. Bob Hackett, OH
Sen. Roger Picard, RI
Rep. Bill Botzow, VT

Other legislators present were:

Asm. Ken Cooley, CA
Asm. Kevin Cahill, NY
Asm. Will Barclay, NY
Rep. Marguerite Quinn, PA

Also in attendance were:
Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 15, 2016, meeting in Portland, Oregon.

MODEL LAW DISCUSSION ORIGIN/HISTORY OF NAIC ROLE IN MODEL LAWS

John Huff, NAIC President and Director of the Missouri Department of Insurance stated that the NAIC has been drafting Model Laws for States to consider since its founding in 1871. What makes the NAIC Model Law process stand out in terms of preserving the state-based system of insurance regulation is that a lot of thought is put in before the drafting process even starts – the NAIC Executive Committee must approve a recommendation from one of the NAIC "parent" committees before drafting a new Model or amending an existing Model begins. The subject matter of the Model must involve either a national standard or an issue that begs for more uniformity among the States. Once the decision is made to begin drafting a Model, the dialogue process with interested parties and legislators begins. Once a Model is drafted, it requires 2/3 approval of NAIC membership to be adopted. Some of the hallmarks of the Model process is its transparency and the ability to track the Model's process on the NAIC website to see how many States have adopted it. It is also important that all States are included in the process – each State has 1 vote.
Rep. Riggs asked how the NAIC Model Law process has changed and/or expanded over the years. For instance, did NAIC start drafting Models solely relating to the accreditation process?

Andy Beal, CEO of NAIC, stated that NAIC has always drafted Models outside of accreditation, but there is no doubt that the accreditation Models receive a higher level of attention. Mike Kreidler, Commissioner of the Washington Insurance Department, stated that the accreditation Models have been a higher priority because a State's failure to adopt one of the accreditation Models could result in that State losing NAIC accreditation status. Rep. Riggs asked if any of the NAIC Commissioners/Directors had an example of enacting legislation in their home State and then taking that idea to the NAIC so a Model could be drafted. Cmsr. Kreidler stated that around 2004, Washington had enacted medical malpractice reporting legislation which led to the NAIC drafting a Model on that issue. Dir. Huff emphasized the word "model" because ultimately it is up to the States to decide what is appropriate to adopt in their State. Rep. Lehman asked how long does a State have to adopt something from the time NAIC adopts it as an accreditation standard? Dir. Huff stated that after a Model is approved by NAIC membership, it goes to the NAIC F Committee to decide if it will become an accreditation standard. The Model then has a 1 year comment period which is then followed by a minimum 2-year window for States to comply.

Rep. Lehman asked what would happen if a State refused to adopt an accreditation Model? David Mattax, Commissioner of the Texas Insurance Department and Chairman of the NAIC Accreditation Committee, stated that it would depend on the facts and circumstances of each situation. For example, was the model introduced and make progress? Rep. Fischer asked what is the impact of a State losing accreditation status? Cmsr. Mattax stated that one of the primary reasons to have accreditation is to have a uniform system of adequate solvency regulation to ensure that the States have faith that their companies are solvent. If a State loses accreditation status, other States lose the ability to rely on that State and then companies within that State are subject to multiple solvency regulations and examinations. Additionally, it can affect other companies' attitudes towards coming into that State to start new business.

Rep. Botzow asked what is the proper check and balance on an entity that creates laws that are tied to accreditation status. Dir. Huff stated that the open and transparent process of the Model process serves as an important check and balance. Additionally, the Models are then subject to each States' legislative process. Further, States can adopt legislation that is "substantially similar" to an NAIC accreditation Model so that it meets that States' specific needs.

DISCUSSION OF REVISED DRAFT OF NAIC INSURANCE DATA SECURITY MODEL LAW
Rep.

Riggs asked if there is a deadline to finish the drafting process of the NAIC Insurance Data Security Model? Dir. Huff stated that there is not a hard deadline but there is a commitment to have a 3rd draft available soon for consideration and to have NAIC membership vote on the Model before the end of the year.

Rep. Riggs stated that it might be difficult to enact legislation that deals with only insurance – why does the insurance industry need to be singled out in this area? Dir. Huff stated that he thinks due to the state-based regulation of insurance and the complexities of the insurance industry, it is best to have an insurance-specific law on cybersecurity. Cmsr. Mattax stated that insurance is different from other industries due to the nature of the information insurers collect from consumers and it is paramount that it be as secure as possible. Eric Cioppa, NAIC Secretary Treasurer and Superintendent of the Maine Bureau of Insurance stated that insurance is a state-based system and it is our duty as state regulators/legislators to protect consumer's information as best as possible.

NAIC UNCLAIMED PROPERTY MODEL UPDATE

Supt. Cioppa stated that NAIC is not trying to duplicate NCOIL's efforts in this area but rather is trying to build on it. One of the differences between the models is that the NAIC model has a period to look back for lapsed policies. Also, the NAIC model has a hardship exemption if insurers face financial compliance problems. Rep. Riggs asked why didn't NAIC come to NCOIL to amend the NCOIL model with those provisions? Supt. Cioppa stated that the end result will be good and that NAIC views its model as building upon NCOIL's. Sen. Holdman stated that he is not prepared to go back to Indiana to try and adopt the NAIC Model on this issue – that battle has already been fought by adopting the NCOIL Model, which was a very difficult process. Rep. Keiser stated that the NCOIL Model has the hardship exemption that Supt. Cioppa mentioned and agreed with Sen. Holdman's comments. Rep. Riggs agreed with Sen. Holdman and Rep. Keiser and stated it is very difficult to go back to his State and re-open this issue. Rep. Quinn reiterated Rep. Riggs' statements and then applauded NAIC's efforts with its lost life insurance policy locator. Rep. Botzow stated that it is important for NCOIL and NAIC to analyze how each can add value to each other's Model Law process.

COLLABORATIVE EFFORT WITH NAIC ON HOW BEST TO REGULATE AIR AMBULANCES

Supt. Cioppa applauded North Dakota's efforts to try and regulate air ambulances – unfortunately the proposed law was preempted. Supt. Cioppa stated that this is a great opportunity for NCOIL and NAIC to work together to help consumers. Rep. Riggs asked if Congress is aware of this issue? John Doak, Commissioner of the Oklahoma Insurance Department, stated that he believes that Congress is aware but there still needs to be some heavy lifting at the federal level to help solve the problems facing consumers. Rep. Keiser stated that this issue is a great opportunity for NCOIL and NAIC to fly-in to Washington D.C. to speak to Congress. Rep. Keiser stated that one option is to have the federal government pay for the difference between the standard billing and the balance billing. Rep. Keiser also stressed that until a critical mass is reached to help solve this issue, Congress will be slow to move – NCOIL needs to be aggressive. Cmsr. Kreidler stated that he is encouraged by the efforts of several States on this issue and that it might be appropriate for NCOIL and NAIC to consider a Model law.

NAIC INCORPORATION BY REFERENCE (IBR)

Dir. Huff thanked NCOIL for its comments on the IBR process and stated that the NAIC is currently reviewing how to improve it with its Governance Review Task Force. Rep. Riggs asked what if someone reviewed an IBR proposal and determined that it wasn't technical in nature but rather substantive? Dir. Huff stated that question is why it is important to have the IBR process be as open and transparent as possible and efforts are being made to do that. Commissioner Tom Considine, NCOIL CEO, stated that whether or not a change is viewed as technical or substantive, it has the effect of changing the statutory laws in States and there is no independent oversight of it. NCOIL has recommended that it serve as the clearinghouse for receiving and reviewing comments on IBR changes but it was not warmly received. NAIC staff had stated that they had received no complaints on its IBR process. Cmsr. Considine stressed that this proposal was not an effort for NCOIL to serve as a "big brother" to NAIC but rather to move the IBR process forward in a more transparent fashion. Dir. Huff stated that the process Cmsr. Considine described is already provided for in the interested party discussion with any IBR changes. NCOIL is free to survey its members and others to comment on any IBR changes and submit them to NAIC. NAIC believes that adding another level of review to the process as proposed by NCOIL does not add any value.

Rep. Keiser noted that State legislators have no one to blame but themselves for the IBR process because they have time and again delegated such authority in statutes to the NAIC. Rep. Keiser further noted that on one hand, he does not want to review technical changes, but on the other hand there have been some changes that could have been argued were policy changes rather than technical changes and he was not happy about that. Dir. Huff stated that NAIC is committed to strengthening its relationship with NCOIL as is evidenced by strong NAIC attendance at this conference. NAIC is willing to involve NCOIL members with technical changes in a process similar to the conference call that was held to review the revised draft of the NAIC Insurance Data Security Model Act. Sen. Rapert stated that he looks forward to working with NAIC to ensure the preservation of the state-based regulation of insurance.

NAIC RETIREMENT SECURITY INITIATIVE

Rep. Riggs applauded NAIC's retirement security initiative and stressed that retirement security is an issue that we must all stay involved in. Dir. Huff stated that 4 out of 10 baby boomers have $0 saved for retirement – this is a crisis. The retirement security initiative focuses on 3 major regulatory areas: consumer protection – making sure NAIC is up to date with its suitability Models and regulations, and launching the lost life insurance policy locator; education – State legislators should continue to raise this issue in their States with ideas such as mandatory financial education for high school students; innovation – making sure the regulatory area is opened up to ensure that consumers are presented with products that meet today's need.

Asm. Cooley stated that we all need to be mindful that retirement security is vital to our economy. When the financial crisis struck, many older citizens wanted to stay in their jobs as long as they could because they knew they were unable to leave and sustain themselves. This resulted in a scarcity of entry-level positions for college graduates. Accordingly, retirement security allows for older works to retire, still spend money on goods and services, and open up jobs for younger workers. Cmsr. Doak agreed and challenged legislators to strengthen/enact mandatory financial education for high-school students.

ADJOURNMENT

There being no further business, the Committee adjourned at 6:15 p.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY COMMITTEE
LAS VEGAS, NEVADA
NOVEMBER 17, 2016
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Property & Casualty Committee met at the Paris Las Vegas Hotel on Thursday, November 17, 2016 at 10:30 a.m.

Representative Matt Lehman of Indiana, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR
Rep. Martin Carbaugh, IN
Rep. Peggy Mayfield, IN
Rep. Joseph Fischer, KY
Rep. Steve Riggs, KY
Rep. Bart Rowland, KY
Sen. Dan "Blade" Morrish, LA
Rep. Michael Webber, MI
Rep. George Keiser, ND
Sen. Jerry, Klein, ND
Sen. David O'Connell, ND
Rep. Don Flanders, NH
Aswm. Maggie Carlton, NV
Asm. Will Barclay, NY
Sen. Neil Breslin, NY
Asm. Kevin Cahill, NY
Sen. Bob Hackett, OH
Rep. Michael Henne, OH
Rep. Bill Botzow, VT

Other legislators present were:

Sen. Joe Hune, MI

Also in attendance were:
Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 16, 2016, meeting in Portland Oregon, and the minutes of its September 29, 2016, interim conference call meeting.

DISCUSSION OF FLOOD INSURANCE MARKET WITH EMPHASIS ON PRIVATE MARKET'S INVOLVEMENT

John Huff, NAIC President and Missouri Insurance Director, began by stating that the private flood insurance market is a great opportunity for the insurance and reinsurance markets, but even more of an opportunity for consumers for the possibility of leveraging the private market to get better prices and potentially better service. Director Huff stated that flood is a very unique peril in the sense that it is a hazard that can hit all 50 States. There is a growing interest in the private flood market – the interest from the admitted market is somewhat limited but there is a great deal of interest from the surplus lines market. There are some regulatory differences between the admitted and surplus lines markets and that is one thing to be cognizant of as we go down the path of private flood insurance.

The biggest opportunities for consumers in a private flood market are a better balance between coverage and price. NAIC supports the growth of the private flood market to provide consumers an alternative to the National Flood Insurance Program (NFIP). The NAIC is also very supportive of H.R. 2901 which passed unanimously in the House. Some of the language in that bill is important to clarify that state insurance regulators do have the same authority and discretion to regulate private flood insurance as they have to regulate other similar insurance products and markets. Director Huff stated that since H.R. 2901 passed the House, federal banking regulators have issued a notice of proposal for rulemaking to implement private flood provisions which would require federally regulated lenders to accept private flood insurance as an alternative to NFIP. The rules are now out for comments until January 6th, 2017 and Director Huff encouraged NCOIL to comment.

Director Huff then stated that another big issue is the upcoming re-authorization of the NFIP that has to be done by September 30, 2017. NAIC staff issued a handout to this committee that highlighted some things that NAIC thinks are important for the viability of the private flood insurance market and the re-authorization of the NFIP. Some highlights include: a long-term re-authorization of the NFIP – it's in the best interests of the long term stability of the marketplace for insurers to be able to plan on a long term basis; growth in the private flood insurance market to complement the NFIP to help consumers have more choices; FEMA should be required to share NFIP information including claims elevation and mapping data – such information should be shared with State insurance regulators and with the market to make sure the private market is able to accurately assess flood risk; encourage support for mitigation planning including mitigation discounts such as premium discounts and insurance rate deductions to people who build/re-build/retro-fit certain residential properties to better resist flood events.

Frank O'Brien from Property Casualty Insurers Association (PCI) stated that there is a lot going on in the flood insurance markets recently due to the recent events in Louisiana. PCI supports H.R. 2901 and agrees with the principles that Director Huff stated. The private flood insurance market continues to evolve and it is fair to say that there is a lot of momentum right now with trying to see the private flood insurance market work.

Eric Goldberg of the American Insurance Association (AIA) stated that AIA also supports H.R. 2901 and agrees with the principles that Director Huff noted. However, there are some hurdles when talking about the admitted market. One is an adverse selection problem and the other is a strong regulatory touch. AIA urges States, when looking at private market flood writers coming into their respective State, to exercise a light regulatory touch that will encourage the market to continue growing. Some States already have statutes that allow regulators to exempt certain specialty lines of coverage from prior approval of rates and form approval – AIA recommends that all States have those statutes.

Rep. Lehman asked the panel if there is a long-term re-authorization of the NFIP, is there an incentive for the private market to continue to delve into the market. Frank O'Brien stated that he thinks there is a general consensus that there continues to be a need for the NFIP whether it functions as a market of first or last resort. The balance that needs to be struck by policymakers, particularly at the federal level, is balancing the need to have some stability and predictability relative to the ongoing nature of the NFIP and its obligations while at the same time allowing the private flood insurance market to evolve. There needs to be encouragement to those that want to be in the market and those who are forced into it. Mr. O'Brien stated that PCI supports re-authorization of the NFIP for a reasonable amount of time because it provides for market stability. Mr. Goldberg stated that short-term re-reauthorization has not been good for anyone

involved in the market. Director Huff stated that the transition of private market involvement will be difficult but there is no better time than now considering the record levels of capital particularly in the global reinsurance markets.

Rep. Keiser stated that he sees a dis-connect in the panel's thought process in that they want to continue the NFIP but also want expansion of the private market. The NFIP will continue to lose money if the private market's involvement grows because the private market will take all the "good" risk. Accordingly, Rep. Keiser stated that a single approach might be best going forward. Mr. Goldberg stated that the notion of requiring people to pay a premium that accurately reflects their risk is rational because people will act rationally if they have a better understanding of what they are facing. AIA is not sure what the flood insurance market will look like in the future but definitely believes that the NFIP needs to be there at the very least in the short-term.

Dennis Burke of the Reinsurance Association of American stated that the private market, particularly the reinsurance market, is interested in writing flood insurance. One way to operate going forward is by supporting the private insurance companies who want to write either on a surplus lines or an admitted basis, and reinsure the NFIP. Additionally, Mr. Burke believes that there is plenty of risk that could be written by private insurers but they don't know about it because they don't have the data from the NFIP.

In closing, Rep. Lehman stated that he has always wondered why we can't roll flood into a standardized policy when spreading the risk across a segment of society. Additionally, Rep. Lehman asked why NFIP isn't structured more like TRIA where it is the backstop to the heavily catastrophic claim.

DISCUSSION OF ASBESTOS CLAIM TRANSPARENCY MODEL LAW

Barry Goldwater, Jr. from Goldwater-Taplin stated that asbestos litigation is the longest running litigation tort in the history of the country and encouraged NCOIL to adopt an asbestos claim transparency model law.

Mark Behrens, Esq. stated that asbestos today is characterized today by widespread and significant manipulation of exposure evidence by plaintiffs and their attorneys – those words are from a federal judge a few years ago involved in a bankruptcy proceeding. Asbestos litigation began in the 1970's – OSHA was formed in 1972 particularly because people found out that asbestos could cause cancer. For 20 years, lawsuits were brought against the companies that were the major asbestos producers. Those companies were culpable and did some very bad things and probably deserved to go bankrupt. However, those companies are not involved in the litigation today – virtually all of them were forced into bankruptcy.

Asbestos bankruptcies are different from any other type of bankruptcy because there is a provision in the bankruptcy code that says when you have an asbestos-related bankruptcy, your liabilities will be channeled into a trust. The company will put up assets into that trust and then when re-emerged from bankruptcy, they are forever immune from ever being sued again in asbestos litigation. There are now over 60 of these trusts and as of 2011, they hold almost $37 billion in trust assets, and that number is probably higher today. So all that money is available to pay claimants and its completely outside the tort system. Asbestos litigation has not dissipated - there are now over 10,000 companies that have been involved in litigation. What the plaintiff's bar did was cast their net wider by going after any company whatsoever that had any nexus, no matter how remote, to asbestos.

Today, a plaintiff has two different avenues towards recovery. You can bring a claim against the trust and bring a claim in the tort system. Because there is a disconnect between those systems, it has created an opportunity to game the system. When plaintiffs today are deposed, they routinely name all of the solvent defendants in the lawsuit when asked to name all defendants. So when the plaintiffs are asked of any other exposures they had, they say they do not recall. Defendants therefore today have a very difficult time defending themselves. And inevitably, after plaintiffs file one lawsuit, they file another against the trusts with information that contradicts their testimony saying they do not recall any other exposure. A sampling was taken among plaintiffs who filed lawsuits against companies and it was discovered that in every single case where plaintiffs said they do not recall, on average they filed subsequently 22 lawsuits with trusts and recovered an additional $560,000.

Consequently, 8 (eight) States have enact legislation simply saying that plaintiffs have to file their trust claims before their tort lawsuit goes to trial. It's not about closing the courthouse doors to anyone or capping damages - this is all about changing the timing requirement. Instead of filing the tort suit first and preventing the defendant from having access to all exposures, it is required to file trust claims first so that the jury can hear evidence about all exposures and make an informed decision about who really is liable. In light of the fact that similar legislation has passed in 8 states, and the drain these duplicative recoveries place on insurance ratepayers, NCOIL should develop a Model based on this legislation.

DISCUSSION OF MODEL TOWING ACT

Rep. Lehman stated that the proposed Model issued to the Committee is not ready for action but it is a good starting point. – hopefully the Model will be ready for action at the Spring Meeting.

Joe Thesing of the National Association of Mutual Insurance Companies (NAMIC) stated that towing is an important issue to both consumers and insurers. When NAMIC first started working on a model, it received tremendous support. While there are many great towing companies, many are not conducting themselves in a proper manner and are creating unwarranted fees because the towing industry is largely unregulated.

The idea behind this model is to create a basic regulatory framework for towing companies. Some highlights include: allowing the Public Utilities Commission or similar division with rulemaking authority to implement and enforce the law; defining emergency and private property tows; requiring a written estimate to be provided; establishing invoice standards including itemization and costs for services provided; describing processes towing companies must follow for identifying the owner or lienholders; outlining prohibited acts and defining penalties. NAMIC is looking forward to working with NCOIL on how to make the model better and to introduce it to States next year.

Tim Lynch of the National Insurance Crime Bureau stated that the timing of NCOIL involvement on this issue is good. Predatory towing has become a problem and several states have taken action. An example is charging consumers a "fuel fee" of $225 when the towing yard was 4 miles away from the accident. California, Illinois and Missouri have passed legislation prohibiting towers from going to accident scenes unless authorized by law enforcement, with some exemptions. Also, some states have put together an approved towing list for law enforcement. Ohio and Pennsylvania are looking to pass similar legislation soon.

Rep. Riggs stated that in the model, the authority as to who might order a tow might need to be expanded past law enforcement to include fire departments, etc. Mr. Thesing agreed that such language should be included in the model.

CONSIDERATION OF PROPOSED AMENDMENTS TO LIMITED LINES TRAVEL INSURANCE MODEL

Rep. Lehman stated that no action will be taken on the proposed amendments today but this is an opportunity to understand what the amendments will do so that they can be properly considered at the Spring meeting.

John Fielding of the United States Travel Insurance Association stated that the reason for the Limited Lines Model in the first place was that things weren't working well in the licensure front – it was sometimes impossible to be licensed in multiple states. 43 States have enacted the Model. The amendments to the model address a broader range of issues besides licensing and they aim to provide for a more clear and effective regulatory framework for the travel insurance industry because there have been some concerns recently in that area. The amendments are based on issues and concerns stated by regulators.

Among other things, the amendments: define what is and isn't travel insurance; clearly identify who pays a premium tax and what its paid on; empower regulators to look at the market and to determine if there is a competitive market which is important to rates and forms; permits travel protection products in competitive markets; creates a new TPA license in states that do not have one; bolster enforcement rules. Going forward, it is important to get this right and the USTIA welcomes the opportunity to work with NCOIL. Mr. Fielding also encouraged NCOIL and NAIC to work together on this issue.

Greg Mitchell stated that the non-traditional distribution channel of travel insurance touches upon many other industries whose primary interest is not travel insurance such as adventure, cruise lines and tour companies. The amendments are a result of trying to update the laws that have existed for major lines of insurance and adapt them to be viable with travel insurance.

Rep. Riggs asked what kind of feedback they have had with State insurance commissioners with the Limited Lines Model. Mr. Mitchell stated that for the most part the 43 states adopted it uniformly. Mr. Fielding stated that hopefully in 2017 the remaining 7 States will adopt it. Mr. Fielding also stated that what helped passage of the Model was that when they visited with State insurance commissioners, they were pleased to know that the model was a product of NCOIL and NAIC working together. Wes Bissett of the Independent Insurance Agents and Brokers of America stated that IIABA looks forward to working with NCOIL on this issue and that while those who offer travel insurance shouldn't be subjected to the full level of regulatory oversight that of a traditional agent, we still need to make sure that consumers are protected. Mr. Bissett stated that there are ways to bolster the current Model to address consumer-protection issues.

CONTINUATION OF BIG DATA/TELEMATICS DISCUSSION

Eric Cioppa, NAIC Secretary-Treasurer and Superintendent of the Maine Bureau of insurance, stated that there are few things that can be as significant and transformative to society as data and insurance is no exception to that. NAIC is anxious to get ahead of the curve and protect consumers. Insurers are collecting more data than ever and the models they use to analyze that data are getting more complex. What's problematic is that most States' rating statutes simply state rates cannot be inadequate, excessive or unfairly discriminatory and it is difficult to merge

the current technology with those laws. NAIC formed a big data working group and will be making a recommendation to the NAIC Executive Committee to form a big data task force. Some issues that the working group have been working on that the task force will continue to work on are: regulators need to review the current regulatory framework used to oversee insurers' use of data; regulators need to propose a mechanism to provide for sharing of resources to facilitate a States' review of complex models; and regulators need to assess their own data needs and tools to properly monitor the marketplace.

Dave Snyder of PCI stated that insurers' use of big data has had beneficial results. It has improved the overall customer experience; improved the claims settlement process; its socially beneficial because usage based insurance data provides feedback to drivers as to how to drive more safely; improves risk assessment and pricing and makes the whole process less subject to judgment and more subject to data for regulators. Mr. Snyder also stated that this issue is so broad, however, that it might lead to disruption of the framework that has created the most competitive and consumer friendly insurance market in the world. PCI looks forward to working with NCOIL on these issues going forward.

Eric Goldberg stated that collecting data and discriminating based on risk is the nature of the insurance business. Mr. Goldberg agreed with Mr. Snyder's remarks in that we need to be careful of upsetting the current regulatory framework when considering this issue.

CONSIDERATION OF RESOLUTION SPONSORED BY REP. KEISER

Rep. Keiser stated that we know that autonomous vehicles are now reality and that we need to be careful that we don't play catchup on this issue the way we did with Uber and Lyft. This Resolution is an effort to get NCOIL involved in this issue and to see if legislation is required and if so, what form should it take. After reading the Resolution, Rep. Keiser stated that this Resolution should not be delayed because all the Resolution does is say that NCOIL should begin to get involved with legislation on this issue and oppose federal intervention.

Wayne Weikel from the Alliance of Automobile Manufactures stated that when reading the Resolution AAM struggled with what it is that insurers will need and what it is that they feel they won't have access to in the future. If it's data from a vehicle to ascertain whether the vehicles are as safe as they predict they will be, that will be borne out by real-world claims data. If it's to get data off a vehicle for safe-driving discounts that's now done by a dongle, that plugs into a port that is required by law in California and the EPA – that's not going away. If it's to ascertain whether the human or the computer is driving in the case of an accident, automakers have a vested interest in that because it's more likely that a human will say it wasn't me, the car was driving itself. The legislation in States now typically revolves around allowing auto manufactures to test vehicles in that State. AAM looks forward to working with NCOIL on these issues.

Jeffrey Stephen of General Motors stated that GM has privacy concerns with the Resolution and requested that it be tabled. Currently there is a privacy regime that governs access to insurance data via event data recorder laws both at the federal and state level. Those laws have defined data elements that insurers or any 3rd party can have access to with respect to vehicle crashes and they also protect consumers in that access to that data cannot be obtained without consumer consent or a court order. The Resolution disrupts that framework. Another concern is that automakers have significant intellectual property and proprietary data that's contained within vehicles and the access talked about in the Resolution raises competitive concerns for GM. Cybersecurity is also a concern for GM because autonomous vehicles are not designed to have

such widespread access. Additionally, while the technology is moving rapidly, there is much learning that needs to take place and GM welcomes the opportunity to work with NCOIL.

John Ashenfelter of State Farm stated that State Farm acknowledges and agrees with GM's and AAM's concerns but noted that State Farm wants to ensure that with respect to rating, underwriting and claim handling, the ability to access and exchange information about the autonomous vehicle and what is has operated is important. State Farm supports the Resolution.

Sen. Hackett stated that in Ohio, there was legislation introduced to require insurance companies to give up data to an outside independent 3rd party. The legislation was defeated because they don't want data being issued to people they can't trust. Sen. Rapert stated that he supports the Resolution and asked the industry representatives to specify what exactly in the Resolution they have problems with. Sen. Rapert also asked Rep. Keiser if the industry representatives specified their concerns to him. Rep. Keiser stressed that this Resolution is simply an effort to state that NCOIL will get involved in these issues. Rep. Fischer echoed Sen. Rapert's question as to what specifically industry representatives have a problem with in the Resolution. Asm. Barlcay stated that he doesn't see how this Resolution moves NCOIL forward on these issues – if NCOIL wants to be involved, it should pass a Model Law, not a Resolution. Sen. Hune and Sen. Breslin agreed with Asm. Barclay. Asw. Carlton stated that no matter what the committee decides on, nothing in the Resolution addresses software issues. Rep. Lehman stated that he is torn on this – if the Resolution brings the insurance and the auto manufacture industries together, then it's a good idea; but if the Resolution is simply stating that NCOIL will get involved, then its meaningless although it won't hurt anyone. Sen. Rapert again stated that industry representatives need to specifically state what is wrong with the Resolution.

After Rep. Keiser's motion to adopt the Resolution was seconded, the Resolution was defeated by a vote of 11-10. Rep. Lehman stated that he hopes this discussion was the start of NCOIL efforts to draft and adopt a model on this issue.

ADJOURNMENT

There being no further business, the Committee adjourned at 12:30 p.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
WORKERS COMPENSATION COMMITTEE
LAS VEGAS, NEVADA
NOVEMBER 19, 2016
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Workers' Compensation Committee met at the Paris Las Vegas Hotel on Saturday, November 19, 2016 at 10:15 a.m.

Senator Jerry Klein of North Dakota, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR
Rep. Martin Carbaugh, IN
Rep. Matt Lehman, IN
Rep. Peggy Mayfield, IN
Rep. Steve Riggs, KY
Rep. George Keiser, ND
Aswm. Maggie Carlton, NV
Sen. James Seward, NY
Rep. Michael Henne, OH
Rep. Marguerite Quinn, PA
Rep. Bill Botzow, VT
Rep. Kathie Keenan, VT

Other legislators present:

Rep. Lana Theis, MI
Asm. Will Barclay, NY

Also in attendance were:
Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 14, 2016 meeting in Portland, Oregon.

DISCUSSION OF NORTH DAKOTA WORKERS COMPENSATION SYSTEM

Rep. Keiser stated that workers comp in ND is called "Workforce Safety and Insurance" and feels there is a lot of benefit in the name. He continued by saying that his presentation is aimed at emphasizing safety prior to coverage. He went on to say that ND is one of the four remaining monopolistic worker's comp systems in the US. The others are Ohio, Washington and Wyoming. Rep. Keiser stated that the reality is when you are a monopolistic State, you own the company. Rep. Keiser further stated that in ND there are no provisions for self-insurance or private insurance for the purposes of workers' comp.

Rep. Keiser continued by saying that claims for occupational injury and disease are filed with WSI and adjudicated by in-house agency claim adjusters and that WSI is a special agency funded solely by employer premiums. He also noted that WSI administers a constitutionally created fund for the benefit of injured workers and those funds are not available for other purposes. He then reviewed ND workers' comp 2016 facts and figures. He went on to say that their benefit structure was established by the Legislature and was set out in their statute, Title 65 of the ND Century Code. He also stated that, historically, the legislature has targeted benefit

enhancements to the most severely injured. He continued by saying that the benefits are most of the standard benefits however, the one that was a bit different was the Death and Scholarship Benefits for the surviving family members in catastrophic or death situations. Rep. Keiser stated that WSI pays lifetime, deductible-free medical benefits related to the work injury and that there is no maximum dollar or duration limit on medical coverage. He did add that in catastrophic cases, WSI can pay a lifetime allowance of up to $75,000 for remodeling or adaptations to homes and up to $150,000 for vehicles and vehicle adaptations.

Rep. Keiser then reviewed Temporary Total Disability (TTD) and Permanent Total Disability (PTD). An injured worker receives tax-free wage-loss benefits equal to 2/3rds of the worker's pre-injury gross weekly wage, plus $15 per week for each dependent child, subject to statutory maximums and minimums. ND's maximum weekly wage-loss benefit is $1,214 per week (125% of state's average weekly wage - SAWW) and the minimum weekly benefit is $583 per week (60% of SAWW) or 100% of the worker's preinjury net wages, whichever is less. Rep. Keiser then stated that TTD benefits are provided for a period of up to 104 weeks in ND or until the workers reaches maximum medical improvement, whichever occurs first. PTD benefits end at the time of social security retirement eligibility at which time the disability benefits convert to additional benefit payable (ABP), a post retirement benefit. Rep. Keiser stated that ND implemented that benefit change because someone on a permanent total that gets injured early in their career never has the earning capacity to generate social security retirement that an average person would and as a result ND put into play ABP based on the time you are injured until you go on social security.

He added that an injured worker who is able to return to work but earns a wage lower than their pre-injury wage receives TPD benefits equal to 2/3rds of the difference between their pre-injury and post-injury earnings. Further, partial disability benefits may not exceed five years - the five-year cap on benefits can be waived in catastrophic cases. Rep. Keiser stated that ND also offers ABP which is a post-retirement benefit paid when total disability benefits cease at the time of eligibility for social security retirement benefits - the amount of this benefit is a percentage of the benefit amount the injured worker was receiving at the time of retirement eligibility. The longer the disability period, the higher the amount. Rep. Keiser stated that ND does have Cost of Living Adjustments (COLAs) on workers comp claims noting that long term disability and death benefit recipients are eligible for COLAS after three consecutive years of disability and that the annual adjustments equals the percent increase in the SAWW. COLAs have averaged in ND 5.6% over the last decade and 6.2% over the last five years. The cumulative effect of COLAs in ND over the past five years is a 35% increase in benefits. Rep. Keiser stated that vocational rehab is a very big program – you try to prevent the injury to begin with but if you are injured, ND tries to work as aggressively as they can. Injured workers get up to 104 weeks of retraining including wage loss, tuition and costs.

Rep. Keiser stated that Permanent Partial Impairment Benefits (PPI) benefits are a onetime lump sum cash award paid in addition to medical wage loss and vocational rehabilitation benefit. PPI benefits are determined as a percent of whole-body impairment utilizing the 6th Edition of the AMA's Guides to the Evaluation of Permanent Impairment. PPI benefits are paid according to a schedule that assigns a statutory multiplier to each percent of impairment starting at 14% - that is ND's attempt to put emphasis on major claims. No PPI benefits are awarded for impairment levels below 14%. The PPI benefit amount is determined by multiplying $340 (35% of SAWW) by the statutory multiplier. For impairment levels between 14% and 100%, PPI awards can range between $3,400 and $510,000. Rep. Keiser stated that with Death Benefits, the surviving spouse receives a weekly benefit that is calculated exactly as if the deceased spouse had remained as total permanent total disability – the lifetime cap on death benefits paid on any one

claim is $300,000. WSI does not offset Social Security benefits. Further, a non-dependency death award in the amount of $15,000 is issued to the estate of a worker who died as a result of a compensable work injury and has no surviving dependents – burial expense reimbursement of up to $10,000 is also provided. Rep. Keiser added that scholarships are provided for dependents and spouses of workers who died as a result of a compensable work related injury or for spouses and children of an injured worker deemed to be catastrophically injured and that the maximum amount payable on behalf of an applicant is $10,000 per year for no more than five years. The total amount of scholarships awarded for any one year cannot exceed $500,000 – that is proportionate to the size/population of ND.

ND believes in fair payment for medical and hospital services which ensures access to qualify healthcare professionals. Based on recent data, WSI reimbursement for physician services equates to 185% of Medicare reimbursement and WSI reimbursement for hospital services was 160% (impatient) and 171% (outpatient) of Medicare reimbursement. ND has a manual classification premium rate which is established annually for 141 rate classifications and to the extent eligible, individual accounts are experienced rated. Accounts with favorable loss experience receive an experience rate credit and accounts with unfavorable loss experience receive an experience rate surcharge. Accounts providing sufficient security can opt for large deductible or retrospective rating policies. If I have a bad experience rating and its costing me money as an employer I can come in and pre-pay an offset and get back into a better experience rating category. Rep. Keiser stated that one of the most important things ND has ever done with workers compensation is that per statute, employers are assessed the first $250 in medical costs for every claim unless the claim is reported within 24 hours of the injury. Importantly, unlike other types of insurance, the frequency of claims does not affect rating. ND has found that frequency went up dramatically because no one wants to pay $250. ND has also found that severity of injury has dropped dramatically as a result of that. ND has continuously been ranked the lowest premium state in the country (2016 Oregon Premium Study) and ND rates are the lowest in the country and 52% below the median state.

Rep. Keiser stated that ND workers comp system was financially stable and they outlined by statute WSI's required surplus levels which are 20% to 40% of reserve liabilities. If WSI's surplus exceeds statutory surplus requirements the statute requires dividends to be issues to policyholders. Total dividends issued in eleven out of the past twelve years have amounted to nearly $1.1 billion in premium dividend credits returned to ND employers; ranging between 30 – 62% per year. Historically, favorable returns from WSI's investment portfolio have resulted in additional surplus growth. He also stated that the WSI fund investment returns for the last five years have averaged 6.6% ranging between 3.3% and 11.7% per year. For the current year, a 50% dividend credit was declared, which equates to an estimated $150 million dividend – that acts as a stimulus for employers.

He went on to say that ND has a very pro-active legislative oversight that targets reforms quickly. Rep. Keiser stated that in 2015 ND passed Opioid Control Legislation – the effect of the legislation has been dramatic. The ND legislature is also active in responding to court decisions. During the interim, there is a very small committee that meets with the injured workers and help them put together their issue and they are able to present their position. In the first interim, there were 11 bills which were passed. Additionally, NDCC 54-03-25 requires that during legislative session, any workers' compensation bill and/or amendment affecting benefits or premium rates requires an actuarial impact statement prior to the measure being acted upon. He continued by saying that WSI has a 12% administrative expense ratio, meaning only ten cents of every premium dollar goes towards administering the system.

Rep. Keiser went on to say that litigation is a cost driver in many jurisdictions and that, in ND, litigation is almost non-existent and the number of appeals that actually make it to court is less than 1%. He went on to say that ND has an alternative dispute resolution process via the Decision Review Office (DRO) which is independent of the WSI Claims Department. He noted that this is an elective process and an injured worker can request an independent review through this office in an attempt to resolve the issue prior to entering into the formal litigation process. Following the completion of the DRO process, if still dissatisfied, the injured worker can request a review with an independent attorney of their choice. By statute, WSI pays attorney fees not exceeding $500 for this independent consult. After that, an injured worker can appeal the decision and request an administrative hearing. Subsequent to the administrative hearing, an injured worker can appeal to the district court and then supreme court. Attorney fees are only paid if the injured worker prevails on all levels.

Rep. Keiser stated that their biggest focus is safety. He stated that they have a department consisting of 14 employees that are safety consultants who will come into your businesses and assist in the prevention of workplace injuries and it is at no cost to the employer. Further, premium discounts are provided to employers for successful participation of up to 25%. Premium discounts to employers for successfully implementing safety programs totaled $26 million in FY 2016. He noted that safety grants are a wonderful way to help savings with the bottom line. Since 2005, WSI has issued $44.5 million in safety grants to employers and industry groups. In addition, qualifying ND associations and employee organization can receive funding of up to $175,000 annually for safety training and education programs.

WSI is a managed care organization and has many medical cost containment elements including a Utilization Review Department which includes RN, PT, and MD Utilization Review specialists. Much of the decision process is based upon evidence based treatment guidelines. In addition, fee schedules exist for: Hospital Outpatient, Ambulatory Surgical Center, Physician Administered Drugs, Pathology, Medicine, Durable Medical Equipment, Clinical Laboratories and Hospital Inpatients, Dental, Evaluation & Management among many others. In addition, one of the biggest cost drivers in the workers' compensation arena is time lost. In ND, time-loss claims account for only 11.5% of total claims. He stated that there is a Statutory hierarchy for return to work plans (unless PTD) – WSI will compile a plan for workers to return to gainful employment even if only at minimum wage. Unless a worker is declared PTD, ND law sets the expectation that an injured worker will return to some type of employment. Rep. Keiser concluded by stating that there is an Overall Customer Satisfaction survey program and on a low to high satisfaction scale of 1 – 5, most recent surveys reflect an injured worker satisfaction rate of 4.10 and an employer satisfaction rate of 4.31.

Sen. Seward stated that while it would be very hard to compete with ND, is the private market prohibited from writing in ND? Rep. Keiser responded stating that as a monopolistic state, the private market is prohibited from writing in the state. Sen. Seward followed up by asking if the $250 co-pay for an unreported injury within 24 hours designed to developed a fraud deterrent. Rep. Keiser responded by stating he did not mention fraud but they have a very established fraud unit and that the $250 co-pay has nothing to do with fraud and that it has all to do with just getting employers to report the accident in a timely way.

Rep. Henne asked if there was any way of putting the responsibility back on the employee for the deductible if the employer is unaware of the accident? And, with so many claims, how do you manage them all? Rep. Keiser stated that their electronic reporting system is a very small page: who, what, where, when and what happened and some responsibility is placed on employees. There are specific guidelines of what needs to be covered and addressed in safety meetings.

Employers eventually have to make a decision whether or not they think they have a claim. He went on to say that early intervention was critical.

Rep. Lehman asked as an agent bordering the monopolistic state of Ohio, one of the concerns is the uniformity of how to handle both credits and debits from two states where the mods might be higher? Rep. Keiser responded by stating that in ND, they have reciprocity agreements with Minnesota, Montana and SD stating that the injured worker goes to the state that the company is domiciled in and that is the coverage that will be provided. However, ND did put in their statute a lot of provisions like what is temporary employment because that is the big issue. For most businesses that are multi-state, they most likely have purchased multi-state coverage.

Rep. Quinn asked have they always been monopolistic or did they have to blow up something and start all over. Rep. Keiser stated that they have always been monopolistic and over the years, benefits have been added. He added that it was the little things that bother the injured worker. He concluded by saying small changes are always being made.

Rep. Botzow asked how do you describe an employee and, in ND are there any frictions in that area? Rep. Keiser stated that sole proprietors can opt not to take coverage. The children of business owners do not have to take coverage. He also stated that ND has clear standards of what an independent contractor is and they have addressed it the best they can but it is not without its problems.

PROPOSED AMENDMENTS TO MODEL STATE STRUCTURED SETTLEMENT ACT

Jack Kelly, National Association of Settlement Purchasers, noted that this was a model act initiated in 2004 and has been adopted in 49 states. Throughout the years certain events have occurred where there were loop holes in the rules of civil procedure that have been identified by New York, Vermont and a number of other states and that needed to be closed. The amendments, among other things, required that there be a personal appearance by the payee and that it be filed in the jurisdiction of the payee's residence. He went on to say that it is endorsed and supported by the National Association of Purchasers and the National Structured Settlements Trade Association. Upon a motion made and seconded, the Committee unanimously readopted the Model State Structured Settlement Protection Act with the proposed amendments.

DISCUSSION ABOUT THE EVOLVING WORKFORCE AND DEFINITION OF "WORK"

Mona Carter of NCCI stated that her topic was "The Uberization of Workers' Comp" which has to do with the many changes that are going on in the 21st century that are beginning to look a lot different than what individuals are used to. She stated that what is needed is to be prepared for the changes. She stated that the first issues typically raised are independent workers, sub-contractors, leased employees, casual labor and product-based workers and where do they fit into this marketplace. She stated that there is a need to review some of the traditional concepts and start to explore some of the newer concepts like on-demand, gig economy, portable benefits, contingent workforce, peer-to-peer and that is how many new workers are finding jobs. What most people are familiar with is the traditional concept of people going to work for 40 hours a week, 8 hours a day. She went on to say the new concepts don't look and feel like anything of what has been talked about.

She asked what is the definition of "employee", "employer" and "work"? In many states a control method has been applied. She stated that lots of questions are coming up because the new

workforce can work off the cloud and source themselves out for six months at a time. She stated that some of the determining factors that California has used include: a distinct occupation or business, what work has been done under the direction of a principal or by a specialist without supervision, what skill are required to do the job, who supplies the tools and place to work, what is the length of time services are to be performed, what is the method of payment – by time or by the job, what is the work part of the regular business of the principle and what are the fights to terminate at will. These are the questions used in the past when looking at traditional jobs. Will these questions work now?

Ms. Carter gave examples of different policies in different states saying that, for example, in New York, the last time they had reform written into the policy was that only a New York policy was acceptable which created quite a furor in the industry because they were used to putting New York on a 3C policy and did that mean that anytime there was a conference in New York a policy needed to be bought?

She continued by saying that new technology has forced new things to appear. She used Lemonade as an example stating that Lemonade is a new insurance company based out of New York. It is an automobile company which writes instant coverage via an app. She went on to say that it is the first one in the country and it is popular in Europe. It probably won't be the last company like this to spring up but it came up out of a need. She also used BizInsure LLC as another example stating that BizInsure LLC will be writing small commercial insurance and they don't say anything about workers' comp right now but, could be.

Ms. Carter stated that needs create new technology and that challenges continue to arise. As we look at all the growing work comp systems there are challenges like out of state coverage, conflicts with other lines of coverage - when is it comp when is it liability. There are also generational challenges – young people want things quick and fast. There are so many teenagers that have businesses today – how are they hiring people? She noted that a study about drones was being done to see if they are being properly classified. Ms. Carter concluded by stating that other issues will continue to come up and the need to be proactive is paramount.

Rep. Riggs stated that this was a very special presentation because it asks so many questions and gets your mind thinking about a lot of these questions no one has asked before. He thanked Ms. Carter for attending and presenting to the committee as these issues will come up and they will need to be addressed.

Rep. Botzow stated that this vast change in the workforce is a fascinating issue. He went on to say that one thing he heard was that the DOL last did a count on the contingent workforce around 2000 but there were plans to do another one so that you could start to quantify a population for temporary worker. His concern was that this is an area that needs policy development and if you do policy development, you have to have some definitions so you know how to count things and know what your impacts are. In some states, there are no definitions for a temporary worker and how can you work off that if you don't know what it is to start with? He continued by stating that what he does know is that the last count the DOL did, he believed that they are up to 40% of the workforce which could be put into a variety of "we don't even know what to call it" groups. Do you think we are at the point where we need to put pressure on to at least get basic data that everyone has reasonably agreed on to get policy development?

Ms. Carter stated that she believes that a lot of these issues have grown out of temp staffing and even PEO could be on the fringe of that but that there are some major employers in our country that are using contingent work forces and most of the time we don't think about it very much

because typically, they are part-time, minimal wage type workers. But when she started to learn that professionals are now part of that realm – doctors, nurses, then that moves us to another realm. She stated that she did not know if a definition of a temporary worker was needed because at the end of the day you have to decide who the work comp benefit is there for. It was always the employer who had the responsibility to pay the benefits to any workers. Some states have exempted workers like farmers and jockeys but you would have to define whether or not you were going to exempt a temporary worker. If you remember the ACA issue and it took Congress and the federal government a long time to define what a temporary worker was going to be and the larger employers said that if it was going to be 39 hour constitute a full-time employee, then my staff will work 32 hours which creates a moral issue.

DISCUSSION REGARDING FEDERAL ISSUES IMPACTING WORKERS' COMPENSATION

Tim Tucker of NCCI stated that he knows the committee had received a comprehensive presentation in Portland on the federal focus on state workers' comp issues. At that time, the committee heard that both Federal Agencies and members of Congress were concerned about the state system and had raised those concerns to Secretary Perez at the DOL and he wanted to call to the committee's attention that, since Portland, the DOL had issued a report last month entitled "Does Workers Compensation System fulfill Its Obligation to Injured Workers". This was released at a forum at the DOL and the highest-ranking members of the administration spoke, Secretary Perez, Dr. Michaels the head of OSHA. as well as the acting commissioner of the social security administration. He went on to say that the report really goes back to a lot of the issues that were raised back when the DOL did an extensive examination of the state system which was in 1972. A provision included in the OSHA act created that commission and they issued a report in 1972, made some recommendations on the improvements to the system, and the states did respond. He went on to stay that he did want to make sure that the committee was aware of this, as it echoes some of the concerns that had previously been raised about the adequacy of the state system, and the equitability of it as well. He went on to say that this was an issue that would gain some more steam at the Federal level and some of that might have changed in the past couple weeks with the general election and the outcome. He stated that he thinks what the committee heard in Portland was this interest did serve as a clearing call for all stake holders who have gathered in national meetings as well as in individual state work compensation conference to look at the system and identify areas where additional improvements could be made. He went on to say that this has sparked some dialogue that will lead to some outcomes and that the national conversation and the folks that are heading that up, in which NCCI is a part of, will at the end of this year be issuing a report and they will make sure that they bring that to the attention of the committee as well.

The one item from the report that he wanted to mentioned was the enhanced coordination between state workers compensation and federal programs such as Medicare and social security disability insurance and making sure that the obligations that are properly placed in those programs or in the state system are, indeed, happening. We did see in just this past week that the social security administration is undertaking a pilot project working with some of the individual states and making sure that the 36 states are currently able to have an offset of social security benefits with workers' compensation which is, indeed, occurring so there is increased efforts to make sure there is integrity both in the federal programs and in the state system. He concluded by saying that we were really gearing up for a more robust and comprehensive dialogue but we will see where things go.

Frank O'Brien of PCI stated that there were two presentations on this: Pre-elections and Post-election. Post-election is clear – no one knows what is clear at this particular point in time. Prior

to the election, it was pretty clear that the DOL was going to use the bully pulpit to argue for increased intervention by the Federal government in the state workers' compensation system. Now, post-election day, that is not so clear. What is clear from the discussion here today and from the contents of the report, is that there continues to be a tremendous amount of attention that is going to continue to be paid regarding the evolving nature of the workers' compensation system. Some say we are going into a third industrial revolution. The workers' compensation system was a product of the industrial revolution. It is an evolving system, it is a living system. Rep. Keiser's presentation shows that one size does not fit all and there will be multiple approaches to this and, at the end of the day, there will be multiple approaches that work.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:45 a.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
2017 ANNUAL MEETING
PARIS HOTEL, LAS VEGAS, NV
BUSINESS PLANNING COMMITTEE
NOVEMBER 19TH, 2016

The NCOIL Business Planning Committee met at the Paris Hotel in Las Vegas on Sunday, November 20, 2016 at 9:00 a.m.

Chair of the Committee, Senator Travis Holdman, presided.

Other Members of the Committee Present:
Vice President, Rep. Steve Riggs, KY
Secretary, Sen. Jason Rapert, AR
Treasurer, Rep. Bill Botzow, VT
Rep. Martin Carbaugh, IN
Rep. Matt Lehman, IN
Sen. Thomas Buford, KY
Rep. Jeff Greer, KY
Sen. Dan "Blade" Morrish, LA
Asm. William Barclay, NY
Asm. Kevin Cahill, NY
Sen. James Seward, NY*
Sen. Jerry Klein, ND
Sen. David O'Connell, ND
Rep. Marguerite Quinn, PA

ALSO PRESENT:
Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director NCOIL Support Services
Will Melofchik, Legislative Director, NCOIL Support Services

A motion was made by Rep. Riggs and seconded by Rep. Botzow to adopt the minutes of the Business Planning Committee from the Summer Meeting in Portland, OR.

Senator Holdman asked Sen. Morrish and Jeff Drozda to give a report on the Spring Meeting planning in New Orleans in March. Mr. Drozda said they are planning something that showcases the city and state and have asked the Governor to attend and give the keynote address.

The scheduled future meetings are as such, Spring 2017 in New Orleans, LA; Summer 2017 in Chicago, IL; Annual 2017 in Phoenix, AZ; Spring 2017 in Atlanta Buckhead, GA; Summer 2018 in Salt Lake City, UT; which was moved from 2017 due to incompatible dates.

Commissioner Considine gave an update on prospective future meeting sites. Per the committee, the 2018 meeting will be in Oklahoma City and they were presented with two options. A motion was made to select the Marriott Renaissance on 12/6 – 12/9 by Rep. Botzow and seconded by Sen. Rapert and carried.

The Committee then discussed the Annual meeting in 2019 to run directly after the NAIC Meeting at the JW Marriott in Austin, TX. Commissioner Considine reported that we had gotten

favorable rates from the hotel and asked for ratification to hold the meeting from December 10th – 13th. Sen. Rapert made a motion at Sen. Seward seconded. The motion carried.

There being no other business, the committee adjourned at 9:28 a.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
2017 ANNUAL MEETING
PARIS HOTEL, LAS VEGAS, NV
EXECUTIVE COMMITTEE
NOVEMBER 19TH, 2016

The NCOIL Executive Committee met at the Paris Hotel in Las Vegas on Sunday, November 20, 2016 at 10:00 a.m.

Chair of the Committee, Senator Travis Holdman, presided.

Other Members of the Committee Present:

Vice President, Rep. Steve Riggs, KY
Secretary, Sen. Jason Rapert, AR
Treasurer, Rep. Bill Botzow, VT
Rep. Martin Carbaugh, IN
Rep. Matt Lehman, IN
Sen. Thomas Buford, KY
Rep. Jeff Greer, KY
Sen. Dan "Blade" Morrish, LA
Asm. William Barclay, NY
Asm. Kevin Cahill, NY
Sen. James Seward, NY*
Sen. Jerry Klein, ND
Sen. David O'Connell, ND
Rep. Marguerite Quinn, PA
Rep. Kathie Keenan, VT*

Paul Penna, NCOIL Support Service Executive Director gave the meeting report that there were 273 attendees, 63 legislators, 7 insurance commissioners or equivalent and 11 insurance departments represented. Mr. Penna stated that 25 states had paid their dues for 2016-2017 and the unaudited 3rd quarter financials showed revenue of $261,841.76 and expenses of $223,373.80 for a net revenue of $38,467.96.

A motion was made and seconded to accept the following members from contributing member states to the Executive Committee:

Rep. Sam Kito (AK)
Sen. Greg Stanridge (AR)
Asm. Ken Cooley (CA)
Rep. Bart Rowland (KY)
Asw. Maggie Carlton (NV)
Rep. Glenn Mulready (OK)
Sen. Roger Picard (RI)
Sen. Ronnie Kromer (SC)

A motion was made to accept the non-controversial calendar. Asm. Cahill announced that under his leadership on the Health Committee, a Task Force was being appointed to examine solutions to the issues surrounding balance billing of Air Ambulances. He expected the Task Force to be formed and will meet via teleconference in December. Asm. Cahill also noted that a

teleconference will be held in December to discuss possible changes to the ACA in the new Trump Administration.

The following model laws and Resolutions were adopted and re-adopted:

Model Act to Protect Minors from Identity Theft

Model Act regarding Disability Insurance

Amendments to and re-adoption of Structured Settlement

Model Law Re-adoption of the Identity Theft Protection Model Act

Re-adoption of the Company Licensing Modernization Model Act

Re-adoption of the Market Conduct Surveillance Model Law

Adopted Resolution Reaffirming Support for the U.S. State-Based System of Insurance Regulation in Response to Recent Federal Encroachment

A motion was made and seconded to adopt all committee reports and model laws. It passed unanimously.

Sen. Rapert asked for consideration of Resolution in Opposition to DOL Fiduciary Rule that passed the Financial Services and Investment Products Committee in at the Summer Meeting in Portland. The motion carried on a voice vote with Rep. Botzow and Asm. Cahill voting nay.

Commissioner Considine gave an update on the Griffith Foundation Legislator breakfast with a presentation by Professor Terri Vaughan of Drake University discussing the differences between insurance regulatory structures in the United States and the European Union.

He also highlighted the interesting remarks offered by Rep. Carter and Gov. Hodges at the keynote luncheon. The Welcome Breakfast had an interesting presentation about Presentation by Jeff Johnston, Senior Director, Financial Regulatory Affairs – Domestic Policy & Implementation, NAIC about NAIC Solvency Analytics, Reporting, and Capital Standards and the completion and conclusion of the SWOT exercise that legislators and participants worked on during the year. A copy of the memo will be sent with the meeting minutes and NCOIL leadership will consider suggestions and make changes as appropriate. Commissioner Considine was struck by how many legislators and participants suggested moving from three meetings a year to two and remarked that it was worthy of consideration.

President Holdman gave the Nominating Committee Report and Election of Officers. Rep. Riggs was elected President, Sen. Rapert was elected Vice-President, Rep. Botzow was elected Secretary and Rep. Matt Lehman was elected Treasurer. Sen. Holdman was elevated to Immediate Past President. A motion was made and seconded to accept the Nominating Committee Report.

Commissioner Considine reflected on his first year as CEO and thanked Senators Breslin, Seward and Holdman for their leadership and support during this transitional year. Rep. Riggs and Commissioner Considine recognized outgoing NCOIL President Holdman and presented

him with a ceremonial gavel. President Holdman thanked everyone for their support and hard work during his year as President.

There being no other business, the committee adjourned at 10:26

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
2017 ANNUAL MEETING
PARIS HOTEL, LAS VEGAS, NV
ILF BOARD MEETING
NOVEMBER 19TH, 2016

The Insurance Legislators Foundation Board met at the Paris Hotel in Las Vegas on Saturday, November 19, 2016 at 3:00 p.m.

Chair of the Committee, Senator Travis Holdman, presided.

OTHER MEMBERS OF THE COMMITTEE PRESENT:

Rep. Steve Riggs, KY

Also Present:
Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services

A motion was made, seconded and passed unanimously to waive the quorum.

A motion was made and seconded to accept the minutes of the July 16th Summer Meeting in Portland, OR.

An update on scholarships for the 2016 Annual Meeting was given.

A motion was made to accept the Incoming Officers and Members:

Incoming Officers:

President:
Rep. Steve Riggs, KY
Vice-President: Sen. Jason Rapert, AR
Secretary/Treasurer: Rep. Bill Botzow, VT

Incoming Members:

Sen. Travis Holdman, IN
Sen. Carroll Leavell, NM
Sen. William J. Larkin, Jr. NY
Sen. Neil Breslin, NY
Sen. James Seward, NY
Rep. George Keiser, ND
Rep. Brian Kennedy, RI
Rep. Kathleen Keenan, VT

There being no other business, the committee adjourned at 3:07.

PRELIMINARY WORKING AND DISCUSSION DRAFT

Draft: 8/17/2016 (version 2)
A new model: Insurance Data Security Model Law
Cybersecurity (EX) Task Force

Comments are being requested on this draft by Friday, September 16, 2016. Comments should be sent by email to Sara Robben at srobben@naic.org.

INSURANCE DATA SECURITY MODEL LAW

Table of Contents

Section 1. Title

This act shall be known and may be cited as the “Insurance Data Security Act.”

Section 2. Purpose and Intent

Notwithstanding any other provision of law including [insert reference to state’s general data security breach notification law], the purpose and intent of this Act is to establish the exclusive standards in this state for data security and investigation and notification of a data breach applicable to licensees, as defined in Section 3G. This Act shall not be construed as superseding, altering, or affecting any statute, regulation, order or interpretation of law in this state, except to the extent that such statute, regulation, order or interpretation is inconsistent with the provisions of this Act and then only to the extent of the inconsistency. A state statute, regulation, order or interpretation is not inconsistent with the provisions of this Act if the protection such statute, regulation, order or interpretation affords any person is greater than the protection provided under this Act.

This Act may not be construed to create or imply a private cause of action for violation of its provisions nor to curtail a private cause of action which would otherwise exist in the absence of this Act.

Section 3. Definitions

As used in this Act, the following terms shall have these meanings:

A. “Consumer” means an individual, including but not limited to applicants, policyholders, insureds, beneficiaries, claimants, certificate holders and others whose personal information is in a licensee’s possession, custody or control.

B. “Consumer reporting agency” has the same meaning as “consumer reporting agency that compiles and maintains files on consumers on a nationwide basis” in section 603(p) of the Fair Credit Reporting Act (15 U.S.C. 1681a(p)).

C. “Data breach” means the unauthorized acquisition, release or use of personal information. The term “data breach” does not include the unauthorized acquisition, release or use of encrypted personal information if the encryption, process or key is not also acquired, released or used without authorization.

D. “Encrypted” means the transformation of data into a form which results in a low probability of assigning meaning without the use of a protective process or key.

E. “Harm or inconvenience” means any of the following or the reasonable likelihood thereof:

(1) Identity theft;

(2) Fraudulent transactions on financial accounts; or

(3) Other misuse as defined by [insert state definition of misuse or comparable term if applicable].

Drafting Note: Several states have defined the term “misuse” in state law and can refer to this in Section 3E(3). If a state does not have this term defined, they may consider either deleting that paragraph or defining misuse above using a definition similar to that of other states. For example, see 17-A Me. Rev. Stat. § 905-A, which provides that A person is guilty of misuse of identification if, in order to obtain confidential information, property or services, the person intentionally or knowingly:

A. Presents or uses a credit or debit card that is stolen, forged, canceled or obtained as a result of fraud or deception;

B. Presents or uses an account, credit or billing number that that person is not authorized to use or that was obtained as a result of fraud or deception; or

C. Presents or uses a form of legal identification that that person is not authorized to use.

F. “Information security program” means the safeguards that a licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of, or otherwise handle personal information.

G. “Licensee” means any person or entity licensed, authorized to operate, or registered, or required to be licensed, authorized, or registered pursuant to the insurance laws of this state.

H. “Personal Information” means:

(1) A financial account number relating to a consumer, including a credit card number or debit card number, in combination with any security code, access code, password, or other personal identification information required to access the financial account; or

(2) Information including:

The first name or first initial and last name of a consumer in combination with:

(a) The consumer's non-truncated social security number;
(b) The consumer's driver's license number, passport number, military identification number, or other similar number on a government-issued document;

(c) A user name or e-mail address, in combination with a password or security question and answer that would permit access to an online or financial account of the consumer;

(d) Biometric data of the consumer that would permit access to financial accounts of the consumer;

(e) Any information of the consumer that the licensee has a legal or contractual duty to protect from unauthorized access or public disclosure;

(f) The consumer's date of birth;

(g) Information that the consumer provides to a licensee to obtain an insurance product or service used primarily for personal, family, or household purposes from the licensee;

(h) Information about the consumer resulting from a transaction involving an insurance product or service used primarily for personal, family, or household purposes between a licensee and the consumer;

(i) Information the licensee obtains about the consumer in connection with providing an insurance product or service used primarily for personal, family, or household purposes to the consumer; or

(j) A list, description, or other grouping of consumers (and publicly available information pertaining to them), that is derived using the information described in Section 3H(2)(g) through (i), that is not publicly available.

(3) Any of the data elements identified in Section 3H(2)(a) through (f) when not in connection with the consumer's first name or initial and last name, if those elements would be sufficient to permit the fraudulent assumption of the consumer's identity or unauthorized access to an account of the consumer.

(4) Any information or data except age or gender, that relates to:

(a) The past, present or future physical, mental or behavioral health or condition of a consumer;

(b) The provision of health care to a consumer; or

(c) Payment for the provision of health care to a consumer.

The term "personal information" does not include publicly available information that is lawfully made available to the general public and obtained from federal, state, or local government records; or widely distributed media.

I. “Third-party service provider” means a person or entity that contracts with a licensee to maintain, process, store or otherwise have access to personal information under the licensee’s possession, custody or control.

Section 4. Information Security Program

A. Implementation of an Information Security Program

Commensurate with the size and complexity of the licensee, the nature and scope of the licensee’s activities and the sensitivity of the personal information in the licensee’s possession, custody or control, each licensee shall develop, implement, and maintain a comprehensive written information security program that contains administrative, technical, and physical safeguards for the protection of personal information. The licensee shall document, on an ongoing basis, compliance with its information security program.

B. Objectives of Information Security Program

A licensee’s information security program shall be designed to:

(1) Protect the security and confidentiality of personal information;

(2) Protect against any anticipated threats or hazards to the security or integrity of the information;

(3) Protect against unauthorized access to or use of personal information, and minimize the likelihood of harm or inconvenience to any consumer; and

(4) Define and periodically reevaluate a schedule for retention of personal information and a mechanism for its destruction when no longer needed.

C. Risk Assessment

The licensee shall:

(1) Designate an employee or employees responsible for the information security program;

(2) Identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration or destruction of personal information or personal information systems;

(3) Assess the likelihood and potential damage of these threats, taking into consideration the sensitivity of the personal information;

(4) Assess the sufficiency of policies, procedures, personal information systems and other safeguards in place to manage these threats, including consideration of threats in each relevant area of the licensee’s operations, including:

(a) Employee training and management;

(b) Information systems, including network and software design, as well as information processing, storage, transmission, and disposal; and

(c) Detecting, preventing, and responding to attacks, intrusions, or other systems failures; and

(5) Implement information safeguards to manage the threats identified in its assessment, and regularly assess the effectiveness of the safeguards' key controls, systems, and procedures.

D. Risk Management

The licensee shall, at a minimum:

(1) Design its information security program to mitigate the identified risks, commensurate with the sensitivity of the information, as well as the complexity and scope of the licensee's activities, based on generally accepted cybersecurity principles, including the following security measures, as appropriate:

(a) Place access controls on information systems, including controls to authenticate and permit access only to authorized individuals and controls to prevent the unauthorized acquisition, release or use of personal information to or by employees or unauthorized individuals outside of the licensee;

(b) Restrict access at physical locations containing personal information, only to authorized individuals;

(c) Encrypt all personal information while being transmitted on a public internet network or wirelessly and all personal information stored on a laptop computer or other portable computing or storage device or media;

(d) Ensure that information system modifications are consistent with the licensee's information security program;

(e) Utilize state of the art techniques, such as multi-factor authentication procedures, segregation of duties, and employee background checks for employees with responsibilities for, or access to, personal information;

(f) Regularly test or monitor systems and procedures to detect actual and attempted attacks on, or intrusions into, information systems;

(g) Implement response procedures that specify actions to be taken when the licensee suspects or detects that unauthorized individuals have gained access to information systems;

(h) Implement measures to protect against destruction, loss, or damage of personal information due to environmental hazards, such as fire and water damage or technological failures; and

(i) Develop, implement, and maintain procedures for the secure disposal of personal information in any format.

(2) Include cybersecurity risks in the licensee's enterprise risk management process; and

(3) Use generally accepted cybersecurity principles to share information and stay informed regarding emerging threats or vulnerabilities.

E. Oversight by Board of Directors

If the licensee has a board of directors, the board or an appropriate committee of the board shall, at a minimum:

(1) Oversee the development, implementation, and maintenance of the licensee's information security program, including assigning specific responsibility for the plan to the licensee's executive management; and

(2) Require the licensee's executive management to report in writing at least annually, the following information:

(a) The overall status of the information security program and the licensee's compliance with this Act; and

(b) Material matters related to the information security program, addressing issues such as risk assessment, risk management and control decisions, third-party service provider arrangements, results of testing, data breaches or violations and management's responses thereto, and recommendations for changes in the information security program.

F. Oversight of Third-Party Service Provider Arrangements

The licensee shall contract only with third-party service providers that are capable of maintaining appropriate safeguards for personal information in the licensee's possession, custody or control, and the licensee shall be responsible for any failure by such third-party service providers to protect personal information provided by the licensee to the third-party service providers consistent with this Act.

G. Program Adjustments

The licensee shall monitor, evaluate and adjust, as appropriate, the information security program consistent with any relevant changes in technology, the sensitivity of its personal information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements and changes to personal information systems.

Section 5. Investigation of a Data Breach

A. If the licensee learns that a data breach has or may have occurred in relation to personal information in the possession, custody or control of the licensee or any of the licensee's third-party service providers, the licensee shall conduct a prompt investigation.

B. During the investigation, the licensee shall, at a minimum:

(1) Assess the nature and scope of the data breach or potential data breach;

(2) Identify any personal information that may have been involved in the data breach;

(3) Determine whether the personal information has been acquired, released or used without authorization; and

(4) Perform or oversee reasonable measures to restore the security of the information systems compromised in the data breach in order to prevent further unauthorized acquisition, release or use of personal information in the licensee's possession, custody or control.

Section 6. Notification of a Data Breach

A. If following an investigation under Section 5, the licensee determines that an unauthorized acquisition of personal information listed in Section 3H(1), (2)(a) through (f), (3) or (4) involved in a data breach has occurred, the licensee, or a third party acting on behalf of the licensee, shall notify:

(1) All consumers to whom the personal information relates;

(2) The insurance commissioner in the licensee's state of domicile and the insurance commissioners of all the states in which a consumer whose information was or may have been compromised resides;

(3) The relevant Federal and state law enforcement agencies, as appropriate;

(4) Any relevant payment card network, if the data breach involves payment card numbers; and

(5) Each consumer reporting agency, if the data breach involves personal information relating to 500 or more consumers.

B. Notification to the Commissioner

Notwithstanding the responsibilities prescribed in Sections 5A and 6A of this Act, no later than three (3) business days after determining that a data breach has occurred, the licensee shall notify the commissioner that a data breach has occurred. The licensee shall provide as much of the following information as possible:

(1) Date of the data breach;

(2) Description of the data breach, including how the information was exposed, whether lost, stolen, or breached;

(3) How the data breach was discovered;

(4) Whether any lost, stolen, or breached information has been recovered and if so, how this was done;

(5) The identity of the source of the data breach;

(6) Whether licensee has filed a police report or has notified any regulatory, government or law enforcement agencies and, if so, when such notification was provided;

(7) Description of the type of information lost, stolen, or breached (equipment, paper, electronic, claims, applications, underwriting forms, medical records etc.);

(8) Whether, if the information was encrypted, the encryption, redaction or protection process or key was also acquired without authorization;

(9) The period during which the information system was compromised by the data breach;
(10) The number of total consumers and consumers of each state affected by the data breach;

(11) The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;

(12) Identification of efforts being undertaken to remediate the situation which permitted the data breach to occur;

(13) A copy of the licensee's privacy policy and a statement outlining the steps the licensee will take to investigate and notify consumers affected by the data breach; and

(14) Name of a contact person who is both familiar with the data breach and authorized to act for the licensee.

The licensee shall have a continuing obligation to update and supplement initial and subsequent notifications to the commissioner concerning the data breach.

C. Notification to Consumer Reporting Agencies

The licensee shall notify, as expediently as possible and without unreasonable delay, after determining that a data breach has occurred, each consumer reporting agency, if the data breach involves personal information listed in Section 3H(1), (2)(a) through (f), (3) or (4) relating to 500 or more consumers. Notification must include the date of the data breach, an estimate of the number of persons affected by the data breach, if known, and the actual or anticipated date that persons were or will be notified of the data breach.

D. Notification to Consumers

(1) The licensee shall notify all consumers whose personal information listed in Section 3H(1), (2)(a) through (f), (3) or (4) was affected as expediently as possible and without unreasonable delay, and in no case later than sixty (60) calendar days after determining that a data breach has occurred.

(2) Prior to sending the notification, the licensee shall provide the commissioner with a draft of the proposed written communication to consumers. The commissioner shall have the right to review the proposed communication before the licensee sends it to consumers, to ensure compliance with this subsection and to prescribe the appropriate level of consumer protection pursuant to Section 7. The notice must be written in straightforward language and include the following information::

(a) A description of the type of information involved in the data breach;

(b) A description of the action that the licensee or third-party service provider has taken to safeguard the information;

(c) A summary of rights of victims of identity theft prepared under § 609(d) of the Fair Credit Reporting Act (15 U.S.C. 1681g(d));

(d) The steps consumers can take to protect themselves from identity theft or fraud, which shall include an explanation that consumers shall have a right to do the following:

(i) Place a 90-day initial fraud alert on their consumer reports;

(ii) Place a seven-year extended fraud alert on their consumer reports;

(iii) Place a credit freeze on their consumer reports;

(iv) Have a free copy of their consumer report from each credit bureau;

(v) Receive fraudulent information related to the data breach removed (or "blocked") from their consumer reports;

(vi) Dispute fraudulent or wrong information on their consumer reports;

(vii) Stop creditors and debt collectors from reporting fraudulent accounts related to the data breach;

(viii) Receive copies of documents related to the identity theft; and

(ix) Stop contacts from debt collectors related to the data breach;

(e) Contact information for the three nationwide consumer reporting agencies;

(f) Contact information for the licensee or its designated call center; and

(g) An offer from the licensee to the consumer to provide appropriate identity theft protection services free of cost to the consumer for a period of not less than twelve (12) months, if appropriate, or other consumer protections ordered by the commissioner pursuant to Section 7 of this Act.

(3) The licensee will provide the consumer notification:

(a) In writing by first class mail; or

(b) Electronically if the consumer has agreed to be contacted through e-mail or other means pursuant to [insert reference to state Electronic Transactions Act.]; or

(c) By substitute method, if the licensee demonstrates to the commissioner's satisfaction that the cost of providing notice by Section 6D(3)(a) or (b) would be excessive or that another legitimate reason exists for substitute notice. The substitute method must include conspicuous posting of the notice on the licensee's publicly accessible website and publication in statewide media in this state.

E. Notice Regarding Data Breaches of Third-Party Service Providers

In the event of a data breach in a system maintained by a third-party service provider, the licensee shall comply with Section 6A through D. The computation of licensee's deadlines shall begin on the day after the third-party service provider notifies the licensee of the data breach or the licensee otherwise has actual knowledge of the data breach, whichever is sooner.

F. Notwithstanding the requirements of Section 6C, D, and E, notice may be delayed where requested by an appropriate state or federal law enforcement agency. The commissioner shall be notified of any such request.

Drafting Note: Section 5 and Section 6 may be duplicative of current state law. Each state should conduct its own analysis to determine whether or not Section 5 and Section 6, in whole or in part, are necessary to be included in its statutes.

Section 7. Consumer Protections Following a Data Breach

After reviewing the licensee's data breach notification, the commissioner shall prescribe the appropriate level of consumer protection required following the data breach and how long that protection will be provided. The commissioner may order the licensee to offer to pay for twelve (12) months or more of identity theft protection for affected consumers, pay for a credit freeze, or take other action deemed necessary to protect consumers.

Drafting Note: Many states have statutes providing that a consumer reporting agency cannot charge a fee for a credit freeze on a consumer file when the consumer is a victim of identity theft, which is shown by providing a police report. For an example, see Tex. Bus. & Com. Code § 20.04(b). As an alternative to having the licensee pay for the credit freeze, a state should consider referencing that law and providing that the credit freeze is free for consumers after the data breach is reported to law enforcement by the licensee, by showing a data breach notification letter from the licensee. The state may also need to amend its free credit freeze law to ensure this is covered.

If the data breach has affected consumers in other states, the commissioner shall, consistent with the requirements of [reference to statute describing the commissioner's general powers] and with the circumstances of the data breach as they affect consumers in this state, cooperate with the insurance regulators of those states in prescribing the appropriate level of consumer protection described in the previous sentence.

Section 8. Power of Commissioner

The commissioner shall have power to examine and investigate into the affairs of any licensee to determine whether the licensee has been or is engaged in any conduct in violation of this Act. This power is in addition to the powers which the commissioner has under [insert applicable statutes governing the investigation or examination of insurers]. Any such investigation or examination shall be conducted pursuant to [insert applicable statutes governing the investigation or examination of insurers].

Section 9. Enforcement

Whenever the commissioner has reason to believe that a licensee has been or is engaged in conduct in this state which violates this Act, the commissioner may issue and serve upon such licensee a statement of charges and notice of hearing to be held at a time and place fixed in the notice. The hearing shall be conducted in accordance with [cite provisions of state administrative procedure act or insurance code applicable to administrative enforcement proceedings for serious violations].

Section 10. Confidentiality

A. Any documents, materials or other information in the control or possession of the department of insurance that are furnished by a licensee or an employee or agent

thereof acting on behalf of licensee pursuant to Section 6B(2), (3), (4), (5), (6), (8), (11), and (12), or that are obtained by the insurance commissioner in an investigation or examination pursuant to Section 8 of this Act shall be confidential by law and privileged, shall not be subject to [insert reference to state open records, freedom of information, sunshine or other appropriate law], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the insurance commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the insurance commissioner's duties.

B. Neither the insurance commissioner nor any person who received documents, materials or other information while acting under the authority of the insurance commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Section 10A.

C. In order to assist in the performance of the insurance commissioner's duties under this Act, the insurance commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Section 10A, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) **[OPTIONAL]** May enter into agreements governing sharing and use of information consistent with this subsection.

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Section 10C.

E. Nothing in this Act shall prohibit the insurance commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to [insert appropriate reference to state law] to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

Drafting Note: States conducting an investigation or examination under their examination law may apply the confidentiality protections of that law to such an investigation or examination.

Section 11. Penalties

In the case of a violation of this Act a licensee may be penalized in accordance with [insert general penalty statute].

Section 12. Rules and Regulations

The commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules, regulations and orders as shall be necessary to carry out the provisions of this Act.

Section 13. Severability

If any provisions of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 14. Effective Date

This Act shall take effect on [insert a date which allows at least a one year interval between the date of enactment and the effective date].

HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Health Benefit Plan Network Access and Adequacy Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose

The purpose and intent of this Act are to:

A. Establish standards for the creation and maintenance of networks by health carriers; and

B. Assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan by:

(1) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered services to covered persons; and

(2) Requiring health carriers to maintain and follow access plans that consist of policies and procedures for assuring the ongoing sufficiency of provider networks consistent with Section 5 of this Act, including any requirements in Section 5E of this Act related to its availability to the public.

Drafting Note: In states that regulate prepaid health services, this Act may be modified for application to contractual arrangements between prepaid limited health service organizations that provide a single or limited number of health care services and the providers that deliver services to covered persons.

Section 3. Definitions

For purposes of this Act:

A."Authorized representative" means:

(1) A person to whom a covered person has given express written consent to represent the covered person;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) The covered person's treating health care professional only when the covered person is unable to provide consent or a family member of the covered person.

B. "Balance billing' means the practice of a provider billing for the difference between the provider's charge and the health carrier's allowed amount.

c. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

D. "Covered benefit" or 'benefit" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

E. 'Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

. "Emergency medical condition" means a physical, mental or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(1) Placing the individual's physical, mental or behavioral health or, with respect to a pregnant woman, the woman's or her [fetus'] [unborn child's] health in serious jeopardy;

(2) Serious impairment to a bodily function;

(3) Serious impairment of any bodily organ or part; or

(4) With respect to a pregnant woman who is having contractions:

(a) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(b) That transfer to another hospital may pose a threat to the health or safety of the woman or [fetus] [unborn child].

G. 'Emergency services" means, with respect to an emergency condition, as defined in Subsection F:

(1) A medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(2) Any further medical or mental health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

Drafting Note: States should be aware that the definition of "emergency services" above is derived from the federal definition for the term. Some states have developed a broader definition of "emergency services." For those states with a broader definition of the term, each state will have to determine which definition is appropriate for their state. States should be aware that if they use this definition of "emergency services," it could mean that emergency transportation is excluded from the special out-of-network cost-sharing protections applied to emergency services.

H. 'Essential community provider" or "ECP" means a provider that:

(1) Serves predominantly low-income, medically underserved individuals, including a health care provider defined in Section 340B(a)(4) of the Public Health Service Act (PHSA); or

(2) Is described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by section 221 of Pub.L.111-8.

Drafting Note: States should be aware that a qualified health plan (QHP) must have a certain number or percentage of essential community providers (ECPs) in a provider network, or if applicable, must meet the alternate standard, in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

1. "Facility' means an institution providing [physical, mental or behavioral] health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Drafting Note: States that regulate Medicaid managed care plans may wish to broaden this definition.

J. 'Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

K. 'Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified [physical, mental or behavioral] health care services consistent with their scope of practice under state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals. not corporate ‚persons."

L. "Health care provider' or "provider" means a health care professional, a pharmacy or a facility.

Drafting Note: A pharmacy is an entity where prescription drugs are prepared, compounded, preserved or dispensed. Many types of pharmacies provide a broad range of access for prescription drug benefits in the health care services delivered to a covered person. Any determination of network sufficiency should consider the broad range of pharmacy access points available to covered persons and that certain provisions of this Act may not apply to pharmacy. States should take note of the federal rules implementing the federal Affordable Care Act (ACA) that go into effect Jan. 1, 2017, which will require carriers providing essential health benefits (EHBs) in the individual and small group markets to provide a range of pharmacy options, including access through mail order pharmacies and retail pharmacies (see Title 45 CFR — Subpart B — Essential Health Benefits Section 156.122(e)).

M. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a physical, mental or behavioral health condition, illness, injury or disease, including mental health and substance use disorders.

N. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

Drafting Note: Section 2791(b)(2) of the PHSA defines the term "health insurance issuer" instead of "health carrier." The definition of "health carrier" above is consistent with the definition of "health insurance issuer" in Section 2791(b)(2) of the PHSA.

o. "Intermediary' means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

p. "Limited scope dental plan" means a plan that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

Drafting Note: In some cases, dental benefits are embedded in or are integral to a health benefit plan, but are separately administered from the medical benefit of the health benefit plan. State insurance regulators should review this definition of "limited scope dental plan" to determine if exceptions from certain specified provisions of this Act should be given to the plan in such situations.

Q. "Limited scope vision plan" means a plan that provides coverage substantially all of which is for treatment of the eye that is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

Drafting Note: In some cases, vision benefits are embedded in or are integral to a health benefit plan, but are separately administered from the medical benefit of the health benefit plan. State insurance regulators should review this definition of "limited scope vision plan" to determine if exceptions from certain specified provisions of this Act should be given to the plan in such situations.

R. "Network" means the group or groups of participating providers providing services under a network plan.

S. "Network plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

Drafting Note: The definition of "network plan" is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for covered persons to choose certain providers over others, such as HMOs, EPOs, PPO, ACOs and other innovative delivery system models.

T. "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

U. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

V. "Primary care" means health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care professional.

Drafting Note: Many states may have an existing definition of "primary care" in their state laws or regulations. Those states that have such a definition should carefully review that definition in comparison with the definition above and decide if the term "primary care" needs to be defined for purposes of this Act using the definition above for "primary care" or the state's existing definition of "primary care."

W. "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

X. (1) 'Specialist" means a physician or non-physician health care professional who:

(a) Focuses on a specific area of physical, mental or behavioral health or a group of patients; and

(b) Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

(2) "Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

Y. "Specialty care" means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions or those health conditions which may manifest in particular ages or subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.

Drafting Note: Some states may have an existing definition of "specialty care" in their state laws or regulations. Those states that have such a definition should carefully review that definition in comparison with the definition above and decide if the term "specialty care" needs to be defined for purposes of this Act using the definition above for "specialty care" or the state's existing definition of "specialty care."

z. "Telemedicine" or "Telehealth" means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located.

Drafting Note: States should review the definition of "telemedicine" or "telehealth" for consistency with any state laws or regulations related to telemedicine or telehealth.

AA. "Tiered network" means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

Drafting Note: Health carriers may use different terms other than the term "tier" to refer to the type of network described in the definition above. State insurance regulators should be aware of this for purposes of the definition above and any changes a state may want to make to the definition above as a result, such as using another term or terms in place of or in addition to the term "tier."

BB. "To stabilize" means with respect to an emergency medical condition, as defined in Subsection F, to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility, or, with respect to an emergency birth with no complications resulting in a continued emergency, to deliver the child and the placenta.

Drafting Note: States should be aware that if they decide not to include the definition of "emergency services" using the language provided in Subsection G, it may not be necessary to include this definition.

CC. "Transfer" means, for purposes of Subsection BB, the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:

(1) Has been declared dead; or

(2) Leaves the facility without the permission of any such person.

Section 4. Applicability and Scope

A. Except as provided in Subsection B, this Act applies to all health carriers that offer network plans.

B. The following provisions of this Act shall not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope vision plans:

(1) Section 5A(2) of this Act;

(2) Section 5F(7)(e), (8)(b) and (11) of this Act;

(3) Section 6L(2)(a)(i)(I) and (Ill) and (c)(iii)(lll) of this Act;

(4) Section 8 of this Act;

(5) Section 9B(2) and (3) of this Act; and

(6) Section 9C(1)(a) and (b), (2) and (3) of this Act.

Drafting Note: In addition to Subsection B, states will need to consider what other types of health benefit plans subject to the insurance laws and regulations of this state that use networks should be subject to the requirements of this Act.

Drafting Note: States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act's requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state and the public its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity or health carrier should provide the state with documentation that the health carrier and its networks have been accredited by the entity and make the underlying accreditation files available to the state upon request.

Section 5. Network Adequacy

A. (1) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

(2) Covered persons shall have access to emergency services twenty-four (24) hours per day, seven (7) days per week.

Drafting Note: Particular attention should be given to network sufficiency, marketing and disclosure in certain health carrier network plan designs, such as tiered, multi-tiered, layered or multi-level network plans, which include different access to benefits and cost-sharing based on a covered person's choice of provider. State insurance regulators should carefully review filings to ensure that the network plan design is not potentially discriminatory for children and adults with serious, chronic or complex health conditions and that carriers will disclose information in a clear and conspicuous manner so that the covered person can understand the use of the tiered. multi-tiered, layered or multi-level network plan to access the benefits offered within the health benefit plan.

B. The commissioner shall determine sufficiency in accordance with the requirements of this section, and may establish sufficiency by reference to any reasonable criteria, which may include but shall not be limited to:

(1) Provider-covered person ratios by specialty;

(2) Primary care professional-covered person ratios;

(3) Geographic accessibility of providers;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with participating providers;

(6) Hours of operation;

(7) The ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency;

(8) Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care; and

(9) The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

Drafting Note: When determining criteria for evaluating network sufficiency provided in Subsection B, state insurance regulators also may want to consider a number of additional factors, such as the extent to which participating providers are accepting new patients, the degree to which participating physicians are authorized to admit patients to participating hospitals and hospital-based providers are participating providers, and the regionalization of specialty care, which may require some children and adults to cross state lines for care. State insurance regulators also may conduct or review available periodic surveys of covered persons and providers to help inform their monitoring of network adequacy and may choose to make the results publicly available.

Drafting Note: State insurance regulators should consider establishing network sufficiency and accessibility standards that are specific to limited scope dental and/or vision plans. Certain network sufficiency and accessibility requirements for comprehensive health benefit plans may not be appropriate for these type benefit plans. For example, hours of operation for dental offices are traditionally standard business hours and are not utilized to illustrate network sufficiency, nor is telehealth widely utilized in the dental and vision industry.

Drafting Note: Some states have developed specific quantitative standards to ensure adequate access that carriers must, at a minimum, satisfy in order to be considered to have a sufficient network. Such standards have included requirements for carriers to have a minimum number of providers within a specified area (such as a rural or urban area, metropolitan or nonmetropolitan area), limits on travel distance to providers, limits on travel time to providers and limits on waiting times to obtain an appointment with a primary care provider. These standards could be incorporated into a law. However, in many cases, these standards are more likely to be included in regulations.

C. (1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

(a) The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

(b) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider as provided in Paragraph (1) when:

(a) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and

Drafting Note: For purposes of this paragraph, "specialized health care services or medical services" include the delivery of covered benefits in a manner that is physically accessible and provides communication and accommodations needed by covered persons with disabilities.

(b) The health carrier:

(i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

(ii) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(3) The health carrier shall treat the health care services the covered person receives from a non-participating provider pursuant to Paragraph (2) as if the services were provided by a participating provider, including counting the covered person's cost-sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

(4) The process described under Paragraphs (1) and (2) shall ensure that requests to obtain a covered benefit from a non-participating provider are addressed in a timely fashion appropriate to the covered person's condition.

Drafting Note: In order to determine what may be considered "in a timely fashion," state insurance regulators may want to review the timeframes and notification requirements provided in its utilization review law or regulation.

(5) The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a non-participating provider under this subsection and shall provide this information to the commissioner upon request.

(6) The process established in this subsection is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with the provisions of this Act nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health carrier's network delivery system options.

(7) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

Drafting Note: It is presumed that the health carrier shall make its process under this subsection available in writing to covered persons and to the commissioner, in a form and manner the commissioner may specify.

D. (1) A health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this provision, the commissioner shall give due consideration to the

relative availability of health care providers with the requisite expertise and training in the service area under consideration.

(2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

Drafting Note: If the commissioner determines that there is a deficiency in access to care for a limited scope dental and /or vision plan, the commissioner may work with the health carrier for approval of in-network reimbursements to covered persons.

E. (1) Beginning [insert effective date], a health carrier shall file with the commissioner [for review] [for approval] prior to or at the time it files a newly offered network, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act.

Drafting Note: States will establish different requirements for the access plan. Paragraph (1) provides for this by giving states the option to require a health carrier to file the access plan with the commissioner for approval before use. Paragraph (1) also gives states the option to require a health carrier to file the access plan with the commissioner for review, but permit the health carrier to use the access plan while it is subject to review. In states that require a health carrier to file access plans with the commissioner for review, the commissioner may want to consider, for example, whether access to specific types of providers or health care services, geographic areas of the state, and other network issues with a past pattern of adequacy concerns require heightened review. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

(2) (a) The health carrier may request the commissioner to deem sections of the access plan as [proprietary, competitive or trade secret] information that shall not be made public. The health carrier shall make the access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request.

(b) For the purposes of this subsection, information is [proprietary or competitive or a trade secret] if revealing the information would cause the health carrier's competitors to obtain valuable business information.

Drafting Note: State insurance regulators should be aware that the intent of Paragraph (2) above is that the access plan be considered public information. Health carriers should not be permitted to request that the entire plan is [proprietary, competitive or trade information] and, as such, no provision of the plan may be made public. State insurance regulators should review their open records laws in determining whether a particular provision, if any, of an access plan is [proprietary, competitive or trade secret] information and should not be made public based on information received from the health carrier supporting its request. For purposes of this paragraph, state insurance regulators also should review their laws or regulations to determine which term "proprietary," "competitive" or "trade secret" is appropriate to use or if some other term is more appropriate. State insurance regulators should rely on the state law or regulation that defines "trade secret" or "proprietary.'

(3) The health carrier shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner of any material change to any existing network plan within fifteen (15) business days after the change occurs. The carrier shall include in the notice to the commissioner a reasonable timeframe within which it will submit to the commissioner for approval or file with the commissioner, as appropriate, an update to an existing access plan.

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Drafting Note: State insurance regulators may want to consider defining "material change" for purposes of Paragraph (3) above. For example, a "material change" may be a certain percentage change, as determined by a state, in the health carrier's network of

providers or type of providers available in the network to provide health care services or specialty health care services to covered persons or it may be any change that renders the health carrier's network non-compliant with one or more network adequacy standards. Types of changes that could be considered material could include: 1) a significant reduction m the number of primary or specialty care physicians available in a network; 2) a reduction in a specific type of provider such that a specific covered service is no longer available; 3) a change to the tiered, multi-tiered, layered or multi-level network plan structure; or 4) a change in inclusion of a major health system that causes the network to be significantly different from what the covered person initially purchased.

Drafting Note: State insurance regulators should be aware that requirements in this section for the access plan may be duplicative of other requirements in other sections of this Act. To the extent there is such duplication, the intent is that the health carrier be required to file or submit, as appropriate, the information one time.

F. The access plan shall describe or contain at least the following:

(1) The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable;

(2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

(4) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;

(5) The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;

(6) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(7) The health carrier's method of informing covered persons of the plan's covered services and features, including but not limited to: (a) The plan's grievance and appeals procedures;

(b) Its process for choosing and changing providers;

(c) Its process for updating its provider directories for each of its network plans;

(d) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and

e) Its procedures for covering and approving emergency, urgent and specialty care, if applicable;

Drafting Note: State insurance regulators should ensure that limited scope dental plans have provisions in their access plans or form filings, as appropriate, consistent with current practice to address situations where covered persons need urgent dental care.

Drafting Note: Some states may have an existing definition of "urgent care" in their state laws or regulations. Those states that have an existing definition of "urgent care" may want to consider including that definition in this Act.

(8) The health carrier's system for ensuring the coordination and continuity of care:

(a) For covered persons referred to specialty physicians; and

(b) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(9) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;

(10) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner;

(11) The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals; and

Drafting Note: If a limited scope dental and/or vision plan uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision plan shall comply with the Act's requirements pertaining to hospitals and/or other type of facility.

(12) Any other information required by the commissioner to determine compliance with the provisions of this Act.

Drafting Note: State insurance regulators may want to consider requiring that an access plan include information on the health carrier's efforts to ensure that its participating providers meet available and appropriate quality of care standards and health outcomes for network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.

Drafting Note: States should be aware that for dental network plans, some state insurance regulators may not require the preparation and submission of a so-called "access plan" for purposes of determining the sufficiency Of a dental provider network. These states may require other documentation to be included in the form filings to accomplish this purpose in order to review and determine the sufficiency of a dental and/or vision provider network. State insurance regulators, however, should be aware that dental carriers seeking certification to offer limited scope dental plans on a health insurance exchange or exchange use the term "access plan."

Section 6. Requirements for Health Carriers and Participating Providers

A health carrier offering a network plan shall satisfy all the requirements contained in this section.

A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services.

B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

c. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue until the earlier of:

(1) The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are m an active course of treatment or totally disabled; or

Drafting Note: The reference to termination of coverage in Paragraph (1) above is meant to encompass all the ways a covered person's coverage can be terminated. The grounds, conditions and effective date of termination are dictated by other provisions of law, which are outside the scope Of this Act, such as for nonpayment of premium or the performance of an act or practice that constitutes fraud or an intentional misrepresentation of material fact m connection with the coverage. State insurance regulators should keep this in mind in implementing Paragraph (1).

(2) The date the contract between the carrier and the provider, including any required extension for covered persons in an active course of treatment, would have terminated if the carrier or intermediary had remained in operation.

D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by Subsections B and C of this section.

Drafting Note: Subsection D above provides that the obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider survives the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the network relationship is extended to provide continuity of care under Subsection L.

E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

F.(1) Health carrier selection standards for selecting and tiering, as applicable, of participating providers shall be developed for providers and each health care professional specialty.

(2) (a) The standards shall be used in determining the selection [and tiering] of participating providers by the health carrier and its intermediaries with which it contracts.

(b) The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].

(3) (a) Selection [and tiering] criteria shall not be established in a manner:

(i) That would allow a health carrier to discriminate against high-risk populations by excluding [and tiering] providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or

(ii) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization.

(b) (i) In addition to Subparagraph (a) of this paragraph, a health carrier's selection criteria may not discriminate with respect to participation under the health benefit plan against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations.

(ii) The provisions of Subparagraph (b)(i) of this paragraph may not be construed to require a health carrier to

contract with any provider willing to abide by the terms and conditions for participation established by the carrier.

Drafting Note: States should be aware that the provisions of Subparagraph (b) above are based in large part on the provisions of Section 2706(a) of the Public Health Service Act (PHSA). The Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments), the federal agencies charged with implementing the ACA, issued on May 26, 2015, sub-regulatory guidance in the form of frequently asked questions (FAQs), which provides an enforcement safe harbor for health insurance issuers subject to Section 2706(a) of the PHSA. Specifically, in the Affordable Care Act Implementation FAQs Part XXVII, Q4 and Q5 issued May 26, 2015, the Departments restated their current enforcement approach to Section 2706(a) of the PHSA which is to not take any enforcement action against a health insurance issuer offering group or individual coverage, with respect to implementing the requirements of Section 2706(a) of the PHSA as long as the issuer is using a good faith, reasonable interpretation of the statutory provision.

(4) Paragraph (3) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this Act.

(5) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under Section 5 of this Act.

Drafting Note: This subsection is intended to prevent health carriers from avoiding risk by excluding either of two types of providers: (1) those providers who are geographically located in areas that contain potentially high-risk populations; or (2) those providers who actually treat or specialize in treating high-risk populations, regardless of where the provider is located. Exclusion based on geographic location may discourage individuals from enrolling in the plan because they would be required to travel outside their neighborhood to obtain services. Exclusion based on the provider's specialty or on the type of patient contained in the provider's practice may discourage a person unwilling to change providers in the course of treatment from enrolling in the plan. For example, if a carrier were permitted to exclude physicians whose practices included many patients infected with HIV, the carrier could avoid enrolling these persons in its plan, since those persons would probably not want to change physicians in the course of treatment. This subsection does not prevent health carriers from requiring all providers that participate in the carrier's network to meet all the carrier's requirements for participation.

. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner. A description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, shall be available to the public.

Drafting Note: State insurance regulators should review how a health carrier markets or represents its network plans to consumers particularly for those network plans that carriers market or represent to consumers as using quality as at least one method of assessing whether to include providers in the network. In addition, for such network plans, state insurance regulators also should review a health carrier's provider selection standards to ensure that quality is actually being used to assess whether to include providers in the network.

Drafting Note: The disclosure of a health carrier's selection standards to providers and consumers is an important issue to be considered by states and could be addressed in this Act or in another law.

H. A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in

practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

1. A health carrier shall not offer an inducement to a provider that would encourage or otherwise incent the provider to deliver less than medically necessary services to a covered person.

J. A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier or m accordance with any rights or remedies available under applicable state or federal law.

Drafting Note: States should be aware that the term "participating provider" is meant to include a health care professional acting within the scope of their authority who may not be in the typical physician office setting or hospital setting, and may include licensed, accredited or certified staff, such as patient care coordinators, operating under the supervision of a participating provider.

K. Every contract between a health carrier and a participating provider shall require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their of medical and health records.

L. (1) (a) A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before the provider is removed or leaves the network without cause.

Drafting Note: In addition to when a provider is removed or leaves the network without cause, with respect to tiered network plans, states may want to consider the implications that consumers may face, including continuity of care and financial implications, when a participating provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements.

(b) The health carrier shall make a good faith effort to provide written notice of a provider's removal or leaving the network within thirty (30) days of receipt or issuance of a notice provided in accordance with Subparagraph (a) of this paragraph to all covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether it is for cause or without cause.

(c) When the provider being removed or leaving the network is a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. When the provider either gives or receives the notice in accordance with Subparagraph (a) of this paragraph, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

(2) (a) For purposes of this paragraph, the following terms have the meanings indicated:

"Active course of treatment" means:

(I) An ongoing course of treatment for a life-threatening condition;

(11) An ongoing course of treatment for a serious acute condition;

(111) The second or third trimester of pregnancy; or

(IV) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

(ii) "Life-threatening health condition" means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(iii) "Serious acute condition" means a disease or condition requiring complex on-going care which the covered person is currently receiving, such as chemotherapy, post-operative visits or radiation therapy.

(b) For purposes of Subparagraph (a)(i) of this paragraph, a covered person shall have been treated by the provider being removed or leaving the network on a regular basis to be considered in an "active course of treatment."

(c) (i) When a covered person's provider leaves or is removed from the network, a health carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.

(ii) The health carrier shall provide the notice required under Paragraph (1), and shall make available to the covered person a list of available participating providers in the same geographic area who are of the same provider type and information about how the covered person may request continuity of care as provided under this paragraph.

(iii) The procedures shall provide that:

(I) Any request for continuity of care shall be made to the health carrier by the covered person or the covered person's authorized representative;

(Il) Requests for continuity of care shall be reviewed by the health carrier's Medical Director after consultation with the treating provider for patients who meet the criteria listed in Paragraph (2) and are under the care of a provider who has not been removed or leaving the network for cause. Any decisions made with respect to a request for continuity of care shall be

subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;

(III) The continuity of care period for covered persons who are in their second or third trimester of pregnancy shall extend through the postpartum period; and

(IV) The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of:

a. The termination of the course of treatment by the covered person or the treating provider;

b. [Ninety (90) days] unless the Medical Director determines that a longer period is necessary;

c. The date that care is successfully transitioned to a participating provider;

d. Benefit limitations under the plan are met or exceeded; or

e. Care is not medically necessary.

Drafting Note: The current accreditation standard for the length of the continuity of care period is 90 days. When determining the length of time for the continuity of care period. states should consider the number of providers, especially specialty providers who are available to treat serious health conditions in their states. States that have relatively few specialists or where consumers face significant wait times for appointments may want to adjust the continuity of care time frame.

(iv) In addition to the provisions of Item (iii)(IV), a continuity of care request may only be granted when:

(I) The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract; and

(11) The provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.

Drafting Note: In the event of a termination of a limited scope dental or vision plan participating provider, the commissioner may work with the plan's health carrier for approval of in-network benefits provided to the covered person until the episode of care is concluded.

Drafting Note: States may want to review other state laws and regulations and consider adding special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer's enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to have been a participating provider at the time of enrollment or when a participating provider was listed as accepting new patients, but was not accepting new patients at the time of enrollment.

M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by either party without the prior written consent of the other party.

N. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

o. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

P. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Q. A health carrier shall establish a mechanism by which participating providers may determine in a timely manner at the time services are provided whether or not an individual is a covered person or is within a grace period for payment of premium during which the carrier may hold a claim for services pending receipt of payment of premium.

Drafting Note: There are situations that may arise when using the mechanism established in accordance with Subsection Q above when a participating provider has verified an individual's eligibility on the date of service, but later the provider learns that the individual was not actually eligible or has been terminated due to failure to pay premium or due to some other situation that may arise due to enrollment timing issues and other issues under the federal Affordable Care Act (ACA). Providers in this situation are permitted to bill the individual for payment of services provided. States may want to look at establishing possible protections for consumers in such situations when carriers have verified eligibility.

R. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

S. A contract between a health carrier and a provider shall not contain provisions that conflict with the provisions contained in the network plan or the requirements of this Act.

T. (1) (a) At the time the contract is signed, a health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions and other documents incorporated by reference in the contract.

(b) While the contract is in force, the carrier shall timely notify a participating provider of any changes to those provisions or documents that would result in material changes in the contract.

(c) For purposes of this paragraph, the contract shall define what is to be considered timely notice and what is to be considered a material change.

Drafting Note: State insurance regulators may want to consider reviewing the sample contract forms filed with the commissioner under Section Il of this Act in order to determine if the provisions in the contract defining what is to be considered timely notice and what is to be considered a material change reflect fair contracting between the parties to the contract. Retroactive application of a change in the contract or in a document incorporated by reference will not be considered timely notice of the change. If the regulatory authority to review provider contracts lies with some state agency other than the insurance department, a state should consider adding language to this section, Section 11 of this Act or some other section of the Act referencing that agency to ensure appropriate regulatory oversight of prouder contracting issues.

(2) A health carrier shall timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider.

Section 7. Requirements for Participating Facilities with Non-Participating FacilityBased Providers

A. For purposes of this section, "facility-based provider" means a provider who provides health care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, emergency room care, radiology or other services provided in an in-patient or ambulatory facility setting. These health care services are typically arranged by the facility by contract or agreement with the facility-based provider as part of the facility's general business operations, and a covered person or the covered person's health benefit plan generally does not specifically select or have a choice of providers from which to receive such services within the facility.

Drafting Note: States should carefully review the definition of "facility-based provider" above to make sure it includes any provider who may bill separately from the facility for health care services provided at the in-patient or ambulatory facility.

B. Non-emergency out-of-network services.

(1) At the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency services to a covered person, the facility shall provide the covered person with an out-of-network services written disclosure that states the following:

(a) That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;

(b) That those facility-based providers may not have contracts with the covered person's health carrier and are therefore considered to be out-of-network;

(c) That the service(s) therefore will be provided on an out-of-network basis;

(d) A description of the range of the charges for the out-of-network service(s) for which the covered person may be responsible;

(e) A notification that the covered person may either agree to accept and pay the charges for the out-of-network service(s), contact the covered person's health carrier for additional assistance or rely on whatever other rights and remedies that may be available under state or federal law; and

(f) A statement indicating that the covered person may obtain a list of facility-based providers from his or her health benefit plan that are participating providers and that the covered person may request those participating facility-based providers.

Drafting Note: The notice required in this subsection could replace the notice in Section 8B Of this Act.

(2) At the time of admission in the participating facility where the nonemergency services are to be performed on the covered person, the facility shall provide the covered person with the written disclosure, as outlined in Paragraph (1), and obtain the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging that the covered person received the disclosure document in advance prior to the time of admission.

c. Out-of-network emergency services.

(1) For out-of-network emergency services, the non-participating facility-based provider shall include a statement on any billing notice sent to the covered person for services provided informing the covered person that he or she is responsible for paying their applicable in-network cost-sharing amount, but has no legal obligation to pay the remaining balance. Such statement also shall inform the covered person of his or her obligation to forward the bill to their health carrier for consideration under the Provider Mediation Process described in Subsection G if the difference in the billed charge and the plan's allowable amount is more than [$500.00].

Drafting Note: A state that has enacted provisions concerning payment for emergency services provided by a nonparticipating provider, which permit a non-participating provider to balance bill the covered person, should be aware that the provisions of Paragraph (1) above would not permit a non-participating provider to balance bill the covered person in that situation. As such, if a state decides to adopt the provisions of Paragraph (1) above, the state should review their laws or regulations that may be equivalent to Section I IC of the Utilization Review and Benefit Determination Model Act (#73) and revise them accordingly.

(2) Nothing in this section precludes a covered person from agreeing to accept and pay the charges for the out-of-network service(s) and not using the Provider Mediation Process described in Subsection G.

D. Limitation on Balance Billing Covered persons.

(1) In instances where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider's service(s), the billing notice shall include the Payment Responsibility Notice in Paragraph (2).

(2) The Payment Responsibility Notice shall state the following or substantially similar language:

"Payment Responsibility Notice — The service[s] outlined below was [were] performed by a facility-based provider who is a non-participating provider with your health care plan. At this time, you are responsible for paying your applicable cost-sharing obligation - copayment, coinsurance or deductible amount — just as you would be if the provider is within your plan's network. With regard to the remaining balance, you have three choices: 1) you may choose to pay the balance of the bill; OR 2) if the difference in the billed charge and the plan's allowable amount is more than [$500.00], you may send the bill to your health care plan for processing pursuant to the health carrier's nonparticipating facility-based provider billing process or the provider mediation process required by [this Section] OR 3) you may rely on other rights and remedies that may be available in your state."

(3) Non-participating facility-based providers may not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's non-participating facility-based provider billing process described in Subsection E.

(4) Non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice, as outlined in Paragraph (2), may not balance bill the covered person.

(5) Nothing in this section precludes a covered person from agreeing to accept and pay the bill received from the non-participating facility-based provider and not using the Provider Mediation Process described in Subsection G.

E. Health carrier out-of-network facility-based provider payments.

(1) Health carriers shall develop a program for payment of non-participating facility-based provider bills submitted pursuant to this section.

(2) Health carriers may elect to pay non-participating facility-based provider bills as submitted or the health carrier may pay in accordance with the benchmark established in Subsection F.

(3) Non-participating facility-based providers who object to the payment(s) made in Paragraph (2) may elect the Provider Mediation Process described in Subsection G.

(4) This section does not preclude a health carrier and an out-of-network facility-based provider from agreeing to a separate payment arrangement.

F. Benchmark for non-participating facility-based provider payments. Payments to nonparticipating facility-based providers shall be presumed to be reasonable if it is based on the higher of the health carrier's contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area.

Drafting Note: Subsection F above proposes that states set a benchmark or benchmarks for payments to non-participating facility-based providers. States can consider a number of options to use as the default reimbursement presumed to be reasonable, including, as provided in Subsection F, using a percentage of the Medicare payment that a state considers appropriate to determine the rate for the same or similar services in the same geographic area as provided in Subsection F and others such as: a) some percentage of a public, independent, database of charges for the same or similar services in the same geographic area; or b) some percentage of

usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation. In setting a benchmark or benchmarks, states should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility-based providers and health carriers to agree on a contract.

G. Provider Mediation Process.

(1) Health carriers shall establish a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in Subsection F.

(2) The health carrier provider mediation process shall be established in accordance with one of the following recognized mediation standards:

(a) The Uniform Mediation Act;

(b) Mediation.org, a division of the American Arbitration Association;

(c) The Association for Conflict Resolution (ACR);

(d) The American Bar Association Dispute Resolution Section; or

(e) The State of [XX] [state dispute resolution, mediation or arbitration section].

Drafting Note: Some states have included a provider mediation process in an independent dispute resolution process. The intent and effect is similar to this process.

(3) Following completion of the provider mediation process, the cost of mediation shall be split evenly and paid by the health carrier and the non-participating facility-based provider.

(4) A health carrier provider mediation process may not be used when the health carrier and the non-participating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the non-participating facility-based provider's charges for the out-of-network service(s).

(5) A health carrier shall maintain records on all requests for mediation and completed mediations under this subsection during a calendar year and, upon request, submit a report to the commissioner in the format specified by the commissioner.

Drafting Note: In promulgating regulations to implement this section, the commissioner and other appropriate state agencies involved in the rulemaking process should consider a number of provisions related to this subsection, such as the timing of the notice that the mediation process has been triggered, the timeframe to trigger the process and the standard rights and obligations of the parties participating in the mediation process.

H. The rights and remedies provided under this section to covered persons shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

1. Enforcement. The [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general] and the [insurance department] shall be responsible for enforcement of the requirements of this section.

J. Applicability.

(1) The provisions of this section shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

(2) The requirements of this section do not apply to providers or covered persons using the process established in Section 5C of this Act.

(3) The requirements of this section do not apply to facilities that have made arrangements with facility-based providers they employ or with whom they have contracts which prevent balance bills from being sent to persons covered by the same health benefit plans with which the facility contracts.

Drafting Note: This section is not intended to be used in situations where the covered person affirmatively chooses, prior to the provision of the services, to obtain health care services from a non-participating facility-based provider.

K. Regulations. The commissioner and the [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general as indicated in Subsection I, above] may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this section. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 8. Disclosure and Notice Requirements

A. (1) A health carrier shall develop a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of pre-certification, if applicable, for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network that there is the possibility that the covered person could be treated by a health care professional that is not in the same network.

(2) The disclosure or notice shall indicate that the covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing if the covered services are performed by a health care professional, who is not in the covered person's plan network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person's plan will pay for the covered services provided by a nonparticipating health care professional is available on request from the

health carrier. The disclosure or notice also shall inform the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.

B. For non-emergency services, as a requirement of its provider contract with a health carrier, a facility shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the facility or at the time of a non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person's network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network.

Drafting Note: States should be aware that network adequacy issues could arise due to an insufficient number of participating providers available to provide adequate and reasonable access for covered persons to covered benefits related to facility-based health care professionals who are not in the same network as the facility. States may want to consider developing appropriate laws and regulations to apply notice and disclosure standards to facilities to advise covered persons of the potential for balance billing by non-participating providers performing covered services at those facilities.

Drafting Note: If a limited scope dental and/or vision plan uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision plan shall comply with the Act's requirements pertaining to hospitals and/or other type of facility.

Section 9. Provider Directories

A. (1) (a) A health carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions, as described in Subsection C.

(b) In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) (a) The health carrier shall update each network plan provider directory at least monthly.

Drafting Note: In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as participating providers who have not submitted claims within the past six months or other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; and 2) closely monitoring consumer complaints.

Drafting Note: In situations in which a covered person receives covered services from a non-participating provider due to a material misrepresentation in the provider directory indicating that the provider is a participating provider, state insurance regulators should refer the issue to their consumer complaint division for a resolution, such as requiring the health carrier to cover the benefit claim as if the services were obtained from a participating provider.

(b) The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.

(3) A health carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information

described in Subsection B upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language in both the electronic and print directory, the following general information:

(a) In plain language, a description of the criteria the carrier has used to build its provider network;

(b) If applicable, in plain language, a description of the criteria the carrier has used to tier providers;

(c) If applicable, in plain language, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and

(d) If applicable, note that authorization or referral may be required to access some providers.

(5) (a) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

(b) The health carrier shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

(6) For the pieces of information required pursuant to Subsections B, C and D in a provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier shall make available through the directory the source of the information and any limitations, if applicable.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

B. The health carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:

(1) For health care professionals:

(a) Name;

(b) Gender;

(c) Participating office location(s);

(d) Specialty, if applicable;

(e) Medical group affiliations, if applicable;

(f) Facility affiliations, if applicable;

(g) Participating facility affiliations, if applicable;

(h) Languages spoken other than English, if applicable; and

(i) Whether accepting new patients.

(2) For hospitals:

(a) Hospital name;

(b) Hospital type (i.e. acute, rehabilitation, children's, cancer);

(c) Participating hospital location; and

(d) Hospital accreditation status; and

(3) For facilities, other than hospitals, by type:

(a) Facility name;

(b) Facility type;

(c) Types of services performed; and

(d) Participating facility location(s).

c. For the electronic provider directories, for each network plan, a health carrier shall make available the following information in addition to all of the information available under Subsection B:

(1) For health care professionals:

(a) Contact information;

(b) Board certification(s); and

(c) Languages spoken other than English by clinical staff, if applicable.

(2) For hospitals: Telephone number; and

(3) For facilities other than hospitals: Telephone number.

D. (1) The health carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

(a) For health care professionals:

(i) Name;

Contact information;

(iii) Participating office location(s);

(iv) Specialty, if applicable;

(v) Languages spoken other than English, if applicable; and

(vi) Whether accepting new patients.

(b) For hospitals:

(i) Hospital name;

(ii) Hospital type (i.e. acute, rehabilitation, children's, cancer); and

(iii) Participating hospital location and telephone number; and

(c) For facilities, other than hospitals, by type:

(i) Facility name;

(ii) Facility type;

(iii) Types of services performed; and

(iv) Participating facility location(s) and telephone number.

(2) The health carrier shall include a disclosure in the directory that the information in Paragraph (1) included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website or call [insert appropriate customer service telephone number] to obtain current provider directory information.

Drafting Note: In addition to the information provided in Subsections B, C and D health carriers may include or make available in their provider directories additional information, such as information concerning the structural accessibility, presence of accessible examination and diagnostic equipment and availability of programmatic accessibility.

Drafting Note: States should consider that the information included in electronic and print provider directories for limited scope dental and/or vision plans may have to differ from the information included in provider directories for major medical, comprehensive health benefit plans. For example, information on provider medical group affiliations and board certifications are not typically included in provider directories for limited scope dental and/or vision plans.

Section 10. Intermediaries

A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Section 6 of this Act.

B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

c. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

D A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

E If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for [cite applicable statutory duration] in a manner that facilitates regulatory review.

G. An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance with this Act.

H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services. If a health carrier requires assignment, the health carrier shall remain obligated to pay the provider for furnishing covered services under the same terms and conditions as the intermediary prior to the insolvency.

1. Notwithstanding any other provision of this section, to the extent the health carrier delegates its responsibilities to the intermediary, the carrier shall

retain full responsibility for the intermediary's compliance with the requirements of this Act.

Drafting Note: States may want to consider requiring intermediaries to register with the state department of insurance, or other state agency as the state may feel is appropriate, or impose some other type of regulatory scheme on such entities, to ensure the state has the regulatory authority to regulate them and keep track of their activities.

Section 11. Filing Requirements and State Administration

A. At the time a health carrier files its access plan, the health carrier shall file [for approval] with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

Drafting Note: States may want to review their open records laws to determine whether the sample contract forms filed under Subsection A are considered public information.

B. A health carrier shall submit material changes to a contract that would affect a provision required under this Act or implementing regulations to the commissioner [for approval] at least [cite period of time in the form approval statute] days prior to use.

Drafting Note: Subsections A and B provide an option for states to require health carriers to file with the commissioner for informational purposes any material changes to a contract or to require health carriers to file contracts and material changes for prior approval. A state should choose which option is appropriate for the state.

Drafting Note: States should consider that when health carriers make changes in contracted provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications, such changes could materially impact a covered person's access to covered benefits or timely access to participating providers; and as such, would be considered a material change to a contract subject to the requirement to file with the commissioner for informational purposes or filing for prior approval.

[C. If the commissioner takes no action within sixty (60) days after submission of a contract or a material change to a contract by a health carrier, the contract or change is deemed approved.]

D The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

Section 12. Contracting

A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

B. All contracts shall be in writing and subject to review.

Drafting Note: Each state should add provisions that are consistent with that state's current regulatory requirements for the approval or disapproval of health carrier contracts, documents or actions. For example, a state may want to add a

provision requiring a health carrier to obtain prior approval of contracts, or requiring a health carrier to file a contract before using it, or requiring a health carrier to certify that all its contracts comply with this Act.

c. All contracts shall comply with applicable requirements of the law and applicable regulations.

Section 13. Enforcement

A. If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's network access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this Act, or that a health carrier has not complied with a provision of this Act, the commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Act.

Drafting Note: The reference to requiring the health carrier to modify the access plan instead of instituting a corrective action is to reflect the idea that sometimes the network changes through no fault of the health carrier and in those instances, the commissioner may require the health carrier to modify the access plan to bring the health carrier into compliance with the network adequacy requirements of this Act.

Drafting Note: State insurance regulators may use a variety of tools and/or methods to determine a health carrier's ongoing compliance with the provisions of this Act and whether the health carrier's provider network is sufficient and provides covered persons with reasonable access to covered benefits. Such tools and/or methods include consumer surveys, reviewing and tracking consumer complaints and data collection on the use of out-of-network benefits.

B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a network plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or one or more providers arising under or by reason of a provider contract or its termination.

Section 14. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 15. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 16. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the

provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 17. Effective Date

This Act shall be effective [insert date]. [If applicable:] The [insert year of adoption] amendments to this Act shall be effective [insert date].

A. All provider and intermediary contracts in effect on [insert effective date] shall comply with this Act no later than eighteen (18) months after [insert effective date]. The commissioner may extend the eighteen (18) months for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.

B. A new provider or intermediary contract that is issued or put in force on or after [insert a date that is six (6) months after the effective date of this Act] shall comply with this Act.

c. A provider contract or intermediary contract not described in Subsection A or Subsection B shall comply with this Act no later than eighteen (18) months after [insert effective date].

D. Transition period for compliance with amended Section 5 of this Act.

Option 1.

For states with access plan requirements comparable to the pre-2015 Act: No later than [twelve (12) months] after [insert effective date of amendments], each health carrier offering or renewing network plans in this state shall file revised access plans consistent with Section 5 of this Act, as amended, for all in-force network plans.

Option 2.

For states without access plan requirements comparable to the pre-2015 Act: No later than [twelve (12) months] after [insert effective date of Act or effective date of amendments], each health carrier offering or renewing network plans in this state shall file access plans consistent with Section 5 of this Act for all in-force network plans.

Chronological Summary of Action (all references are to the Proceedings Of the NAIC).

1996 Proc. 2nd Quarter 10, 30, 732, 767, 770-777 (adopted). 2015 Fall National Meeting — (amended).

Draft: 7/29/16
A new model

Comments are being requested on this draft. Comments should be sent only by email to Jolie Matthews at jmatthews@naic.org.

UNCLAIMED LIFE INSURANCE AND ANNUITIES MODEL ACT

Section 1. Short Title

This Act shall be known and may be cited as the Unclaimed Life Insurance and Annuities Act.

Section 2. Purpose

The purpose and intent of this Act is to provide standards for:

A. Identifying deceased individuals whose deaths may require insurers to pay benefits or proceeds to beneficiaries in accordance with the terms of life insurance policies, annuity contracts or retained asset accounts; and

B. Locating beneficiaries of such deceased individuals and providing appropriate claims forms or instructions to such beneficiaries to make a claim.

Section 3. Definitions

For purposes of this Act:

A. “Annuity contract” does not include an annuity used to fund an employment-based retirement plan or program where:

(1) The insurer does not perform the record keeping services; or

(2) The insurer is not committed by the terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

B. “Beneficiary” or “beneficiaries” means the party or parties entitled or contingently entitled to receive the proceeds from a policy, an annuity contract or a retained asset account.

C. “Death master file” or “DMF” means the United States Social Security Administration’s Death Master File or any other database or service that is at least as comprehensive and accurate as the United States Social Security Administration’s Death Master File for determining that an individual has reportedly died.

D. “Death master file match” means a search of the DMF that results in a match of the social security number or name and date of birth of an insured made and validated in accordance with the requirements of Section 5A of this Act.

E. “Insured” means an individual identified in a policy, retained asset account or annuity contract whose death obligates the insurer to pay benefits or proceeds.

F. “Knowledge of death” means:

(1) Receipt of an original or valid copy of a certified death certificate;

(2) A death master file match; or

(3) Any other information in an insurer’s records from which the insurer should reasonably conclude that the insured has died.

G. “Lapse” means the termination of a policy resulting from nonpayment of premiums or, in the case of variable life and universal life insurance policies, the depletion of cash value below the amount needed to keep the policy in force.

H. (1) “Policy” means any policy or certificate of life insurance that provides a death benefit.

(2) “Policy” does not include:

(a) Any policy or certificate of life insurance that provides a death benefit under an employee welfare benefit plan subject to the federal Employee Retirement Income Security Act of 1974 (ERISA) for which the insurer does not provide recordkeeping services or under any federal employee benefit program;

(b) Preneed insurance;

(c) Any policy or certificate of credit life or mortgage life;

(d) Any accidental death or health policies, riders or certificates, including but not limited to disability and long-term care policies, riders or certificates; or

(e) Any policy issued to a group master policyholder for which the insurer does not provide recordkeeping services.

I. (1) "Preneed insurance" means any life insurance policy or certificate that is used in combination with, in support of, with an assignment to, or as a guarantee for a prearrangement agreement for goods and services to be provided at the time of and immediately following the death of the insured.

(2) Goods and services may include, but are not limited to embalming, cremation, body preparation, viewing or visitation, coffin or urn, memorial stone and transportation of the deceased.

(3) The status of the policy or contract as preneed insurance is determined at the time of issue in accordance with the policy form filing.

J. "Recordkeeping services" means those circumstances under which the insurer has agreed with a group life insurance policy holder or contract owner to be responsible for obtaining, maintaining and administering in its own or its agents' systems, information about each individual insured under an insured's group insurance contract (or a line of coverage thereunder), which shall include at least the following information:

(1) Social security number or name and date of birth;

(2) Beneficiary designation information;

(3) Coverage eligibility;

(4) Benefit amount; and

(5) Premium payment status.

K. (1) "Records" means information regarding policies, annuity contracts and retained asset accounts maintained in the insurer's administrative systems or the administrative systems of any third party retained by the insurer.

(2) “Records” does not include such information maintained by a group life insurance policyholder or contract owner.

L. “Retained asset account” means any mechanism whereby the settlement of proceeds payable under a policy or individual annuity contract, including, but not limited to, the payment of cash surrender value, is accomplished by the insurer or an entity acting on behalf of the insurer establishing an account with check or draft-writing privileges, where those proceeds are retained by the insurer, pursuant to a supplementary contract not involving annuity benefits.

M. “Retained asset account holder” means the owner of a retained asset account or other person to file a claim for, or otherwise receive proceeds in accordance with the terms of the retained asset account.

N. “Thorough search” means reasonable and good faith efforts, which an insurer shall document, to identify a beneficiary, determine a current address for the beneficiary and contact the beneficiary.

Drafting Note: When assessing whether an insurer has used reasonable and good faith efforts in conducting a thorough search, as required under Section 5D of this Act and Section 5H of this Act, states may want to consider whether the insurer searched its records, which means information regarding in-force and certain lapsed policies, annuity contracts and retained asset accounts maintained on the insurer’s administrative systems or the administrative systems of any third party retained by the insurer. States also may want to consider whether the insurer conducted an online search or used any other type of available locator tool to attempt to identify a beneficiary, determine a current address for the beneficiary and contact the beneficiary. In addition, in situations where a beneficiary is unknown or there is no last known address for the beneficiary, if the insurer uses the beneficiary’s last known address maintained in its records to identify a beneficiary, determine a current address for the beneficiary and contact the beneficiary, states may want to consider this attempt as a thorough search for that beneficiary.

Section 4. Applicability and Scope

A. The requirements of this Act shall apply to all in-force and future policies, annuity contracts and retained asset accounts as of the effective date of this Act and policies that have lapsed within eighteen (18) months prior to the effective date of this Act.

Drafting Note: Subsection A above provides for a retroactive application of the requirements of this Act. Each state should conduct its own legal analysis and review of its laws, case law and any other relevant authority to determine whether, and in what

circumstances, retroactive laws are permitted in the state and whether the statute must expressly provide that it is intended to be retroactive.

B. This Act shall not apply to a policy, annuity contract or retained asset account of an insurer unless:

(1) The insurer is domiciled in this state; or

(2) The policy, annuity contract or retained asset account was issued or delivered in this state.

Section 5. Insurer Conduct

A. An insurer shall comply with the following requirements for performing a comparison of its policies, annuity contracts and retained asset accounts against the death master file:

(1) Initially, an insurer shall compare all in-force policies, annuity contracts and retained asset accounts and policies that have lapsed within eighteen (18) months prior to the effective date of this Act in its records against the complete death master file to identify potential matches of its insureds using the search criteria in Paragraph (4).

Drafting Note: States may want to include language in Paragraph (1) providing that the first DMF comparison search insurers must make should take place within [x] months after the effective date of the Act.

(2) Thereafter, an insurer shall compare all in-force policies, annuity contracts and retained asset accounts and policies that have lapsed within eighteen (18) months in its records against any updates to the death master file on at least a semi-annual basis to identify potential matches of its insureds using the search criteria in Paragraph (4). If the insurer conducts death master file searches for any of its other lines of insurance business more frequently than semiannually, the insurer shall conduct a death master file search of all lines of business with the same frequency.

(3) (a) Except as provided in Subparagraph (b) of this paragraph, within six (6) months of acquisition of policies or annuity contracts from another insurer, the acquiring insurer shall compare all newly acquired policies and annuity contracts that were not searched by the previous insurer in compliance with this Act against the complete death master file to identify potential

matches of its insureds and annuitants using the search criteria in Paragraph (4).

(b) Upon any subsequent acquisition of policies or annuity contracts from another insurer, when the previous insurer has already conducted a search of the newly acquired policies and annuity contracts using the complete death master file, the acquiring insurer shall compare all newly acquired policies and annuity contracts using all of the death master file updates since the time the previous insurer conducted the complete search to identify potential matches of its insureds and annuitants using the search criteria in Paragraph (4).

(4) In addition to accounting for exact matches of names, social security numbers and dates of birth, every insurer also shall conduct the comparisons required under this subsection following reasonable procedures that account for:

(a) Initials used in lieu of a first or middle name, use of a middle name, compound first and middle names, and interchanged first and middle names;

(b) Compound last names, maiden or married names, and hyphens, blank spaces or apostrophes in last names;

(c) Transposition of the “month” and “date” portions of the date of birth;

(d) Incomplete social security number; and

(e) Common data entry errors that account for transposed numbers.

(5) Upon identifying a potential match pursuant to this section, an insurer shall promptly make reasonable good faith efforts to validate the match by confirming the death of an insured.

B. (1) (a) The commissioner may exempt an insurer from the DMF comparisons required under Subsection A if the insurer demonstrates to the commissioner’s satisfaction that compliance would result in financial hardship to the insurer or is not cost effective.

(b) In making a determination under Subparagraph (a), the commissioner, among other things, may consider the number of

policies involved, the costs of conducting a retroactive search in relation to the collected premiums for those policies, whether the policy information is stored electronically and whether the insurer previously has engaged in the use of the DMF for its annuity contracts, but not for its life insurance policies.

(2) The commissioner may phase in the requirements for compliance with Subsection A according to a plan and timeline the commissioner approves.

C. (1) Upon receipt of information establishing knowledge of death, other than when an insurer has made a match pursuant to Subsection A, the insurer shall check its records to determine whether the insurer has any other policies, annuity contracts or retained asset accounts for that insured.

(2) Upon receipt of information establishing knowledge of death of an insured the insurer shall:

(a) Notify each United States affiliate, parent or subsidiary, as appropriate, and any entity with which the insurer contracts that may maintain or control records related to policies, annuity contracts or retained asset accounts to which this Act applies of the knowledge of death or match; and

(b) Make a reasonable and good faith effort to ensure that each affiliate, parent or subsidiary or other entity performs a check of their records for purposes of Paragraph (1).

D. Following 120 days of an insurer's receipt of information establishing the insurer's knowledge of death, if the insurer has not been contacted by a beneficiary, the insurer shall commence a thorough search, which shall be completed within one year from the date the insurer received such information.

Drafting Note: In deciding the appropriate timeframe for Subsection D above, states should review the timeframes in their unclaimed property laws and regulations and other laws and regulations, such as their claim settlement laws or regulations, to avoid any potential conflicts.

E. An insurer may disclose the minimum necessary personal information about an insured or beneficiary to a person to whom the insurer reasonably believes may be able to assist the insurer to locate the beneficiary or a person otherwise entitled to payment of the proceeds, provided that the insurer may not implement policies or practices that will or may diminish the rights of or

amounts of proceeds due to beneficiaries under its policies, annuity contracts or retained asset accounts.

F. An insurer or its service provider may not charge any beneficiary or other authorized representative for any fees or costs associated with a death master file search or verification of a death master file match conducted pursuant to this section.

G. If the insurer locates a beneficiary, within fifteen (15) days after the date of location, the insurer shall provide appropriate claims forms or instructions to the beneficiary to make a claim if the insurer has not already received a claim from that beneficiary.

H. In the event, an insurer fails to locate a beneficiary following a thorough search the insurer shall report and remit the proceeds in accordance with [cite state unclaimed property law].

Drafting Note: States need to be aware that under federal law another state may require an insurer to report and remit proceeds as unclaimed property even if the insurer is not domiciled in the other state and even if the policy, annuity contract or retained asset account was not issued or delivered in this state. Under Texas v. New Jersey, 379 U.S. 674 (1965) and its progeny, the U.S. Supreme Court has held that "the State of the last known address of the creditor, as shown by the debtor's books and records" has priority over all other states in requiring a holder (including an insurer) to report and remit unclaimed property. This obligation to report and remit unclaimed property cannot be waived by the terms of an insurance contract. See Connecticut Mutual Life Insurance Co. v. Moore, 333 U.S. 541 (1947). Under the Revised Uniform Unclaimed Property Act and the unclaimed property laws of most states, the address of the insured is the default address for determining which state has priority in requiring the insurer to report and remit the proceeds as unclaimed property.

Drafting Note: The NAIC group that developed this Act intends to recommend that the NAIC require insurers subject to the Act to report annually to the state insurance commissioner information concerning the number and amount of policy, annuity contract and retained asset account proceeds transferred to the state unclaimed property funds and the number and amount of policy, annuity contract and retained asset account proceeds provided to beneficiaries as a result of the death master file matches made in accordance with the search requirements of this Act in the format and manner the NAIC considers appropriate, such as through an annual statement blank note, disclosure or exhibit, market conduct annual statement report or some other format and manner that promotes the uniformity of the information collected. If the NAIC does not establish the reporting requirement, states should consider establishing such a requirement.

I. (1) Except as set forth in Paragraph (2), at no later than the policy delivery or the establishment of an account and upon any change of insured or beneficiary, an insurer shall request information sufficient to ensure that all benefits or proceeds are distributed to the appropriate persons upon the death of the insured including, at a minimum, the name, address, date of birth, social security number, and telephone number of every insured and beneficiary of such policy or account, as applicable.

(2) Where an insurer issues a policy or provides an account based on information received directly from an insured's employer, the insurer may obtain the beneficiary information described in Paragraph (1) by communicating with the insured after the insurer's receipt of the information from the insured's employer.

Section 6. Unfair Insurance Practices

Failure to meet any requirement of this Act with such frequency as to constitute a general practice is a violation of [insert reference to the state Unfair Trade Practices law]. Nothing herein shall be construed to create or imply a private right of action for a violation of this Act.

Drafting note: Some states' Unfair Trade Practices statutes specify that an act must be shown to be a "pattern" or "general business practice" in order to constitute a violation of that statute. In those instances, care should be taken in the adoption of this Act to ensure consistency across those two statutes.

[Section 7. Unfair Insurance Practices

The [insert reference to state unfair insurance practices code] is amended by changing [section xxx] as follows: [provide amended language].]

Section 8. Regulations

The commissioner may, after notice and hearing, promulgate regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert reference to state law relating to the adoption and promulgation of rules and regulations or state Administrative Procedures Act].

Section 9. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the

provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 10. Effective Date

This Act shall take effect no more than one year after the date signed into law.

Drafting Note: States may want to include language providing that the first DMF comparison search insurers must make should take place within [x] months after the effective date of the Act. States should be mindful of the time between the Act's effective date and the first required DMF comparison search.

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

Proposed Model Act Regarding Network Adequacy and Use of Out-of-Network Providers*

To be considered by the NCOIL Health, LTC & Health Retirement Issues Committee on November 19, 2016. ***Sponsored by Sen. James Seward, NY***

Table of Contents

Section 1 Short Title

This Act may be called the *Model Act Regarding Network Adequacy and Use of Out-of-Network Providers*.

Section 2 Purpose

The purpose of this Act is to protect consumers from unexpected medical bills as a result of using out-of-network physicians. New network adequacy requirements, improved disclosures from insurers and providers to consumers, and a procedure for appealing out-of-network referral denials will help consumers better navigate the insurance process and reduce the incidence of costly, surprise bills.

Section 3 Network Coverage

A. An insurer that issues a health insurance policy or contract with a network of healthcare providers shall ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. The

commissioner shall review the network of health care providers for adequacy at the time of the commissioner's initial approval of a health insurance policy or contract; at least every three years thereafter; and upon application for expansion of any service area associated with the policy or contract. To the extent that the network has been determined by the commissioner of health to meet the standards set forth in *[insert applicable section of public health law]*, such network shall be deemed adequate by the commissioner.

B. An insurer that issues a comprehensive group or group remittance health insurance policy or contract that covers out-of-network health care services shall make available and, if requested by the policyholder or contract holder, provide at least one option for coverage for at least eighty percent of the usual and customary cost of each out-of-network healthcare service after imposition of a deductible or any permissible benefit maximum.

C. If there is no coverage available pursuant to subparagraph (B) of this section in a rating region, then the commissioner may require an insurer issuing a comprehensive group or group remittance health insurance policy or contract in the rating region, to make available and, if requested by the policyholder or contract holder, provide at least one option for coverage of eighty percent of the usual and customary cost of each out-of-network health care service after imposition of any permissible deductible or benefit maximum. The commissioner may, after giving consideration to the public interest, permit an insurer to satisfy the requirements of this paragraph on behalf of another insurer, corporation, or health maintenance organization within the same holding company system. The commissioner may, upon written request, waive the requirement for coverage of out-of-network health care services to be made available pursuant to this subparagraph if the commissioner determines that it would pose an undue hardship upon an insurer.

D. For the purposes of this subsection, "usual and customary cost" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner. The nonprofit organization shall not be affiliated with an insurer.

E. This subsection shall not apply to emergency care services in hospital facilities or pre-hospital emergency medical services as defined by *[insert applicable section of state law]*.

F. Nothing in this subsection shall limit the commissioner's authority to establish minimum standards for the form, content, and sale of accident and health insurance policies and subscriber contracts, to require additional coverage

options for out-of-network services, or to provide for standardization and simplification of coverage.

G. When an insured or enrollee under a contract or policy that provides coverage for emergency services receives the services from a health care provider that does not participate in the provider network of an insurer, the health care plan shall ensure that the insured or enrollee shall incur no greater out-of-pocket costs for the emergency services than the insured or enrollee would have incurred with a health care provider that participates in the health care plan's provider network.

a. For the purpose of this section, "emergency services" includes any healthcare services provided in a healthcare facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part

[Drafting note: The definition of "emergency services" is identical to the "emergency medical care" definition in the 2011 NCOIL Healthcare Balance Billing Disclosure Model Act.]

Section 4 Insurer Notice to Consumers

A. Where applicable, an insurer must give notice to an insured that:

a. an insured enrolled in a managed care product or in a comprehensive contract that utilizes a network of providers offered by the corporation may obtain a referral or preauthorization for a health care provider outside of the corporation's network or panel when the corporation does not have a health care provider who is geographically accessible to the insured and who has the appropriate training and experience in the network or panel to meet the particular health care needs of the subscriber and the procedure by which the subscriber can obtain such referral or preauthorization;

b. an insured enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation with a

condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

c. an insured enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation with (1) a life-threatening condition or disease, or (2) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the subscriber's medical care and the procedure for requesting and obtaining such a specialist;

d. an insured enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation with (1) a life-threatening condition or disease, or (2) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request access to a specialty care center and the procedure by which such access may be obtained;

e. an enrollee shall have direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy

B. Where applicable, an insurer must give to an insured:

a. a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the insurer’s website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer’s network or a change in a physician's hospital affiliation;

b. with respect to out-of-network coverage:

(1) a clear description of the methodology used by the insurer to determine reimbursement for out-of-network health care services;

(2) a description of the amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a

percentage of the usual and customary cost for out-of-network health care services; and

(3) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; and

c. information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services

Section 5 Out-of-Network Referral Denials

A. “Out-of-network referral denial" means a denial under a managed care product of a request for an authorization or referral to an out-of-network provider on the basis that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service. The notice of an out-of-network referral denial provided to an insured shall include information explaining what information the insured must submit in order to appeal the out-of-network referral denial. An out-of-network referral denial under this subsection does not constitute an adverse determination.

B. A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information. To the extent practicable, such written notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification shall identify:

a. whether the services are considered in-network or out-of-network;

b. whether the insured will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment, co-insurance or deductible;

c. as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and

d. as applicable, information explaining how an insured may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services

C. An insured or the insured's designee may appeal an out-of-network referral denial by a health care plan by submitting a written statement from the insured's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, provided that:

a. the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of the insured for the health service; and

b. the attending physician recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the insured, and who is able to provide the requested health service

D. For external appeals requested relating to an out-of-network referral denial, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the out-of-network referral shall be covered by the health plan, provided that such determination shall:

a. be conducted only by one or a greater odd number of clinical peer reviewers;

b. be accompanied by a written statement:

(1) that the out-of-network referral shall be covered by the health care plan either when the reviewer or a majority of the panel of reviewers determines, upon review of the training and experience of the in-network health care provider or providers proposed by the plan, the training and experience of the requested out-of-network provider, the clinical standards of the plan, the information provided concerning the insured, the attending physician's recommendation, the insured's medical record, and any other pertinent information, that the health plan does not have a provider with the appropriate training and experience to meet the particular health care needs of an insured who is able to provide the requested health service, and that the out-of-network provider has the appropriate training and experience to meet the particular health care

needs of an insured, is able to provide the requested health service, and is likely to produce a more clinically beneficial outcome; or

(2) upholding the health plan's denial of coverage

c. be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan;

d. be binding on the plan and the insured; and

e. be admissible in any court proceeding

Section 6 Provider Notice to Consumers

A. A health care professional, or a group practice of health care professionals, a diagnostic and treatment center or a health center on behalf of health care professionals rendering services at the group practice, diagnostic and treatment center or health center, shall disclose to patients or prospective patients in writing or through an internet website the health care plans in which the health care professional, group practice, diagnostic and treatment center or health center, is a participating provider and the hospitals with which the health care professional is affiliated prior to the provision of non-emergency services and verbally at the time an appointment is scheduled.

B. If a health care professional, or a group practice of health care professionals, a diagnostic and treatment center or a health center on behalf of health care professionals rendering services at the group practice, diagnostic and treatment center or health center, does not participate in the network of a patient's or prospective patient's health care plan, the health care professional, group practice, diagnostic and treatment center or health center, shall:

a. prior to the provision of non-emergency services, inform a patient or prospective patient that the amount or estimated amount the health care professional will bill the patient for health care services is available upon request; and

b. upon receipt of a request from a patient or prospective patient, disclose to the patient or prospective patient in writing the amount or estimated amount or, with respect to a health center, a schedule of fees that the health care professional, group practice, diagnostic and treatment center or health center, will bill the patient or prospective patient for health care services provided or anticipated to be provided to the patient or prospective patient absent unforeseen medical circumstances that may arise when the health care services are provided.

C. A health care professional who is a physician shall provide a patient or prospective patient with the name, practice name, mailing address, and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology or assistant surgeon services in connection with care to be provided in the physician's office for the patient or coordinated or referred by the physician for the patient at the time of referral to or coordination of services with such provider.

D. A health care professional who is a physician shall, for a patient's scheduled hospital admission or scheduled outpatient hospital services, provide a patient and the hospital with the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time of the pre-admission testing, registration or admission at the time non-emergency services are scheduled; and information as to how to determine the healthcare plans in which the physician participates.

E. A hospital shall establish, update and make public through posting on the hospital's website, to the extent required by federal guidelines, a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the federal social security act.

F. A hospital shall post on the hospital's website:

a. the health care plans in which the hospital is a participating provider;

b. a statement that:

(1) physician services provided in the hospital are not included in the hospital's charges;

(2) physicians who provide services in the hospital may or may not participate with the same health care plans as the hospital, and

(3) the prospective patient should check with the physician arranging for the hospital services to determine the health care plans in which the physician participates

c. as applicable, the name, mailing address and telephone number of the physician groups that the hospital has contracted with to provide services including anesthesiology, pathology or radiology, and instructions how to contact these groups to determine the health care plan participation of the physicians in these groups; and

d. as applicable, the name, mailing address, and telephone number of physicians employed by the hospital and whose services may be provided at the hospital, and the health care plans in which they participate

G. In registration or admission materials provided in advance of non-emergency hospital services, a hospital shall:

a. advise the patient or prospective patient to check with the physician arranging the hospital services to determine:

(1) the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician; and

(2) whether the services of physicians who are employed or contracted by the hospital to provide services including anesthesiology, pathology and/or radiology is reasonably anticipated to be provided to the patient; and

b. provide patients or prospective patients with information as to how to timely determine the health care plans participated in by physicians who are reasonably anticipated to provide services to the patient at the hospital, as determined by the physician arranging the patient's hospital services, and who are employees of the hospital or contracted by the hospital to provide services including anesthesiology, radiology and/or pathology

Section 7 Effective Date

This Act shall take effect on *[insert months]* following enactment.

** Based on provisions in New York State's 2014-15 budget bill, S.2551 (2013).*

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August 12, 2016

The Honorable Jim L. Ridling
Commissioner, Alabama Department of Insurance
Chair, NAIC Governance Review Task Force
c/o John Bauer, Esq.
Via e-mail: jbauer@naic.org

Re: NAIC Governance Review Task Force Administrative Due Process Issues

Dear Commissioner Ridling,

Please accept these comments on behalf of the National Conference of Insurance Legislators (NCOIL). NCOIL is a legislative organization comprised principally of legislators serving on state insurance and financial institutions committees around the nation. NCOIL writes Model Laws in insurance, works to both preserve the state jurisdiction over insurance as established by the McCarran-Ferguson Act seventy years ago and to serve as an educational forum for public policy makers and interested parties. Founded in 1969, NCOIL works to assert the prerogative of legislators in making state policy when it comes to insurance and educate state legislators on current and perennial insurance issues.

NCOIL appreciates the opportunity to offer comments on the NAIC Governance Review Task Force's (Task Force) efforts to improve upon its administrative due process. NCOIL believes that part of the reason why the U.S. state-based system of insurance regulation has consistently and effectively protected both consumers and company solvency throughout the years is the open and transparent method in which the laws and regulations are developed and enacted. However, as noted by the Task Force, some of NAIC's work product has the force of law without any further action required by a State (e.g. financial statement blanks, *Accounting Practices and Procedures Manual*, and *Valuation Manual*). This is because the NAIC Models enacted in States have incorporated by reference certain NAIC work product such as the Manuals mentioned above.

As a group that focuses on ensuring that State insurance legislators are equipped with the most up-to-date knowledge about new and recurring insurance issues and how they may affect their respective States and the insurance industry as a whole, NCOIL is very concerned about NAIC's ability to internally make a policy decision by way of amending

one of its manuals or handbooks, and have that policy decision automatically become law in a State without further action.

Accordingly, NCOIL supports the suggestion from the National Association of Mutual Insurance Companies (NAMIC) of having proposed changes to NAIC work product submitted to NCOIL with a 60-day comment and review period, followed by an open meeting where all comments are discussed. The current process of developing or making changes to NAIC work product such as its manuals and handbooks is entirely internal within the NAIC – there is no review by an independent, separately accountable group. In contrast, as noted in slide 10 and in the comments submitted by NAMIC, when State agencies set policy through rulemaking, many States' impose legislative committee oversight and/or approval requirements.

NAMIC's suggestion of having NCOIL operate as the clearinghouse for proposed changes and comments to certain NAIC work product represents a tremendous opportunity for NCOIL and NAIC to work together to ensure that any proposed changes undergo an external review process. Obtaining valuable input from State insurance legislators on proposed changes to NAIC work product would surely be beneficial to the optics surrounding NAIC's administrative due process and to the work product itself.

We hope that these comments are helpful to the Task Force as it continues its important work. Thank you for the opportunity to comment and please do not hesitate to contact me with any questions.

With appreciation for your consideration and kind regards, I am,

Very truly yours,

Thomas B. Considine
NCOIL CEO

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December 7, 2016

The Honorable Jim L. Ridling
Commissioner, Alabama Department of Insurance
Chair, NAIC Governance Review Task Force
c/o John Bauer, Esq.
Via e-mail: jbauer@naic.org

Re: NAIC Governance Review Task Force Administrative Due Process Issues

Dear Commissioner Ridling,

Thank you for allowing the National Conference of Insurance Legislators (NCOIL) to again offer comments on the NAIC Governance Review Task Force's (Task Force) efforts to improve upon its administrative due process. As you know, our previous comments focused on the NAIC's incorporation by reference (IBR) authority which is essentially the ability for NAIC to internally make a policy decision by way of amending one if its manuals or handbooks, and have that policy decision automatically become law in a State without further action. We supported the suggestion from the National Association of Mutual Insurance Companies (NAMIC) of having proposed changes to NAIC work product submitted to NCOIL with a 60-day comment and review period, followed by an open meeting where all comments were discussed. We noted that the current process of developing or making changes to NAIC work product such as its manuals and handbooks is entirely internal within the NAIC – there is no review by an independent, separately accountable group. In contrast, when State agencies set policy through rulemaking, many States' impose legislative committee oversight and/or approval requirements.

Unfortunately, our suggestion was not well received. During the conference calls held on September 13, 2016, and November 14, 2016, representatives from California and Vermont were strongly opposed to our suggestion. Our member legislators were surprised and frankly dismayed that a number of NAIC members found any independent oversight of NAIC work product to be highly objectionable. Additionally, in a memo to the Task Force dated November 9, 2016, NAIC staff noted that there were no complaints from State legislative groups on this issue. It is important to note that rather than complain, NCOIL came forward with this proactive suggestion to work cooperatively to improve the process.

During the NCOIL-NAIC Dialogue at our recent Annual Meeting in Las Vegas, Nevada, Director John Huff stated that it is important to have the IBR process be as open and

transparent as possible and efforts are being made to do that. However, Director Huff also stated that the NAIC believes that adding another level of review to the IBR process as proposed by NCOIL does not add any value. Additionally, Director Huff stated that NCOIL is free to do everything it proposes within the current process in terms of sharing regulatory proposals and aggregating states' comments. While NCOIL could do this on its own, it would not make it part of the official, systematic process, and thereby incorporate independence into that process. While transparency is good, transparency plus independence is inarguably better.

Director Huff further stated that the NAIC is willing to involve NCOIL members with technical changes in a process similar to the conference call that was held to review the revised draft of the NAIC Insurance Data Security Model Law. While NCOIL appreciates that offer, the problem is that many of the changes labeled by the NAIC as "technical" are in fact substantive in nature and represent sweeping policy changes done without any legislative involvement. This was never the intent of IBR, and the legislators comprising NCOIL's membership believe strongly that it supports independent legislative oversight of the IBR process. We will examine the Financial Condition Examiners Handbook and the Accounting Practices and Procedures Manual for such examples. The latter of these, the Codification project, makes clear from its very name that the changes involved were far more than technical adjustments. Frankly, I remember at the time being mystified how the NAIC could make this Codification change without doing at least a Model Regulation, if not a Model Law.

Financial Condition Examiners Handbook

The Financial Condition Examiners Handbook has undergone significant rewrites in the past decade. These changes, most of which were related to the NAIC Solvency Modernization Initiative, a response to international pressures, squarely fall within the realm of policymaking, not technical accounting guidance, as NAIC cited at the NCOIL Annual Meeting.

We can look to NAIC's own words in the international community for illustrations of this point. One example of NAIC's admission of the extent to which this policymaking by handbook has taken place are the NAIC's self-assessments for the International Monetary Fund's Financial Sector Assessment Program (FSAP) reviews of the U.S. regulatory system for compliance with the International Association of Insurance Supervisors (IAIS) Insurance Core Principles (ICPs). The ICPs by definition are "Principles" and on their face clearly have a policymaking purpose both in name and function.

For instance, ICP 7, Corporate Governance, requires that "The supervisor requires insurers to establish and implement a corporate governance framework which provides for sound and prudent management and oversight of the insurer's business and adequately recognizes and protects the interests of policyholders."

In its self-assessment, NAIC explained that it had met the substantive requirements of this Principle through additions to the NAIC Financial Condition Examiners Handbook:

> "U.S. insurance supervisors address many of the corporate governance criteria … through conducting on-site inspections. The NAIC Financial Condition Examiners Handbook recognizes corporate governance assessment as a critical step in planning an effective financial examination. In order to complete an examination under the risk-focused surveillance approach, examiners must consider and evaluate the insurer's corporate governance and established risk management processes. By understanding the corporate governance structure the examiner will obtain information on the quality of guidance and oversight provided by the Board and the effectiveness of management. Recently, as a result of Solvency Modernization Initiative efforts, the United States has developed additional guidance for regulator use in these areas."

These changes to the Examiners Handbook were extensively tailored to the ICPs. ICP 7.1 instructs that "The supervisor requires the insurer's Board to set and oversee the implementation of the insurer's business objectives and strategies for achieving those objectives, including its risk strategy and risk appetite, in line with the insurer's long term interests and viability."

The NAIC explained:

> "Current law sets requirements for the legal duties of individual Board members (e.g., duty of care, duty of loyalty, etc.); there are additional expectations for Board involvement as outlined in the Examiners Handbook. In relation to the Board's role in overseeing risk strategy and risk appetite, the NAIC adopted the Risk Management and Own Risk and Solvency Assessment Model Act (RMORSA Model Act #505) in 2013 to outline expectations for insurers in this area. As a result of these new developments, large insurers will be required to provide detailed information regarding Board oversight of risk management practices through the filing of an ORSA Summary Report as early as 2015. Also, it is anticipated that all insurers will be required to disclose the Board's role in risk management oversight through a Corporate Governance Annual Disclosure beginning as early as 2016."

Unpacking this response, one sees that NAIC IBR work products provide the entire substantive response to this requirement: fiduciary duties are enforced under the common law, not by insurance regulators; the "expectations for Board involvement" that are "outlined in the Examiners Handbook" are by definition substantive requirements; and the substance of the ORSA is contained not in the model law or regulation but in the incorporated by reference ORSA manual.

The Handbooks' lead role in the NAIC's implementation of corporate governance policy is extensive and goes on repeatedly. NAIC's self-assessment similarly referenced the Handbooks in its responses to ICP 7.2 (allocation of responsibilities between the board and management; NAIC responded that "Guidance in the analysis and examination handbooks

provides an overview of appropriate roles and responsibilities in these areas."); ICP 7.3 (board composition, practices, and powers; NAIC referenced "guidance in the Handbooks" with respect to eight enumerated areas); ICP 7.5 (board oversight of risk management and internal controls; NAIC referenced "guidance in the handbooks addressing best practices in these areas"); ICP 7.9 (board policies and procedures over senior management regarding operations, culture, risk management, and regulatory communication; NAIC referenced "guidance/expectations in this area … outlined in the handbooks" in six enumerated areas).

The NAIC self-assessment followed a similar pattern in its responses pertaining to ICP 8, Risk Management and Internal Controls, providing such responses to ICP 8 (requiring effective such systems; NAIC responded that the "Examiners Handbook … states that risk mitigation strategies/controls are generally based on five overarching principles, which are applicable to all critical activities of an insurer. Compliance with the Examiners Handbook is required under the Accreditation Program [listing the five enumerated principles]."); ICP 8.3 (requiring effective risk management function; NAIC response begins, "The NAIC Financial Condition Examiners Handbook provides guidance in this area to be considered in assessing the risk management practices of insurers (Exhibit M)."); ICP 8.4 (requiring effective compliance function; NAIC response begins, "The Examination Handbook provides guidance in this area to be considered in assessing the compliance function of insurers—both compliance with laws and regulations as well as internal policies and limits."); ICP 8.6 (requiring effective internal audit function; NAIC responded that "NAIC Financial Condition Examiners Handbook outlines the appropriate role of an internal audit function.").

In addition, with respect to suitability (ICP 5), NAIC added extensive provisions to the Examiners Handbook in 2013. According to the draft of these changes prepared by the Financial Examiners Handbook Technical Group, "The proposed handbook revisions were drafted to include consideration for certain governance principles highlighted in the International Association of Insurance Supervisors Insurance Core Principles in preparation for the upcoming FSAP review."

Furthermore, with respect to corporate governance and suitability, NAIC added large parts of the substantive provisions in its new Corporate Governance Disclosure Models to the Financial Analysis Handbook, which is partially incorporated by reference in many state laws and as a practical matter is widely used in the States. This is another example of lawmaking by Handbook, since the CGAD Models have not yet been widely adopted, have not yet been adopted as an accreditation standard, yet their substantive provisions are being implemented via the states' use of the Analysis Handbook. (See p. 2-152 of the 2015 Analysis Handbook, "Compliance with Corporate Governance Disclosure Requirements. 1. Does the disclosure provide information regarding the following areas as required by Model #306 [followed by three pages of substantive provisions taken mostly verbatim from the CGAD Model Regulation].")[3]

[3] See 2014 NAIC FSAP self-assessment ("In addition, as aforementioned the Corporate Governance Annual Disclosure Model Act and accompanying Corporate Governance Annual Disclosure Model Regulation was adopted at the NAIC Corporate Governance Working Group at the Summer 2014 National Meeting. This model law and supporting regulation will require insurers to report detailed information on

As discussed above, NAIC referred extensively to passages in the Examiners Handbook regarding corporate governance, internal controls, and suitability in its FSAP self-assessment. These provisions, totaling scores if not hundreds of pages, were added following the NAIC's four year comprehensive rewrite of that Handbook between 2002-2006, implemented in the 2007 edition. These were substantive changes that resulted in changes to the substantive insurance law of the states.

The substantive, non-technical nature of these provisions is clear from a review of their extensive text as well as the Handbook's lengthy preamble and introduction, which spend 15 pages simply introducing the reader to the new concepts that are to come in the rest of the tome, explaining that:

> • The NAIC engaged in a multi-year project "to review and enhance the utilization of risk assessment … in the regulation of financial solvency" and "recognized the need to develop modifications to this Handbook to incorporate an enhanced risk-assessment process and new risk assessment tools."
>
> • Risk assessment was a fundamentally different approach going far beyond running the numbers as before. "A broader, organization-wide business risk assessment including strategic and operational issues enhances the process for evaluating the entire solvency risks inherent in an insurer's operations."
>
> • This was recognized as a major change. "Due to the extent of the new tools established within the Handbook and the need to administer a comprehensive training program among the states on the revised approach, the revisions to this guidance were considered significant enough for accreditation purposes."
>
> • These changes became mandatory policy in every state. "[A]s the risk-focused surveillance approach within this Handbook is a set process, examiners are not able to choose between the conceptual approach initially included within this Handbook and those included within earlier editions."
>
> • The heart of the changes involved non-technical, non-accounting reviews. "In order to complete an examination under the risk-focused surveillance approach, examiners must consider and evaluate the insurer's corporate governance and established risk management processes. By understanding the corporate governance structure and assessing the 'tone at the top,' the examiner will obtain information on the quality of guidance and oversight provided by the board of directors and the effectiveness of management."
>
> • This included implementation of new policies that on their face have no direct relationship to balance sheet regulation. "Consideration of 'other than financial'

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governance practices on an annual basis. As this information is intended to be reported to regulators starting in 2016, additional regulatory guidance will be added into the analysis and examination handbooks and manuals to explain how this information may be used in the regulatory assessment process.").

> risks. One of the increased benefits of the enhanced risk-focused approach is the expansion of the examiner's consideration from the retrospective verification of financial condition, to include consideration of other than financial risks that could impact the insurer's future solvency."
>
> • The Handbook describes a qualitatively different approach to get at solvency evaluation through non-technical means. "Goals of risk-focused examinations. … Key goals of this process during the examination are to assess the quality and reliability of corporate governance to identify, assess and manage the risk environment facing the insurer in order to identify current or prospective solvency risk areas; and to assess the risks that a company's surplus is materially misstated."

When the NAIC Plenary adopted these changes in December 2006, the project history describing this massive undertaking ran nine pages, followed by what appears to be the relevant changes to the Handbook, which consume over 275 pages.

The corporate governance additions to the Handbook were a sea change: A word search performed upon the 2006 edition of the Handbook shows zero usages of the term "corporate governance," whereas today the term "corporate governance" appears in the Handbook at least 85 times. This constituted a major revision of the corporate governance law for insurers of the fifty states, and it was done via IBR.

The result of this is that state legislators throughout the country previously voted to incorporate a book by reference that arguably shared only a name with the new product that the NAIC produced at the end of 2006—but which, upon adoption by NAIC with no review or independent oversight by any public officials other than NAIC members (and with zero legislative involvement, participation, or supervision) automatically became the law in every U.S. jurisdiction. This strongly belies the picture that NAIC members painted in their dialogue with legislators at the recent NCOIL meeting. Again, the legislators comprising the membership of NCOIL find this troubling.

Accounting Practices and Procedures Manual

We find and note a similar scenario on a prior rewrite of another NAIC work product, the Accounting Procedures and Practices Manual.

A 2000 bulletin from the Maryland insurance commissioner explained that the NAIC had recently finished a nine year project known as NAIC Codification of Statutory Accounting Principles. "The purpose of the NAIC Codification is to establish a comprehensive basis of accounting, for insurance departments, insurers, and auditors that is recognized and adhered to in the absence of conflict with, or silence of, state statutes and/or regulations."

The Commissioner emphasized the massive nature of the changes and their expected substantial effect on insurers:

> "Impact on regulated entities: Many companies may see **major impacts** as a result of adopting the NAIC Codification. We can not stress enough the importance of assessing the impact of the adoption of the NAIC codification on your entity. … [T]he adoption of the NAIC Codification **may have a major impact on your entity's reported surplus. … This may require significant system changes. The assessment** of the impact of the NAIC Codification on your regulated entity **should start immediately**, and not be left to the last minute."

(Emphasis in original.)

One would think that such wholesale changes, representing a significant policy change, would require the approval of a state's elected policymakers, its legislators, through either statute or administrative rulemaking. After all, the name of the project was "Codification." Yet the NAIC implemented it unilaterally: When Codification was adopted internally at NAIC, it automatically became the law throughout the country.

What is most remarkable is that commissioners and others involved in the process explicitly stated that, because the new manual retained the title of the old manual, which was incorporated by reference in state law throughout the U.S., insurance commissioners would simply enforce the new NAIC work product as authoritative even though it had not been reviewed, voted on, or accepted in any way by their legislatures or even promulgated as new regulation:

> "The existing (1998) version of the NAIC Accounting Practices and Procedures Manual will be maintained until December 31, 2000. Subsequent to that date, effective January 1, 2001, Codification of Statutory Accounting Principles will be renamed the Accounting Practices and Procedures Manual. According to Code of Maryland Regulations 31.04.01.04 'A person who is required under Insurance Article, Annotated Code of Maryland or Health-General Article, Annotated Code of Maryland, to file an annual financial statement, interim financial statement, audited financial report, or annual actuarial opinion shall prepare the documents in accordance with the Annual Statement Instructions and the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners.' Since the 8 NAIC Codification is being named the NAIC Accounting Practices and Procedures Manual, current Maryland laws and regulations do not need to be amended for the State of Maryland to adopt the NAIC Codification."

The bulletin is clear that NAIC Codification was essentially a new manual, but since it was "being named the NAIC Accounting Practices and Procedures Manual," this major piece of policy-setting was not being run through democratic process, exposed to the legislative process or even exposed to the independent review of regulatory promulgation literally because it was being given a name that was already incorporated by reference in state law.

This appears to have been by design and intent. At the 2001 Valuation Actuary Symposium on "NAIC Statutory Reporting Codification," the presentation explained:

> The name of the guide continues to be the Accounting Practices and Procedures Manual. By keeping the name the same, there are a lot of efficiencies for certain states in adopting codification. That is because their laws and regulations already refer to the Accounting Practices and Procedures Manual; therefore, it was automatically adopted.

This was the express intent of NAIC, as explained in a trade press article. "If the task force recommendations are adopted, Connecticut will not need legislation to adopt codification because it follows the NAIC Accounting Practices and Procedures Manual and Codification will take the name of the manual. In fact, 35 states would not have to change their laws or regulations, including California, explained Norris Clark, chair of the working group of regulators that developed the codification project." National Underwriter, May 25, 1998.

Thus, rather than simply using IBR for technical changes, NAIC has a demonstrated history of implementing significant policy changes via a mechanism of revising its incorporated by reference work products such that once adopted by the NAIC, the new policies automatically become new substantive law in every State.

NAIC has multiple work products which are incorporated by reference in state law, allowing its new policies to become law through cross referencing of these work products. For instance, the Codification project was implemented nationally through a combination of NAIC products. A New York bulletin referenced a statutory provision which incorporated the NAIC Annual Statement Instructions by reference.

> "Section 307(a)(1) of the Insurance Law requires every insurer authorized in New York to file an annual statement showing its financial condition in such form as prescribed by the Superintendent. Section 307(a)(2) permits the use of the annual statement form adopted from time to time by the NAIC. The NAIC's instructions to insurers for completing their 2001 annual statement forms include the following: 'The annual statement is to be completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures Manual - version effective 9 January 1. 2001 except to the extent that: (1) state law may differ, or (2) state rules or regulations require differences in reporting. If guidance is not available from those sources, the domiciliary state's insurance regulatory authority should be consulted.'"

(Emphasis in original.)

To be clear, NCOIL's proposal is not an effort for NCOIL to serve as a "big brother" to NAIC but rather is an effort to move the IBR process forward in a more transparent fashion, and one that adds greater public and legislative confidence to the NAIC. As Commissioner

Jim Donelon noted in his letter of November 10th to this Task Force, the NAIC is "an instrumentality of the states" and therefore the administrative due process for regulatory promulgation at the individual state level should be extant at the NAIC level, including independent legislative oversight.

The current process, left unchanged, appears to be out of compliance with that which is required at the state level and NCOIL firmly believes that NAIC cannot exempt itself from oversight. Obtaining valuable input in a systematic way from State insurance legislators on proposed changes to NAIC work product would surely be beneficial to NAIC's administrative due process and to the work product itself. NCOIL stands ready and willing to assist the NAIC in bringing its process into compliance with the analogous APAs of the states, as set forth in our letter of August 12, 2016.

We hope that these comments are helpful to the Task Force as it continues its important work. Thank you for the opportunity to comment and please do not hesitate to contact me with any questions.

With appreciation for your consideration and kind regards, I am,

Very truly yours,

Thomas B. Considine
NCOIL CEO

NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES
PROPOSED
23 NYCRR 500

CYBERSECURITY REQUIREMENTS FOR FINANCIAL SERVICES COMPANIES

I, Maria T. Vullo, Superintendent of Financial Services, pursuant to the authority granted by sections 102, 201, 202, 301, 302 and 408 of the Financial Services Law, do hereby promulgate Part 500 of Title 23 of the Official Compilation of Codes, Rules and Regulations of the State of New York, to take effect upon publication in the State Register, to read as follows:

(ALL MATTER IS NEW)

Section 500.00 Introduction.

The New York State Department of Financial Services ("DFS") has been closely monitoring the ever-growing threat posed to information and financial systems by nation-states, terrorist organizations and independent criminal actors. Recently, cybercriminals have sought to exploit technological vulnerabilities to gain access to sensitive electronic data. Cybercriminals can cause significant financial losses for DFS regulated entities as well as for New York consumers whose private information may be revealed and/or stolen for illicit purposes. The financial services industry is a significant target of cybersecurity threats. DFS appreciates that many firms have proactively increased their cybersecurity programs with great success.

Given the seriousness of the issue and the risk to all regulated entities, certain regulatory minimum standards are warranted, while not being overly prescriptive so that cybersecurity programs can match the relevant risks and keep pace with technological advances. Accordingly, this regulation is designed to promote the protection of customer information as well as the information technology systems of regulated entities. This regulation requires each company to assess its specific risk profile and design a program that addresses its risks in a robust fashion. Senior management must take this issue seriously and be responsible for the organization's cybersecurity program and file an annual certification confirming compliance with these regulations. A regulated entity's cybersecurity program must ensure the safety and soundness of the institution and protect its customers.

It is critical for all regulated institutions that have not yet done so to move swiftly and urgently to adopt a cybersecurity program and for all regulated entities to be subject to minimum standards with respect to their programs. The number of cyber events has been steadily increasing and estimates of potential risk to our financial services industry are stark. Adoption of the program outlined in these regulations is a priority for New York State.

Section 500.01 Definitions.

For purposes of this Part only, the following definitions shall apply:

(a) *Affiliate* means any Person that controls, is controlled by or is under common control with another Person. For purposes of this subsection, control means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of stock of such Person or otherwise.

(b) *Authorized User* means any employee, contractor, agent or other Person that participates in the business operations of a Covered Entity and is authorized to access and use any Information Systems and data of the Covered Entity.

(c) *Covered Entity* means any Person operating under or required to operate under a license, registration, charter, certificate, permit, accreditation or similar authorization under the Banking Law, the Insurance Law or the Financial Services Law.

(d) *Cybersecurity Event* means any act or attempt, successful or unsuccessful, to gain unauthorized access to, disrupt or misuse an Information System or information stored on such Information System.

(e) *Information System* means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic information, as well as any specialized system such as industrial/process controls systems, telephone switching and private branch exchange systems, and environmental control systems.

(f) *Multi-Factor Authentication* means authentication through verification of at least two of the following types of authentication factors:

(1) Knowledge factors, such as a password; or

(2) Possession factors, such as a token or text message on a mobile phone; or

(3) Inherence factors, such as a biometric characteristic.

(g) *Nonpublic Information* shall mean all electronic information that is not Publicly Available Information and is:

(1) Business related information of a Covered Entity the tampering with which, or unauthorized disclosure, access or use of which, would cause a material adverse impact to the business, operations or security of the Covered Entity;

(2) Any information concerning an individual which because of name, number, personal mark, or other identifier can be used to identify such individual, in combination with any one or more of the following data elements: (i) social security number, (ii) drivers' license number or non-driver identification card number, (iii)account number, credit or debit card number, (iv) any security code, access code or password that would permit access to an individual's financial account; or (v) biometric records.

(3) Any information or data, except age or gender, in any form or medium created by or derived from a health care provider or an individual and that relates to (i) the past, present or future physical, mental or behavioral health or condition of any individual or a

member of the individual's family, (ii) the provision of health care to any individual, or (iii) payment for the provision of health care to any individual.

(h) *Person* means any individual or any non-governmental entity, including but not limited to any nongovernmental partnership, corporation, branch, agency or association.

(i) *Penetration Testing* means a test methodology in which assessors attempt to circumvent or defeat the security features of an Information System by attempting unauthorized penetration of databases or controls from outside or inside the Covered Entity's Information Systems.

(j) *Publicly Available Information* means any information that a Covered Entity has a reasonable basis to believe is lawfully made available to the general public from: federal, state or local government records; widely distributed media; or disclosures to the general public that are required to be made by federal, state or local law.

(1) For the purposes of this subsection, a Covered Entity has a reasonable basis to believe that information is lawfully made available to the general public if the Covered Entity has taken steps to determine:

(i) That the information is of the type that is available to the general public; and

(ii) Whether an individual can direct that the information not be made available to the general public and, if so, that such individual has not done so.

(k) *Risk Assessment* means the risk assessment that each Covered Entity is required to conduct under section 500.09 of this Part.

(l) *Risk-Based Authentication* means any risk-based system of authentication that detects anomalies or changes in the normal use patterns of a Person and requires additional verification of the Person's identity when such deviations or changes are detected, such as through the use of challenge questions.

(m) *Senior Officer(s)* means the senior individual or individuals (acting collectively or as a committee) responsible for the management, operations, security, information systems, compliance and/or risk of a Covered Entity, including a branch or agency of a foreign banking organization subject to this Part.

(n) *Third Party Service Provider(s)* means a Person that (i) is not an Affiliate of the Covered Entity, (ii) provides services to the Covered Entity, and (iii) maintains, processes or otherwise is permitted access to Nonpublic Information through its provision of services to the Covered Entity.

Section 500.02 Cybersecurity Program.

(a) Cybersecurity Program. Each Covered Entity shall maintain a cybersecurity program designed to protect the confidentiality, integrity and availability of the Covered Entity's Information Systems.

(b) The cybersecurity program shall be based on the Covered Entity's Risk Assessment and designed to perform the following core cybersecurity functions:

(1) identify and assess internal and external cybersecurity risks that may threaten the security or integrity of Nonpublic Information stored on the Covered Entity's Information Systems;

(2) use defensive infrastructure and the implementation of policies and procedures to protect the Covered Entity's Information Systems, and the Nonpublic Information stored on those Information Systems, from unauthorized access, use or other malicious acts;

(3) detect Cybersecurity Events;

(4) respond to identified or detected Cybersecurity Events to mitigate any negative effects;

(5) recover from Cybersecurity Events and restore normal operations and services; and

(6) fulfill applicable regulatory reporting obligations.

(c) A Covered Entity may meet the requirements of this Part by adopting a cybersecurity program maintained by an Affiliate, provided that the Affiliate's cybersecurity program covers the Covered Entity's Information Systems and Nonpublic Information and meets the requirements of this Part.

(d) All documentation and information relevant to the Covered Entity's cybersecurity program shall be made available to the superintendent upon request.

Section 500.03 Cybersecurity Policy.

(a) Cybersecurity Policy. Each Covered Entity shall implement and maintain a written policy or policies, approved by a Senior Officer or the Covered Entity's board of directors (or an appropriate committee thereof) or equivalent governing body, setting forth the Covered Entity's policies and procedures for the protection of its Information Systems and Nonpublic Information stored on those Information Systems. The cybersecurity policy shall be based on the Covered Entity's Risk Assessment and address the following areas to the extent applicable to the Covered Entity's operations:

(1) information security;

(2) data governance and classification;

(3) asset inventory and device management;

(4) access controls and identity management;

(5) business continuity and disaster recovery planning and resources;

(6) systems operations and availability concerns;

(7) systems and network security;

(8) systems and network monitoring;

(9) systems and application development and quality assurance;

(10) physical security and environmental controls;

(11) customer data privacy;

(12) vendor and Third Party Service Provider management;

(13) risk assessment; and

(14) incident response.

Section 500.04 Chief Information Security Officer.

(a) Chief Information Security Officer. Each Covered Entity shall designate a qualified individual responsible for overseeing and implementing the Covered Entity's cybersecurity program and enforcing its cybersecurity policy (for purposes of this Part, "Chief Information Security Officer" or "CISO"). The CISO may be employed by the Covered Entity, one of its Affiliates or a Third Party Service Provider. To the extent this requirement is met using a Third Party Service Provider or an Affiliate, the Covered Entity shall:

(1) retain responsibility for compliance with this Part;

(2) designate a senior member of the Covered Entity's personnel responsible for direction and oversight of the Third Party Service Provider; and

(3) require the Third Party Service Provider to maintain a cybersecurity program that protects the Covered Entity in accordance with the requirements of this Part.

(b) Report. The CISO of each Covered Entity shall report in writing at least annually to the Covered Entity's board of directors or equivalent governing body. If no such board of directors or equivalent governing body exists, such report shall be timely presented to a Senior Officer of the Covered Entity responsible for the Covered Entity's cybersecurity program. The CISO shall report on the Covered Entity's cybersecurity program and material cybersecurity risks. The CISO shall consider to the extent applicable:

(1) the confidentiality of Nonpublic Information and the integrity and security of the Covered Entity's Information Systems;

(2) the Covered Entity's cybersecurity policies and procedures;

(3) material cyber risks to the Covered Entity;

(4) overall effectiveness of the Covered Entity's cybersecurity program; and

(5) material Cybersecurity Events involving the Covered Entity during the time period addressed by the report.

Section 500.05 Penetration Testing and Vulnerability Assessments.

(a) The cybersecurity program for each Covered Entity shall include monitoring and testing, developed in accordance with the Covered Entity's Risk Assessment, designed to assess the effectiveness of the Covered Entity's cybersecurity program. The monitoring and testing shall include continuous monitoring or periodic penetration testing and vulnerability assessments, and shall be done periodically. Absent effective continuous monitoring, or other systems to detect, on an ongoing basis, changes in Information Systems that may create or indicate vulnerabilities, Covered Entities shall conduct:

(1) annual penetration testing of the Covered Entity's Information Systems determined each given year based on relevant identified risks in accordance with the Risk Assessment; and

(2) bi-annual vulnerability assessments, including any systematic scans or reviews of Information Systems reasonably designed to identify publicly known cybersecurity vulnerabilities in the Covered Entity's Information Systems based on the Risk Assessment.

Section 500.06 Audit Trail.

(a) Each Covered Entity shall securely maintain systems that, to the extent applicable and based on its Risk Assessment:

(1) are designed to reconstruct material financial transactions sufficient to support normal operations and obligations of the Covered Entity; and

(2) include audit trails designed to detect and respond to Cybersecurity Events that have a reasonable likelihood of materially harming any material part of the normal operations of the Covered Entity.

(b) Each Covered Entity shall maintain records required by this section for not fewer than five years.

Section 500.07 Access Privileges.

As part of its cybersecurity program, based on the Covered Entity's Risk Assessment each Covered Entity shall limit user access privileges to Information Systems that provide access to Nonpublic Information and shall periodically review such access privileges.

Section 500.08 Application Security.

(a) Each Covered Entity's cybersecurity program shall include written procedures, guidelines and standards designed to ensure the use of secure development practices for in-house developed applications utilized by the Covered Entity, and procedures for

evaluating, assessing or testing the security of externally developed applications utilized by the Covered Entity within the context of the Covered Entity's technology environment.

(b) All such procedures, guidelines and standards shall be periodically reviewed, assessed and updated as necessary by the CISO (or a qualified designee) of the Covered Entity.

Section 500.09 Risk Assessment.

(a) Each Covered Entity shall conduct a periodic Risk Assessment of the Covered Entity's Information Systems sufficient to inform the design of the cybersecurity program as required by this Part. Such Risk Assessment shall be updated as reasonably necessary to address changes to the Covered Entity's Information Systems, Nonpublic Information or business operations. The Covered Entity's Risk Assessment shall allow for revision of controls to respond to technological developments and evolving threats and shall consider the particular risks of the Covered Entity's business operations related to cybersecurity, Nonpublic Information collected or stored, Information Systems utilized and the availability and effectiveness of controls to protect Nonpublic Information and Information Systems.

(b) The Risk Assessment shall be carried out in accordance with written policies and procedures and shall be documented. Such policies and procedures shall include:

(1) criteria for the evaluation and categorization of identified cybersecurity risks or threats facing the Covered Entity;

(2) criteria for the assessment of the confidentiality, integrity, security and availability of the Covered Entity's Information Systems and Nonpublic Information, including the adequacy of existing controls in the context of identified risks; and

(3) requirements describing how identified risks will be mitigated or accepted based on the Risk Assessment and how the cybersecurity program will address the risks.

Section 500.10 Cybersecurity Personnel and Intelligence.

(a) Cybersecurity Personnel and Intelligence. In addition to the requirements set forth in 500.04(a), each Covered Entity shall:

(1) utilize qualified cybersecurity personnel of the Covered Entity, an Affiliate or a Third Party Service Provider sufficient to manage the Covered Entity's cybersecurity risks and to perform or oversee the performance of the core cybersecurity functions specified in section 500.02(b)(1)-(6) of this Part;

(2) provide cybersecurity personnel with cybersecurity updates and training sufficient to address relevant cybersecurity risks; and

(3) verify that key cybersecurity personnel take steps to maintain current knowledge of changing cybersecurity threats and countermeasures.

(b) A Covered Entity may choose to utilize an Affiliate or qualified Third Party Service Provider to assist in complying with the requirements set forth in this Part, subject to the requirements set forth in section 500.11 of this Part.

Section 500.11 Third Party Service Provider Security Policy.

(a) Third Party Service Provider Policy. Each Covered Entity shall implement written policies and procedures designed to ensure the security of Information Systems and Nonpublic Information that are accessible to, or held by, Third Party Service Providers. Such policies and procedures shall be based on the Risk Assessment of the Covered Entity and shall address to the extent applicable:

(1) the identification and risk assessment of Third Party Service Providers;

(2) minimum cybersecurity practices required to be met by such Third Party Service Providers in order for them to do business with the Covered Entity;

(3) due diligence processes used to evaluate the adequacy of cybersecurity practices of such Third Party Service Providers; and

(4) periodic assessment of such Third Party Service Providers based on the risk they present and the continued adequacy of their cybersecurity practices.

(b) Such policies and procedures shall include relevant guidelines for due diligence and/or contractual protections relating to Third Party Service Providers including to the extent applicable guidelines addressing:

(1) the Third Party Service Provider's policies and procedures for access controls including its use of Multi-Factor Authentication as defined by section 500.12 to limit access to sensitive systems and Nonpublic Information;

(2) the Third Party Service Provider's policies and procedures for use of encryption as defined by section 500.15 to protect Nonpublic Information in transit and at rest;

(3) notice to be provided to the Covered Entity in the event of a Cybersecurity Event directly impacting the Covered Entity's Information Systems or Non-public Information being held by the Third Party Service Provider; and

(4) representations and warranties addressing the Third Party Service Provider's cybersecurity policies and procedures that relate to the security of the Covered Entity's Information Systems or Nonpublic Information.

(c) Limited Exception. An agent, employee, representative or designee of a Covered Entity who is itself a Covered Entity need not develop its own Third Party Information Security Policy pursuant to this section if the agent, employee, representative or designee follows the policy of the Covered Entity that is required to comply with this Part.

Section 500.12 Multi-Factor Authentication.

(a) Multi-Factor Authentication. Based on its Risk Assessment, each Covered Entity shall use effective controls, which may include Multi-Factor Authentication or Risk-Based Authentication, to protect against unauthorized access to Nonpublic Information or Information Systems.

(b) Multi-Factor Authentication shall be utilized for any individual accessing the Covered Entity's internal networks from an external network, unless the Covered Entity's CISO has approved in writing the use of reasonably equivalent or more secure access controls.

Section 500.13 Limitations on Data Retention.

As part of its cybersecurity program, each Covered Entity shall include policies and procedures for the secure disposal on a periodic basis of any Nonpublic Information identified in 500.01(g)(2)-(3) that is no longer necessary for business operations or for other legitimate business purposes of the Covered Entity, except where such information is otherwise required to be retained by law or regulation, or where targeted disposal is not reasonably feasible due to the manner in which the information is maintained.

Section 500.14 Training and Monitoring.

(a) As part of its cybersecurity program, each Covered Entity shall:

(1) implement risk-based policies, procedures and controls designed to monitor the activity of Authorized Users and detect unauthorized access or use of, or tampering with, Nonpublic Information by such Authorized Users; and

(2) provide for regular cybersecurity awareness training for all personnel that is updated to reflect risks identified by the Covered Entity in its Risk Assessment.

Section 500.15 Encryption of Nonpublic Information.

(a) As part of its cybersecurity program, based on its Risk Assessment, each Covered Entity shall implement controls, including encryption, to protect Nonpublic Information held or transmitted by the Covered Entity both in transit over external networks and at rest.

(1) To the extent a Covered Entity determines that encryption of Nonpublic Information in transit over external networks is infeasible, the Covered Entity may instead secure such Nonpublic Information using effective alternative compensating controls reviewed and approved by the Covered Entity's CISO.

(2) To the extent a Covered Entity determines that encryption of Nonpublic Information at rest is infeasible, the Covered Entity may instead secure such Nonpublic Information using effective alternative compensating controls reviewed and approved by the Covered Entity's CISO.

(b) To the extent that a Covered Entity is utilizing compensating controls under (a) above, the feasibility of encryption and effectiveness of the compensating controls shall be reviewed by the CISO at least annually.

Section 500.16 Incident Response Plan.

(a) As part of its cybersecurity program, each Covered Entity shall establish a written incident response plan designed to promptly respond to, and recover from, any Cybersecurity Event materially affecting the confidentiality, integrity or availability of the Covered Entity's Information Systems or the continuing functionality of any aspect of the Covered Entity's business or operations.

(b) Such incident response plan shall address the following areas:

(1) the internal processes for responding to a Cybersecurity Event;

(2) the goals of the incident response plan;

(3) the definition of clear roles, responsibilities and levels of decision-making authority;

(4) external and internal communications and information sharing;

(5) identification of requirements for the remediation of any identified weaknesses in Information Systems and associated controls;

(6) documentation and reporting regarding Cybersecurity Events and related incident response activities; and

(7) the evaluation and revision as necessary of the incident response plan following a Cybersecurity Event.

Section 500.17 Notices to Superintendent.

(a) Notice of Cybersecurity Event. Each Covered Entity shall notify the superintendent as promptly as possible but in no event later than 72 hours from a determination that a Cybersecurity Event as follows has occurred:

(1) Cybersecurity Events of which notice is required to be provided to any government body, self-regulatory agency or any other supervisory body; and

(2) Cybersecurity Events that have a reasonable likelihood of materially harming any material part of the
normal operation(s) of the Covered Entity.

(b) Annually each Covered Entity shall submit to the superintendent a written statement by February 15, in such form set forth as Appendix A, certifying that the Covered Entity is in compliance with the requirements set forth in this Part. Each Covered Entity shall maintain for examination by the Department all records, schedules and data supporting this certificate for a period of five years. To the extent a Covered Entity has identified areas, systems or processes that require material improvement, updating or redesign, the Covered Entity shall document the identification and the remedial efforts planned and underway to address such areas, systems or processes. Such documentation must be available for inspection by the superintendent.

Section 500.18 Confidentiality.

Information provided by a Covered Entity pursuant to this Part is subject to exemptions from disclosure under the Banking Law, Insurance Law, Financial Services Law, Public Officers Law or any other applicable state or federal law.

Section 500.19 Exemptions.

(a) Limited Exemption. Each Covered Entity with:

(1) fewer than 10 employees including any independent contractors, or

(2) less than $5,000,000 in gross annual revenue in each of the last three fiscal years, or

(3) less than $10,000,000 in year-end total assets, calculated in accordance with generally accepted accounting principles, including assets of all Affiliates, shall be exempt from the requirements of Sections 500.04, 500.05, 500.06, 500.08, 500.10, 500.12, 500.14, 500.15, and 500.16 of this Part.

(b) An employee, agent, representative or designee of a Covered Entity, who is itself a Covered Entity, is exempt from this Part and need not develop its own cybersecurity program to the extent that the employee, agent, representative or designee is covered by the cybersecurity program of the Covered Entity.

(c) A Covered Entity that does not directly or indirectly operate, maintain, utilize or control any Information Systems, and that does not, and is not required to, directly or indirectly control, own, access, generate, receive or possess Nonpublic Information shall be exempt from the requirements of Sections 500.02, 500.03, 500.04, 500.05, 500.06, 500.07, 500.08, 500.10, 500.12, 500.14, 500.15, and 500.16 of this Part.

(d) A Covered Entity that qualifies for an exemption pursuant to this section shall file a Notice of Exemption in such form set forth as Appendix B.

(e) In the event that a Covered Entity, as of its most recent fiscal year end, ceases to qualify for an exemption, such Covered Entity shall have 180 days from such fiscal year end to comply with all applicable requirements of this Part.

Section 500.20 Enforcement.

This regulation will be enforced by the superintendent pursuant to, and is not intended to limit, the superintendent’s authority under any applicable laws.

Section 500.21 Effective Date.

This Part will be effective March 1, 2017. Covered Entities will be required to annually prepare and submit to the superintendent a Certification of Compliance with New York State Department of Financial Services Cybersecurity Regulations under section 500.17(b) commencing February 15, 2018.

Section 500.22 Transitional Periods.

(a) Transitional Period. Covered Entities shall have 180 days from the effective date of this Part to comply with the requirements set forth in this Part, except as otherwise specified.

(b) The following provisions shall include additional transitional periods. Covered Entities shall have:

(1) One year from the effective date of this Part to comply with the requirements of sections 500.04(b), 500.05, 500.09, 500.12, and 500.14(a)(2) of this Part.

(2) Eighteen months from the effective date of this Part to comply with the requirements of sections 500.06, 500.08, 500.13, 500.14 (a)(1) and 500.15 of this Part.

(3) Two years from the effective date of this Part to comply with the requirements of section 500.11 of this Part.

Section 500.23 Severability.

If any provision of this Part or the application thereof to any Person or circumstance is adjudged invalid by a court of competent jurisdiction, such judgment shall not affect or impair the validity of the other provisions of this Part or the application thereof to other Persons or circumstances.

APPENDIX A (Part 500)

_____

(Covered Entity Name)

February 15, 20_____

Certification of Compliance with New York State Department of Financial Services Cybersecurity Regulations

The Board of Directors or a Senior Officer(s) of the Covered Entity certifies:

(1) The Board of Directors (or name of Senior Officer(s)) has reviewed documents, reports, certifications and opinions of such officers, employees, representatives, outside vendors and other individuals or entities as necessary;

(2) To the best of the (Board of Directors) or (name of Senior Officer(s)) knowledge, the Cybersecurity Program of (name of Covered Entity as of (date of the Board Resolution or Senior Officer(s) Compliance Finding) for the year ended (year for which Board Resolution or Compliance Finding is provided) complies with Part ___.

Signed by the Chairperson of the Board of Directors or Senior Officer(s)

(Name)_____ Date: _____
[DFS Portal Filing Instructions]

APPENDIX B (Part 500)

_____

(Covered Entity Name)

(Date)_____

Notice of Exemption

In accordance with 23 NYCRR § 500.19(d), (Covered Entity Name) hereby provides notice that (Covered Entity Name) qualifies for the following Exemption(s) under 23 NYCRR § 500.19 (check all that apply):

□ Section 500.19(a)(1)

□ Section 500.19(a)(2)

□ Section 500.19(a)(3)

□ Section 500.19(b)

□ Section 500.19(c)

If you have any question or concerns regarding this notice, please contact:

(Insert name, title, and full contact information)

(Name)_____ Date: _____
(Title)
(Covered Entity Name)

[DFS Portal Filing Instructions]

BILATERAL AGREEMENT BETWEEN THE EUROPEAN UNION AND THE UNITED STATES OF AMERICA ON PRUDENTIAL MEASURES REGARDING INSURANCE AND REINSURANCE

Preamble

The European Union (EU) and the United States of America (United States or U.S.), Parties to this Agreement,

Sharing the goal of protecting insurance and reinsurance policyholders and other consumers, while respecting each Party's system for insurance and reinsurance supervision and regulation;

Affirming that for the United States, prudential measures applicable in the European Union, together with the requirements and undertakings provided for in this Agreement, achieve a level of protection for policyholders and other consumers with respect to reinsurance cessions and group supervision consistent with the requirements of the Federal Insurance Office Act of 2010;

Acknowledging the growing need for co-operation between EU and U.S. supervisory authorities including the exchange of confidential information, given the increased globalisation of insurance and reinsurance markets;

Taking into account that practical arrangements concerning cross-border cooperation are essential for supervision of insurers and reinsurers both during times of stability and during times of crisis;

Taking into account information exchanged on each Party's regulatory frameworks and after careful consideration of these frameworks;

Noting the benefits of enhancing regulatory certainty in the application of insurance and reinsurance regulatory frameworks for insurers and reinsurers operating in the territory of each Party;

Acknowledging risk mitigation effects of reinsurance agreements in a cross-border context provided applicable prudential conditions are fulfilled and taking into account protection of policyholders and other consumers;

Acknowledging that group supervision of insurers and reinsurers enables supervisory authorities to form sound judgments of the financial position of these groups;

Acknowledging the need for a group capital requirement or assessment for insurers and reinsurers forming part of a group that operates in the territory of both Parties, and that a group capital requirement or assessment at the level of the worldwide parent undertaking can be based on the approach of the Home Party;

Affirming the importance of specifications for the group capital requirement or assessment for group supervision and of, where warranted, the application of corrective or preventive or otherwise responsive measures by a supervisory authority based on that requirement or assessment; and

Encouraging exchange of information between supervisory authorities in order to supervise insurers and reinsurers in the interest of policyholders and other consumers,

Hereby agree:

Article 1 – Objectives

This Agreement addresses the following:

(a) the elimination, under specified conditions, of local presence requirements imposed by a Party or its supervisory authorities on an assuming reinsurer which has its head office or is domiciled in the other Party, as a condition for entering into any reinsurance agreement with a ceding insurer which has its head office or is domiciled in its territory or for allowing the ceding insurer to recognise credit for reinsurance or credit for risk mitigation effects of such reinsurance agreement;

(b) the elimination, under specified conditions, of collateral requirements imposed by a Party or its supervisory authorities on an assuming reinsurer which has its head office or is domiciled in the other Party, as a condition for entering into any reinsurance agreement with a ceding insurer which has its head office or is domiciled in its territory or for allowing the ceding insurer to recognise credit for reinsurance or credit for risk mitigation effects of such reinsurance agreement;

(c) the role of the Host and Home supervisory authorities with respect to prudential group supervision of an insurance or reinsurance group whose worldwide parent undertaking is in the Home Party, including, under specified conditions, (i) the elimination at the level of the worldwide parent undertaking of Host Party prudential insurance solvency and capital, governance, and reporting requirements, and (ii) establishing that the Home supervisory authority, and not the Host supervisory authority, will exercise worldwide prudential insurance group supervision, without prejudice to group supervision by the Host Party of the insurance or reinsurance group at the level of the parent undertaking in its territory; and

(d) the Parties' mutual support for the exchange of information between supervisory authorities of each Party, and recommended practices for such exchange.

Article 2 – Definitions

For the purposes of this Agreement the following definitions shall apply:

(a) "Ceding insurer" means an insurer or reinsurer that is counterparty to an assuming reinsurer under a reinsurance agreement;
(b) "Collateral" means assets, such as cash and letters of credit, pledged by the reinsurer for the benefit of the ceding insurer or reinsurer to guarantee or secure the assuming reinsurer's liabilities to the ceding insurer arising from a reinsurance agreement;

(c) “Credit for reinsurance or credit for risk mitigation effects of reinsurance agreements” means the right of a ceding insurer under prudential regulatory framework to recognise amounts due from assuming reinsurers relating to paid and unpaid losses on ceded risks as assets or reductions from liabilities respectively;

(d) “Group” means two or more undertakings, at least one of which is an insurance or reinsurance undertaking, where one has control over one or more insurance or reinsurance undertakings or other non-regulated undertaking;

(e) “Group Supervision” means the application of regulatory and prudential oversight by a supervisory authority to an insurance or reinsurance group for purposes including protecting policyholders and other consumers, and promoting financial stability and global engagement;

(f) “Home Party” means the Party in whose territory the worldwide parent of the insurance or reinsurance group or undertaking has its head office or is domiciled;

(g) “Home supervisory authority” means a supervisory authority from the Home Party;

(h) “Host Party” means the Party in which the insurance or reinsurance group or undertaking has operations, but is not the territory in which the worldwide parent undertaking of the insurance or reinsurance group or undertaking has its head office or is domiciled;

(i) “Host supervisory authority” means a supervisory authority from the Host Party;

(j) “Insurer” means an undertaking which is authorised or licensed to take up or engage in the business of direct or primary insurance;

(k) “Parent” means a regulated or unregulated undertaking that directly or indirectly owns or controls another undertaking;

(l) “Personal Data” means any information relating to an identified or identifiable natural person;

(m) “Reinsurer” means an undertaking which is authorised or licensed to take up or engage in the business of reinsurance activities;

(n) “Reinsurance activities” means the activity consisting of accepting risks ceded by an insurer or by another reinsurer;

(o) “Reinsurance agreement” means a contract whereby an assuming reinsurer has accepted risk ceded by an insurer or reinsurer;

(p) “Supervisory authority” means any insurance and reinsurance supervisor in the European Union or in the United States;

(q) “Undertaking” means any entity engaged in economic activity;

(r) “U.S. State” means any State, commonwealth, territory, or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, or the United States Virgin Islands;

(s) “Worldwide” means all operations or activities of a group wherever they occur; and

(t) “Worldwide parent undertaking” means the ultimate parent undertaking of a group.

Article 3 – Reinsurance

1. Subject to the conditions in paragraph 4, a Party shall not, and shall ensure that its supervisory authorities or any other competent authorities do not, as a condition to allow an assuming reinsurer which has its head office or is domiciled in the territory of the other Party (hereunder for the purpose of Article 3, a “Home Party Assuming Reinsurer”) to enter into a reinsurance agreement with a ceding insurer which has its head office or is domiciled in its territory (hereunder for the purpose of Article 3, a “Host Party Ceding Insurer”):

(a) maintain or adopt any requirement to post collateral in connection with cessions from a Host Party Ceding Insurer to a Home Party Assuming Reinsurer and any related reporting requirement attributable to such removed collateral, or

(b) maintain or adopt any new requirement with substantially the same regulatory impact on the Home Party Assuming Reinsurer as collateral requirements removed under this Agreement or any reporting requirement attributable to such removed collateral,

which, in the case of either (a) or (b), results in less favourable treatment of Home Party Assuming Reinsurers than assuming reinsurers which have their head office or are domiciled in the territory of the same supervisory authority as a Host Party Ceding Insurer. This paragraph does not prohibit a Party in whose territory a ceding insurer has its head office or is domiciled (hereunder for the purpose of Article 3, a "Host Party") or its supervisory authorities from applying requirements as a condition to allow the Home Party Assuming Reinsurers to enter into a reinsurance agreement with a Host Party Ceding Insurer if the same requirements apply to reinsurance agreements between a ceding insurer and an assuming reinsurer which have their head office or are domiciled in the territory of the same supervisory authority.

2. Subject to the conditions in paragraph 4, a Host Party shall not, and shall ensure that its supervisory authorities or any other competent authorities do not, as a condition to allow a Host Party Ceding Insurer to take credit for reinsurance or for risk mitigation effects of reinsurance agreements concluded with a Home Party Assuming Reinsurer:

(a) maintain or adopt any requirement to post collateral in connection with cessions from a Host Party Ceding Insurer to a Home Party Assuming Reinsurer and any related reporting requirement attributable to such removed collateral, or

(b) maintain or adopt any new requirement with substantially the same regulatory impact on the Home Party Assuming Reinsurer as collateral requirements removed under this Agreement or any reporting requirement attributable to such removed collateral,

which, in the case of either (a) or (b), results in less favourable treatment of Home Party Assuming Reinsurers than assuming reinsurers which have their head office or are domiciled in the territory of the same supervisory authority as a Host Party Ceding Insurer. This paragraph does not prohibit a Host Party or its supervisory authorities from applying requirements as a condition to allow a Host Party Ceding Insurer to take credit for reinsurance or risk mitigation effects of reinsurance agreements concluded with a Home Party Assuming Reinsurer if the same requirements apply to reinsurance

agreements between a ceding insurer and an assuming reinsurer which have their head office or are domiciled in the territory of the same supervisory authority.

3. Subject to the conditions in paragraph 4, a Host Party shall not, and shall ensure that its supervisory authorities or any other competent authorities, as applicable, do not, as a condition of entering into a reinsurance agreement with a Host Party Ceding Insurer or as a condition to allow the Host Party Ceding Insurer to recognise credit for such reinsurance or credit for risk mitigation effect of such reinsurance agreement:

(a) maintain or adopt any requirement for a Home Party Assuming Reinsurer to have a local presence, or

(b) maintain or adopt any new requirement with substantially the same regulatory impact on the Home Party Assuming Reinsurer as local presence, which, in the case of either (a) or (b), results in less favourable treatment of a Home Party Assuming Reinsurer than assuming reinsurers which have their head office or are domiciled in the territory of the supervisory authority of the Host Party Ceding Insurer or which have their head office or are domiciled in the territory of the Host Party and are licensed or permitted to operate in the territory of the supervisory authority of the Host Party Ceding Insurer. For a U.S. State, “permitted to operate” shall mean, for purposes of this provision, admitted in that State.

4. Paragraphs 1 to 3 apply subject to the following conditions:

(a) the assuming reinsurer has and maintains on an ongoing basis,

(i) at least 226 million Euro, where the ceding insurer has its head office in the EU, or 250 million U.S. dollars, where the ceding insurer is domiciled in the United States, of own funds or capital and surplus, calculated according to the methodology of its home jurisdiction; or

(ii) if the assuming reinsurer is an association including incorporated and individual unincorporated underwriters:

(A) minimum capital and surplus equivalents (net of liabilities) or own funds, calculated according to the methodology applicable in its home jurisdiction, of at least 226 million Euro, where the ceding insurer has its head office in the EU, or 250 million U.S. dollars, where the ceding insurer is domiciled in the United States; and

(B) a central fund containing a balance of at least 226 million Euro, where the ceding insurer has its head office in the EU, or 250 million U.S. dollars, where the ceding insurer is domiciled in the United States;

(b) the assuming reinsurer has and maintains on an ongoing basis:

(i) a solvency ratio of 100 percent SCR under Solvency II or an RBC of 300 percent Authorized Control Level, as applicable in the territory in which the assuming reinsurer has its head office or is domiciled; or

(ii) if the assuming reinsurer is an association including incorporated and individual unincorporated underwriters, a solvency ratio of 100 percent SCR under Solvency II or an RBC of 300 percent Authorized Control Level, as applicable in the territory in which the assuming reinsurer has its head office or is domiciled;

(c) the assuming reinsurer agrees to provide prompt written notice and explanation to the supervisory authority in the territory of the ceding insurer if:

(i) it falls below the minimum capital and surplus or own funds, as applicable, specified in subparagraph (a), or the solvency or capital ratio, as applicable, specified in subparagraph (b); or

(ii) any regulatory action is taken against it for serious noncompliance with applicable law;

(d) the assuming reinsurer provides written confirmation to the Host supervisory authority of consent to the jurisdiction of the courts of the territory in which the ceding insurer has its head office or is domiciled, in accordance with applicable requirements of that territory for providing such consent. Nothing in this Agreement shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms;

(e) where applicable for “service of process” purposes, the assuming reinsurer provides written confirmation to the Host supervisory authority of consent to the appointment of that supervisory authority as agent for service of process. The Host supervisory authority may require that such consent be provided to it and included in each reinsurance agreement under its jurisdiction;

(f) the assuming reinsurer consents in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained;

(g) the assuming reinsurer agrees in each reinsurance agreement subject to this Agreement that it will provide collateral for 100 percent of the assuming reinsurer’s liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming reinsurer resists enforcement of a final judgment that is enforceable under the law of the territory in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its resolution estate, if applicable;

(h) The assuming reinsurer or its legal predecessor or successor, where applicable, provides the following documentation to the Host supervisory authority, if requested by that supervisory authority:

(i) with respect to the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, its annual audited financial statements, in accordance with the applicable law of the territory of its head office, including the external audit report;

(ii) with respect to the two years preceding entry into the reinsurance agreement, solvency and financial condition report or actuarial opinion, if filed with the assuming reinsurer's supervisor;

(iii) prior to entry into the reinsurance agreement and not more than semiannually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers of the jurisdiction of the ceding insurer; and

(iv) prior to entry into the reinsurance agreement and not more than semiannually thereafter, information regarding the assuming reinsurer's assumed reinsurance by ceding company, ceded reinsurance by the assuming reinsurer, and reinsurance recoverable on paid and unpaid losses by the assuming reinsurer, to allow for the evaluation of the criteria set forth in subparagraph (i) of paragraph 4;

(i) the assuming reinsurer maintains a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:

(i) more than 15 percent of the reinsurance recoverables are overdue and in dispute as reported to the supervisor;

(ii) more than 15 percent of the reinsurer's ceding insurers or reinsurers have overdue reinsurance recoverables on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer 90,400 Euro, where the assuming reinsurer has its head office in the EU, or 100,000 U.S. dollars, where the assuming reinsurer is domiciled in the United States; or

(iii) the aggregate amount of reinsurance recoverables on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds 45,200,000 Euro, where the assuming reinsurer has its head office in the EU, or 50,000,000 U.S. dollars, where the assuming reinsurer is domiciled in the United States;

(j) the assuming reinsurer confirms that it is not presently participating in any solvent scheme of arrangement, which involves Host Party Ceding Insurers, and agrees to notify the ceding insurer and its supervisory authority and to provide 100 percent collateral to the ceding insurer

consistent with the terms of the scheme should the assuming reinsurer enter into such an arrangement;

(k) if subject to a legal process of resolution, receivership, or winding-up proceedings as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the resolution, receivership, or winding-up proceedings is pending, may obtain an order requiring that the assuming reinsurer post collateral for all outstanding ceded liabilities; and

(l) the assuming reinsurer's Home supervisory authority confirms to the Host Party supervisory authority on an annual basis that the assuming reinsurer complies with subparagraph (b).

5. Nothing in this Agreement precludes an assuming reinsurer from providing to supervisory authorities information on a voluntary basis.

6. Each Party shall ensure that, in its capacity as a Host Party, with respect to its supervisory authorities, where the Host supervisory authority determines that a Home Party Assuming Reinsurer no longer satisfies one of the conditions listed in paragraph 4, the Host supervisory authority only imposes any of the requirements addressed in paragraphs 1 to 3 if that Host supervisory authority follows the procedure set out in subparagraphs (a) to (c).

(a) prior to imposing any such requirements the Host supervisory authority communicates with the assuming reinsurer and, except for exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection, provides the assuming reinsurer with 30 days from the initial communication to submit a plan to remedy the defect and 90 days from the initial communication to remedy the defect, and informs the Home supervisory authority;

(b) only where, after the expiry of this period of 90 days or less under exceptional circumstances as set out in (a), the Host supervisory authority considers that no or insufficient action was taken by the assuming reinsurer, the Host supervisory authority may impose any of the requirements as set out in paragraphs 1 to 3; and

(c) the imposition of any of the requirements set out in paragraphs 1 to 3 is explained in writing and communicated to the assuming reinsurer concerned.

7. Subject to applicable law and the terms of this Agreement, nothing in this Article shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for collateral or other terms in that reinsurance agreement.

8. This Agreement shall apply only to reinsurance agreements entered into, amended, or renewed on or after the date on which a measure that reduces collateral pursuant to this Article takes effect, and only with respect to losses incurred and reserves reported from and after the later of (i) the date of the measure, or (ii) the effective date of such new reinsurance agreement, amendment, or renewal. Nothing in

this Agreement shall limit or in any way alter the capacity of parties to any reinsurance agreement to renegotiate such reinsurance agreement.

9. For greater clarity, in the event of termination of this Agreement, nothing in this Agreement prevents supervisory authorities, or other competent authorities, from requiring the local presence of Host Party assuming reinsurers, or requiring posting of collateral and related requirements, or compliance with other provisions of applicable law, with respect to any liabilities under reinsurance agreements described in this Agreement.

Article 4 – Group supervision

For the purposes of Articles 9 and 10, the Parties set forth the following practices of group supervision:

(a) Without prejudice to subparagraphs (c) to (h) and participation in supervisory colleges, a Home Party insurance or reinsurance group is subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by its Home supervisory authorities, and is not subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by any Host supervisory authority.

(b) Notwithstanding subparagraph (a), Host supervisory authorities may exercise supervision with regard to a Home Party insurance or reinsurance group as set out in subparagraphs (c) to (h). Host supervisory authorities may exercise group supervision, where appropriate, with regard to a Home Party insurance or reinsurance group at the level of the parent undertaking in its territory. Host supervisory authorities do not otherwise exercise worldwide group supervision with regard to a Home Party insurance or reinsurance group, without prejudice to group supervision of the insurance or reinsurance group at the level of the parent undertaking in the territory of the Host Party.

(c) Where a worldwide risk management system, as evidenced by the submission of a worldwide group Own Risk and Solvency Assessment (ORSA), is applied to a Home Party insurance or reinsurance group according to the applicable law, the Home supervisory authority that requires the ORSA provides a summary of the worldwide group ORSA:

(i) to the Host supervisory authorities, if they are members of the insurance or reinsurance group’s supervisory college, without delay, and;

(ii) to the supervisory authorities of significant subsidiaries or branches of thatgroup in the Host Party, at the request of those supervisory authorities.

Where no such worldwide group ORSA is applied to a Home Party insurance or reinsurance group, according to applicable law, the relevant

U.S. State or EU Member State's supervisory authority provides equivalent documentation which is prepared consistent with applicable law of the Home supervisory authority as referred to in subparagraphs (i) and (ii) above.

(d) The summary of the worldwide group ORSA, or the equivalent documentation as set out in subparagraph (c), includes the following elements:

(i) a description of the insurance or reinsurance group's risk management framework;

(ii) an assessment of the insurance or reinsurance group's risk exposure; and

(iii) a group assessment of risk capital and a prospective solvency assessment.

(e) Notwithstanding subparagraph (a), if the summary of the worldwide group ORSA, or, where applicable, equivalent documentation as set out in subparagraph (c), exposes any serious threat to policyholder protection or financial stability in the territory of the Host supervisory authority, that Host supervisory authority may impose preventive, corrective, or otherwise responsive measures with respect to insurers or reinsurers in the Host Party. Prior to imposing such measures, the Host supervisory authority consults the insurance or reinsurance group's relevant Home supervisory authority. The Parties encourage supervisory authorities to continue to address prudential insurance group supervision matters within supervisory colleges.

(f) Prudential insurance group supervision reporting requirements as set out in the applicable law in the territory of the Host Party do not apply at the level of the worldwide parent undertaking of the insurance or reinsurance group unless they directly relate to the risk of a serious impact on the ability of undertakings within the insurance or reinsurance group to pay claims in the territory of the Host Party.

(g) A Host supervisory authority retains the ability to request and obtain information from an insurer or reinsurer pursuing activities in its territory, whose worldwide parent undertaking has its head office in the territory of the Home Party, for purposes of prudential insurance group supervision, where such information is deemed necessary by the Host supervisory authority to protect against serious harm to policyholders or serious threat to financial stability or a serious impact on the ability of an insurer or reinsurer to pay its claims in the territory of the Host supervisory authority. The Host supervisory authority bases such information request on prudential supervisory criteria and, whenever possible, avoids burdensome and duplicative requests. The requesting supervisory authority informs the supervisory college of such a request. Notwithstanding subparagraph (a), the failure of an insurer or reinsurer to comply with such an information request may result in preventive,

corrective or otherwise responsive measures being imposed within the Host supervisory authority's territory.

(h) With regard to a Home Party insurance or reinsurance group with operations in the Host Party and that is subject to a group capital assessment in the Home Party which fulfils the following conditions:

(i) the group capital assessment includes a worldwide group capital calculation capturing risk at the level of the entire group, including the worldwide parent undertaking of the insurance or reinsurance group, which may affect the insurance or reinsurance operations and activities occurring in the territory of the other Party; and

(ii) the supervisory authority in the territory of the Party where the group capital assessment as set out in subparagraph (i) above is applied has the authority to impose preventive, corrective, or otherwise responsive measures on the basis of the assessment, including requiring, where appropriate, capital measures;

the Host supervisory authority does not impose a group capital assessment or requirement at the level of the worldwide parent undertaking of the insurance or reinsurance group according to the applicable law in its territory.

Where a Home Party insurer or reinsurer is subject to a group capital requirement in the territory of the Home Party, the Host supervisory authority does not impose a group capital requirement or assessment at the level of the worldwide parent undertaking of the insurance or reinsurance group.

(i) Notwithstanding any provision in this Agreement, this Agreement does not and is not intended to limit or restrict the ability of EU supervisory authorities to exercise supervisory or regulatory authority over entities or groups that own or control credit institutions in the EU, have banking operations in the EU, or whose material financial distress or the nature, scope, size, scale, concentration, interconnectedness or mix of activities have been determined could pose a threat to the financial stability of the EU, including through exercise of: Directive 2002/87/EC of the European Parliament and of the Council of 16 December 2002 on the supplementary supervision of credit institutions, insurance undertakings and investment firms in a financial conglomerate and amending Council Directives 73/239/EEC, 79/267/EEC, 92/49/EEC, 92/96/EEC, 93/6/EEC and 93/22/EEC, and Directives 98/78/EC and 2000/12/EC of the European Parliament and of the Council, Directive 2013/36/EU of the European Parliament and of the Council of 26 June 2013 on access to the activity of credit institutions and the prudential supervision of credit institutions and investment firms amending Directive 2002/87/EC and repealing Directives 2006/48/EC and 2006/49/EC (CRD IV), Regulation (EU) No 575/2013 of the European Parliament and of the Council of 26 June 2013 on prudential requirements for credit institutions and

investment firms and amending Regulation (EU) No 648/2012 (CRR), Directive 2014/59/EU of the European Parliament and of the Council of 15 May 2014 establishing a framework for the recovery and resolution of credit institutions and investment firms and amending Council Directive 82/891/EEC, and Directives 2001/24/EC, 2002/47/EC, 2004/25/EC, 2005/56/EC, 2007/36/EC, 2011/35/EU, 2012/30/EU and 2013/36/EU and Regulations (EU) No 1093/2010 and (EU) No 648/2012, of the European Parliament and of the Council, Regulation (EU) No 806/2014 of the European Parliament and of the Council of 15 July 2014 establishing uniform rules and a uniform procedure for the resolution of credit institutions and certain investment firms in the framework of a Single Resolution Mechanism and a Single Resolution Fund and amending Regulation (EU) No 1093/2010 and Council Regulation (EU) No 1024/2013 of 15 October 2013 conferring specific tasks on the European Central Bank concerning policies relating to the prudential supervision of credit institutions, or other related laws and regulations.

Notwithstanding any provision in this Agreement, this Agreement does not and is not intended to limit or restrict the ability of the applicable U.S. supervisory authority to exercise supervisory or regulatory authority over entities or groups that own or control depository institutions in the United States, have banking operations in the United States, or whose material financial distress or the nature, scope, size, scale, concentration, interconnectedness, or mix of activities have been determined could pose a threat to the financial stability of the United States, including through exercise of authority pursuant to the Bank Holding Company Act (12 U.S.C. § 1841 et seq.), the Home Owners' Loan Act (12 U.S.C. § 1461 et seq.), the International Banking Act (12 U.S.C. § 3101 et seq.), the Dodd-Frank Wall Street Reform and Consumer Protection Act (12 U.S.C. § 5301 et seq.), or other related laws or regulations.

Article 5 – Exchange of Information

1. The Parties shall encourage supervisory authorities in their respective jurisdictions to cooperate in exchanging information pursuant to the practices set forth in the Annex. The Parties understand that the use of such practices will enhance cooperation and information sharing, while respecting a high standard of confidentiality protection.

2. Nothing in this Agreement addresses requirements that may apply to the exchange of personal data by supervisory authorities.

Article 6 – Annex

The Annex to this Agreement shall form an integral part of this Agreement.

Article 7 – Joint Committee

1. The Parties hereby establish a Joint Committee, composed of representatives of the United States and representatives of the European Union, which shall provide the

Parties with a forum for consultation and to exchange information on the administration of the Agreement and its proper implementation.

2. The Parties shall consult within the Joint Committee regarding this Agreement:

(a) upon mutual agreement of the Parties if either Party proposes consultation;

(b) at least once within 180 days after the date of entry into force or provisional application of this Agreement, whichever is earlier, and once per year thereafter, unless the Parties otherwise decide;

(c) if a written request for mandatory consultation is made by either Party; and

(d) if either Party provides written notice of intent to terminate.

3. The Joint Committee may address:

(a) matters related to the implementation of the Agreement;

(b) the effects of the Agreement, in the Parties' jurisdictions, on insurance and reinsurance consumers, and the commercial operations of insurers and reinsurers;

(c) any amendments to this Agreement proposed by either Party;

(d) any matter that requires mandatory consultation;

(e) a notice of intent to terminate this Agreement; and

(f) other matters as may be decided by the Parties.

4. The Joint Committee may adopt rules of procedure.

5. The Joint Committee shall be chaired in turn on an annual basis by each of the Parties, unless decided otherwise. The Joint Committee may be convened by its Chair at such time and manner as may be decided by the Parties.

6. The Joint Committee may convene any working group to facilitate its work.

Article 8 – Entry into force

This Agreement shall enter into force seven days after the date the Parties exchange written notifications certifying that they have completed their respective internal requirements and procedures, or on such other date as the Parties may agree.

Article 9 – Implementation of the Agreement

1. From the date of entry into force or provisional application of this Agreement, whichever is earlier, the Parties shall encourage relevant authorities to refrain from taking any measures which are inconsistent with any of the conditions or obligations of

the Agreement, including with respect to the elimination of collateral and local presence requirements pursuant to Article 3. This may include, as appropriate, exchanges of letters between relevant authorities on matters pertaining to this Agreement.

2. From the date of entry into force or provisional application of this Agreement, whichever is earlier, the Parties shall take all measures, as appropriate, to implement and apply this Agreement as soon as possible in accordance with Article 10.

3. From the date of entry into force or provisional application of this Agreement, whichever is earlier, the United States shall encourage each U.S. State to promptly adopt the following measures:

(a) the reduction, in each year following the date of entry into force or provisional application of this Agreement, of the amount of collateral required by each State to allow full credit for reinsurance by 20 percent of the collateral that the U.S. State required as of the January 1 before signature of this Agreement; and

(b) the implementation of relevant U.S. State credit for reinsurance laws and regulations consistent with Article 3, as the method for adopting measures in conformity with paragraphs 1 and 2 of that Article.

4. Provided that this Agreement has entered into force, on a date no later than the first day of the month, 42 months after the date of signature of this Agreement, the United States shall begin evaluating a potential preemption determination under its laws and regulations with respect to any U.S. State insurance measure that the United States determines is inconsistent with this Agreement and results in less favourable treatment of an EU insurer or reinsurer than a U.S. insurer or reinsurer domiciled, licensed, or otherwise admitted in that U.S. State. Provided that this Agreement has entered into force, on a date no later than the first day of the month 60 months after the date of signature of this Agreement, the United States shall complete any necessary preemption determination under its laws and regulations with respect to any U.S. State insurance measure subject to such evaluation. For the purposes of this paragraph, the United States shall prioritise those States with the highest volume of gross ceded reinsurance for purposes of potential preemption determinations.

Article 10 – Application of the Agreement

1. Except as otherwise specified, this Agreement shall apply on the date of the entry into
force, or 60 months from the date of signature of this Agreement, whichever is later.

2. Notwithstanding Article 8 and paragraph 1 of this Article:

(a) the European Union shall provisionally apply Article 4 of this Agreement until the date of entry into force of this Agreement and then apply Article 4 thereafter by ensuring that supervisory authorities and other competent authorities follow the practices set forth therein from the seventh day of the month following the date on which the Parties have notified each other that their internal requirements and procedures necessary for the provisional application of this Agreement have been completed.

The United States shall provisionally apply Article 4 of this Agreement until the date of entry into force of this Agreement and then apply Article 4 thereafter by using best efforts and encouraging supervisory authorities and other competent authorities to follow the practices set forth therein from the seventh day of the month following the date on which the Parties have notified each other that their internal requirements and procedures necessary for the provisional application of this Agreement have been completed.

(b) On the date of entry into force of this Agreement, or 60 months after signature of this Agreement, whichever is later:

(i) the obligations of a Party set forth in Article 3, paragraphs 1 and 2 and Article 9 shall be applicable only if, and thereafter for as long as, the supervisory authorities of the other Party exercise supervision as set forth in Article 4 and satisfy the obligations set forth in Article 3, paragraph 3;

(ii) the practices of a Party set forth in Article 4 and the obligations set forth in Article 3, paragraph 3 shall be applicable only if, and thereafter for as long as, the supervisory authorities of the other Party satisfy the obligations set forth in Article 3, paragraphs 1 and 2; and

(iii) the obligations of a Party set forth in Article 3, paragraph 3 shall be applicable only if, and thereafter for as long as, the supervisory authorities of the other Party exercise supervision as set forth in Article 4 and satisfy the obligations set forth as in Article 3, paragraphs 1 and 2.

(c) where under Article 4, subparagraph (i), measures are applied by the applicable U.S. supervisory authorities outside the territory of the United States to an EU insurance or reinsurance group, the distress or activities of which the Financial Stability Oversight Council has determined could pose a threat to the financial stability of the United States, through application of the Dodd-Frank Wall Street Reform and Consumer Protection Act (12 U.S.C. § 5301 et seq.), either Party may terminate this Agreement under an accelerated mandatory consultation and termination. Where, under Article 4, subparagraph (i), measures are applied by an EU supervisory authority outside the territory of the European Union to a U.S. insurance or reinsurance group, in relation to a threat to the financial stability of the EU, either Party may terminate this Agreement under an accelerated mandatory consultation and termination.

(d) Until the date set forth in subparagraph (b), and without prejudice to the mechanisms set forth therein, the reinsurance provisions of Article 3, paragraphs 1 and 2 shall apply with respect to an EU reinsurer in a U.S. State on the earlier of:

(i) adoption by such U.S. State of a measure consistent with Article 3, paragraphs 1 and 2; or

(ii) the effective date of any determination by the United States under its laws and regulations that such U.S. State insurance measure is preempted because it is inconsistent with this Agreement and results in less favourable treatment of an EU insurer or reinsurer than a U.S. insurer or reinsurer domiciled, licensed, or otherwise admitted in that U.S. State.

(e) from the date of provisional application as set out in subparagraph (a) and for 60 months thereafter, in the application of Article 4, subparagraph (h), supervisory authorities in the European Union shall not impose a group capital requirement at the level of the worldwide parent undertaking of the insurance or reinsurance group, with regard to a U.S. insurance or reinsurance group with operations in the European Union.

(f) from the date of signature of this Agreement, during the 60 month period referred to in subparagraph (b), if a Party does not meet the obligations of Article 3, with respect to local presence requirements, the supervisory authorities of the other Party may, after mandatory consultation, impose a group capital assessment or group capital requirement at the level of the worldwide parent undertaking on an insurance or reinsurance group which has its head office or is domiciled in the other Party.

(g) Article 3, paragraph 3 shall be implemented and applicable in the territory of the EU no later than 24 months from the date of signature of this Agreement, provided that the Agreement has been provisionally applied or has entered into force;

(h) subject to subparagraphs (b) and (d), Article 3, paragraphs 1 and 2 shall be implemented and fully applicable in all of the territory of both Parties no later than 60 months from the date of signature of this Agreement by both Parties, provided that the Agreement has entered into force; and

(i) as from the date of entry into force or provisional application of this Agreement, whichever is earlier, both Parties shall apply Articles 7, 11 and 12.

3. Where a Party does not adhere to paragraph 2 by the dates stipulated therein, the other Party may seek mandatory consultation through the Joint Committee.

Article 11 – Termination and Mandatory Consultation

1. Following mandatory consultation, either Party may terminate this Agreement at any time by giving written notification to the other Party, subject to the procedures of this Article. Unless otherwise agreed by the Parties in writing, such termination shall be effective in 180 days, or 90 days with respect to termination described in Article 10, subparagraph 2(c), after the date of such notification. In particular, the Parties may terminate this Agreement where either Party has failed to fulfil its obligations under this Agreement or has taken measures inconsistent with the objectives of this Agreement.

2. Prior to notifying a decision to terminate this Agreement, including with respect to the provisions of Article 10, a Party shall notify the Chair of the Joint Committee.

3. The Parties shall take the necessary steps to communicate to interested parties the effect of termination on insurers and reinsurers in their respective jurisdictions.

4. Mandatory consultation through the Joint Committee shall be required if requested by either Party to the Chair of the Joint Committee, and shall commence not later 30 days, or 7 days if requested as described in Article 10, subparagraph 2(c), after such request unless the Parties agree otherwise. The Party requesting mandatory consultation shall provide written notice of the bases for the mandatory consultation. The mandatory consultation may be hosted at a site determined by the Parties, and if the Parties cannot agree on a location, then the Party requesting mandatory consultation shall propose three neutral sites outside of the territory of either Party, and the other Party shall select one of the proposed three neutral sites.

5. Mandatory consultation will be required prior to the termination of this Agreement, including with respect to the provisions of Article 10.

6. If a Party refuses to participate in a mandatory consultation as provided in this Article, then the Party seeking to terminate may proceed to terminate the Agreement as provided in paragraph 1 of this Article.

Article 12 – Amendment

1. The Parties may agree, in writing, to amend this Agreement.

2. If a Party wishes to amend this Agreement, it shall notify the other Party in writing of a request to begin negotiations to amend the Agreement.

3. A request to begin negotiations to amend the Agreement shall be notified to the Joint Committee.

ANNEX – Model Memorandum of Understanding Provisions on Exchange of Information between Supervisory Authorities

Article 1. Objective

1. The Supervisory Authority of (U.S. State) and the national Supervisory Authority of (EU Member State), the Authorities signing this Memorandum of Understanding, recognise the need for co-operation in exchange of information.

2. The Authorities recognise that practical arrangements concerning cross-border cooperation and information exchange are essential for both crisis situations and day-to day supervision.

3. The purpose of this Memorandum of Understanding is to facilitate cooperation in the exchange of information between the Authorities to the extent permitted by Applicable Law and consistent with supervisory and regulatory purposes.

4. The Authorities recognise that nothing in this Memorandum of Understanding addresses requirements that may apply to the exchange of personal data by supervisory authorities.

5. Applicable Law on exchange and protection of Confidential Information is in place in the territory of the Authorities, with the aim of protecting the confidential nature of data exchanged between Authorities under this Memorandum of Understanding. Amongst other things, this Applicable Law seeks to ensure that:

(a) The exchange of Confidential Information is only for purposes directly related to the fulfilment of the supervisory functions of the Authorities; and

(b) All persons gaining access to such Confidential Information in the course of their duties will maintain the confidentiality of such information, except in certain defined circumstances as set forth in Article 7.

Article 2. Definitions

1. For the purpose of this Memorandum of Understanding, the following definitions should apply:

(a) "Applicable Law" means any law, regulation, administrative provision or other legal practice applicable in the jurisdiction of an Authority relevant to insurance and reinsurance supervision, the exchange of supervisory information, the protection of confidentiality and the handling and disclosure of information;
(b) "Confidential Information" means any Provided Information regarded as confidential by the jurisdiction of the Requested Authority;
(c) "Insurer" means an undertaking which is authorised or licensed to take up or engage in the business of direct or primary insurance;
(d) "Person" means a natural person, legal entity, partnership, or unincorporated association;
(e) "Personal Data" means any information relating to an identified or identifiable natural person;
(f) "Provided Information" means any information provided by a Requested Authority to a Requesting Authority in response to a request for information;
(g) "Regulated Entity" means an insurer or reinsurer authorised or supervised by a Supervisory Authority of the European Union or the United States;
(h) "Reinsurer" means an undertaking which is authorised or licensed to take up or engage in the business of reinsurance activities;
(i) "Requested Authority" means the Authority to whom a request for information is made;
(j) "Requesting Authority" means the Authority making a request for information;
(k) "Supervisory Authority" means any insurance and reinsurance supervisor in the European Union or in the United States; and
(l) "Undertaking" means any entity engaged in economic activity.

Article 3. Cooperation

1. Subject to Applicable Law, the Requested Authority should consider requests from the Requesting Authority seriously and should respond in a timely fashion. It should provide the Requesting Authority with the fullest possible response to a request for information consistent with its regulatory functions.

2. Subject to Applicable Law, the existence and content of any request for information should be treated as confidential by both the Requested and the Requesting Authorities, unless both Authorities mutually decide otherwise.

Article 4. Use of Provided Information

1. The Requesting Authority should only make requests for information if it has a legitimate regulatory or supervisory purpose for the request directly relevant to a Requesting Authority's lawful supervision of a Regulated Entity. It is generally not considered a legitimate regulatory or supervisory purpose for a Requesting Authority to seek information on individuals, unless the request is directly relevant to the fulfilment of supervisory functions.

2. The Requesting Authority should use Provided Information only for lawful purposes related to the Authority's regulatory, supervisory, financial stability, or prudential functions.

3. Subject to Applicable Law, any Provided Information exchanged belongs to, and will remain the property of, the Requested Authority.

Article 5. Request for Information

1. Requests for information by the Requesting Authority should be in writing, or in accordance with paragraph 2 where it is urgent, and include the following elements:

(a) the Authorities involved, the field of supervision concerned and the purpose for which the information is sought;

(b) the name of the person or Regulated Entity concerned;

(c) details of the request which may include a description of the facts underlying the request, specific questions under investigation, and an indication of any sensitivity about the request;

(d) the information requested;

(e) the date by which the information is requested and any relevant legal deadlines; and

(f) if relevant, whether, how, and to whom any of the information may be passed consistent with Article 7.

2. For urgent requests, a request can be presented orally, and should be followed by written confirmation without undue delay.

3. The Requested Authority should handle the request as follows:

(a) The Requested Authority should confirm receipt of the request.

(b) The Requested Authority should assess each request on a case-by-case basis to determine the fullest extent of information that can be provided under the terms of this Memorandum of Understanding and the procedures applicable in the jurisdiction of the Requested Authority. In deciding whether and to what extent to fulfil a request, the Requested Authority may take into account:

(i) whether the request conforms with the Memorandum of Understanding;

(ii) whether compliance with the request would be so burdensome as to disrupt the proper performance of the Requested Authority's functions;

(iii) whether it would be otherwise contrary to the essential interest of the Requested Authority's jurisdiction to provide the information requested;

(iv) any other matters specified by the Applicable Law of the Requested Authority's jurisdiction (in particular those relating to confidentiality and professional secrecy, data protection and privacy, and procedural fairness); and

(v) whether complying with the request may otherwise be prejudicial to the performance by the Requested Authority of its functions.

(c) Where a Requested Authority denies or is unable to provide all or part of the requested Information, the Requested Authority should, to the extent practical and appropriate subject to Applicable Law, explain its reasons for not providing the information and consider possible alternative ways to meet the supervisory objective of the Requesting Authority. A request for Information may, in particular, be denied by the Requested Authority where the request would require the Requested Authority to act in a manner that would violate its Applicable Law.

Article 6. Treatment of Confidential Information

1. As a general rule, any information received under this Memorandum of Understanding should be treated as Confidential Information except where otherwise indicated.

2. The Requesting Authority should take all lawful and reasonably practicable actions to preserve the confidentiality of Confidential Information.

3. Subject to Article 7 and Applicable Law, the Requesting Authority should restrict access to Confidential Information received from a Requested Authority to persons working for the Requesting Authority or acting on its behalf who:

(a) are subject to the Requesting Authority's obligations in its jurisdiction to prevent unauthorized disclosure of Confidential Information;

(b) are under the supervision and control of the Requesting Authority;

(c) have a need for such information that is consistent with, and directly related to, a lawful regulatory or supervisory purpose; and

(d) are subject to ongoing confidentiality requirements after leaving the Requesting Authority.

Article 7. Onward Sharing of Provided Information

1. Except as provided in Article 7(2), a Requesting Authority should not transmit to a third party Provided Information received from the Requested Party, unless:

(a) the Requesting Authority has obtained prior written consent from the Requested Authority for onward sharing of such information unless the request is urgent, in which case it can be presented orally followed by written confirmation without delay; and

(b) the third party commits to abide by restrictions which maintain a substantially similar level of confidentiality as the one to which the Requesting Authority is subject to as set forth in this Memorandum of Understanding.

2. Subject to Applicable Law, if the Requesting Authority is subject to a legally compelled demand for or under a legal obligation to disclose Provided Information, the Requesting Authority should provide the Requested Authority with as much notice as reasonably practical of such demand and any related proceedings to facilitate opportunities to intervene and assert privilege. If the Requested Authority's consent to the production of Provided Information is not given, the Requesting Authority should take all reasonable steps where appropriate to resist disclosure, including by employing legal means to resist such disclosure and to assert and protect the confidentiality of any Confidential Information subject to potential disclosure.

WEST VIRGINIA CODE

CHAPTER 55. ACTIONS, SUITS AND ARBITRATION; JUDICIAL SALE.
ARTICLE 7F. ASBESTOS BANKRUPTCY TRUST CLAIMS TRANSPARENCY ACT.

§55-7F-1. Short title.

This article shall be known and may be cited as the Asbestos Bankruptcy Trust Claims Transparency Act.

§55-7F-2. Findings and purpose.

(a) The West Virginia Legislature finds that:

(1) The United States Supreme Court in *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 598 (1997) described the asbestos litigation as a crisis;

(2) Approximately one hundred employers have declared bankruptcy at least partially due to asbestos-related liability;

(3) These bankruptcies have resulted in a search for more solvent companies, resulting in over eight thousand five hundred companies being named as asbestos defendants, including many small- and medium-sized companies, in industries that cover eighty-five percent of the United States economy;

(4) Scores of trusts have been established in asbestos-related bankruptcy proceedings to form a multibillion dollar asbestos bankruptcy trust compensation system outside of the tort system, and new asbestos trusts continue to be formed;

(5) Asbestos claimants often seek compensation for alleged asbestos-related conditions from solvent defendants in civil actions and from trusts or claims facilities formed in asbestos bankruptcy proceedings;

(6) There is limited coordination and transparency between these two paths to recovery;

(7) An absence of transparency between the asbestos bankruptcy trust claim system and the civil court systems has resulted in the suppression of evidence in asbestos actions and potential fraud;

(8) West Virginia's Mass Litigation Panel has previously entered cases management orders that apply substantive transparency provisions requiring plaintiffs to disclose, among other things, any claims that may exist against asbestos bankruptcy trusts; and

(9) It is in the interest of justice that there be transparency for claims made in the asbestos bankruptcy trust claim system and for claims made in civil asbestos litigation.

(b) It is the purpose of this article to:

(1) Provide transparency for claims made in the asbestos bankruptcy trust claim system and for claims made in civil asbestos litigation; and

(2) Reduce the opportunity for fraud or suppression of evidence in asbestos actions.

§55-7F-3. Definitions.

For the purpose of this article:

(1) "Asbestos action" means a claim for damages or other civil or equitable relief presented in a civil action arising out of, based on or related to the health effects of exposure to asbestos, including loss of consortium, wrongful death, mental or emotional injury, risk or fear of disease or other injury, costs of medical monitoring or surveillance and any other derivative claim made by or on behalf of a person exposed to asbestos or a representative, spouse, parent, child or other relative of that person. The term does not include a claim for compensatory benefits pursuant to workers' compensation law or for veterans' benefits as defined by article seven-f of this chapter.

(2) "Asbestos trust" means a government-approved or court-approved trust, qualified settlement fund, compensation fund or claims facility created as a result of an administrative or legal action, a court-approved bankruptcy, or pursuant to 11 U. S. C. §524(g) or 11 U. S. C. §1121(a) or other applicable provision of law, that is intended to provide compensation to claimants arising out of, based on or related to the health effects of exposure to asbestos.

(3) "Plaintiff" means a person asserting an asbestos action, a decedent if the action is brought through or on behalf of an estate, or a parent or guardian if the action is brought through or on behalf of a minor or incompetent.

(4) "Trust claims materials" means a final executed proof of claim and all other documents and information related to a claim against an asbestos trust, including claims forms and supplementary materials, affidavits, depositions and trial testimony, work history, medical and health records, documents reflecting the status of a claim against an asbestos trust, and if the asbestos trust claim has settled, all documents relating to the settlement of the asbestos trust claim.

(5) "Trust governance documents" means all documents that relate to eligibility and payment levels, including claims payment matrices, trust distribution procedures or plans for reorganization, for an asbestos trust.

§55-7F-4. Required disclosures by plaintiff.

(a) For each asbestos action filed in this state, the plaintiff shall provide all parties with a sworn statement identifying all asbestos trust claims that have been filed by the plaintiff or by anyone on the plaintiff's behalf, including claims with respect to asbestos-related conditions other than those that are the basis for the asbestos action or that potentially could be filed by the plaintiff against an asbestos trust. The sworn statement shall be provided no later than one hundred twenty days prior to the date set for trial for the asbestos action. For each asbestos trust claim or potential asbestos trust claim identified in the sworn statement, the statement shall include the name, address and

contact information for the asbestos trust, the amount claimed or to be claimed by the plaintiff, the date the plaintiff filed the claim, the disposition of the claim and whether there has been a request to defer, delay, suspend or toll the claim. The sworn statement shall include an attestation from the plaintiff, under penalties of perjury, that the sworn statement is complete and is based on a good faith investigation of all potential claims against asbestos trusts.

(b) The plaintiff shall make available to all parties all trust claims materials for each asbestos trust claim that has been filed by the plaintiff or by anyone on the plaintiff's behalf against an asbestos trust, including any asbestos-related disease.

(c) The plaintiff shall supplement the information and materials provided pursuant to this section within ninety days after the plaintiff files an additional asbestos trust claim, supplements an existing asbestos trust claim or receives additional information or materials related to any claim or potential claim against an asbestos trust.

(d) Failure by the plaintiff to make available to all parties all trust claims materials as required by this article shall constitute grounds for the court to extend the trial date in an asbestos action.

§55-7F-5. Discovery; use of materials.

(a) Trust claims materials and trust governance documents are presumed to be relevant and authentic and are admissible in evidence. No claims of privilege apply to any trust claims materials or trust governance documents.

(b) A defendant in an asbestos action may seek discovery from an asbestos trust. The plaintiff may not claim privilege or confidentiality to bar discovery and shall provide consent or other expression of permission that may be required by the asbestos trust to release information and materials sought by a defendant.

§55-7F-6. Scheduling trial; stay of action.

(a) A court shall stay an asbestos action if the court finds that the plaintiff has failed to make the disclosures required under section four of this article within one hundred twenty days prior to the trial date.

(b) If, in the disclosures required by section four of this article, a plaintiff identifies a potential asbestos trust claim, the judge shall have the discretion to stay the asbestos action until the plaintiff files the asbestos trust claim and provides all parties with all trust claims materials for the claim. The plaintiff shall also state whether there has been a request to defer, delay, suspend or toll the claim against the asbestos trust.

§55-7F-7. Identification of additional or alternative asbestos trusts by defendant.

(a) Not less than ninety days before trial, if a defendant identifies an asbestos trust claim not previously identified by the plaintiff that the defendant reasonably believes the plaintiff can file, the defendant shall meet and confer with plaintiff to discuss why defendant believes plaintiff has an additional asbestos trust claim, and thereafter the defendant may move the court for an order to require the plaintiff to file the asbestos

trust claim. The defendant shall produce or describe the documentation it possesses or is aware of in support of the motion.

(b) Within ten days of receiving the defendant's motion under subsection (a) of this section, the plaintiff shall, for each asbestos trust claim identified by the defendant, make one of the following responses:

(1) File the asbestos trust claim;

(2) File a written response with the court setting forth the reasons why there is insufficient evidence for the plaintiff to file the asbestos trust claim; or

(3) File a written response with the court requesting a determination that the plaintiff's expenses or attorney's fees and expenses to prepare and file the asbestos trust claim identified in the defendant's motion exceed the plaintiff's reasonably anticipated recovery from the trust.

(c) (1) If the court determines that there is a sufficient basis for the plaintiff to file the asbestos trust claim identified by a defendant, the court shall order the plaintiff to file the asbestos trust claim and shall stay the asbestos action until the plaintiff files the asbestos trust claim and provides all parties with all trust claims materials no later than thirty days before trial.

(2) If the court determines that the plaintiff's expenses or attorney's fees and expenses to prepare and file the asbestos trust claim identified in the defendant's motion exceed the plaintiff's reasonably anticipated recovery from the asbestos trust, the court shall stay the asbestos action until the plaintiff files with the court and provides all parties with a verified statement of the plaintiff's history of exposure, usage or other connection to asbestos covered by the asbestos trust.

(d) Not less than thirty days prior to trial in an asbestos action, the court shall enter into the record a trust claims document that identifies each claim the plaintiff has made against an asbestos trust.

§55-7F-8. Valuation of asbestos trust claims; judicial notice.

(a) If a plaintiff proceeds to trial in an asbestos action before an asbestos trust claim is resolved, the filing of the asbestos trust claim may be considered as relevant and admissible evidence.

(b) Trust claim materials that are sufficient to entitle a claim to consideration for payment under the applicable trust governance documents may be sufficient to support a jury finding that the plaintiff may have been exposed to products for which the asbestos trust was established to provide compensation and that such exposure may be a substantial factor in causing the plaintiff's injury that is at issue in the asbestos action.

§55-7F-9. Setoff; credit.

In any asbestos action in which damages are awarded, a defendant is entitled to a setoff or credit in the amount of the valuation established under the applicable trust governance documents, including payment percentages for asbestos trust claims pending at trial and any amount the plaintiff has been awarded from an asbestos trust claim that has been identified at the time of trial. If multiple defendants are found liable for damages, the court shall distribute the amount of setoff or credit proportionally between the defendants, according to the liability of each defendant.

§55-7F-10. Failure to provide information; sanctions.

A plaintiff who fails to provide all of the information required under this article is subject to sanctions as provided in the West Virginia Rules of Civil Procedure and any other relief for the defendants that the court considers just and proper.

§55-7F-11. Application.

The provisions of this article apply to all asbestos actions filed on or after the effective date of this article.

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

Resolution in Support of an Exemption for Community Banks from Onerous and Unnecessary Regulations

To be discussed during the NCOIL Financial Services Committee on March 4, 2017.
Sponsored by Sen. Travis Holdman (IN)

WHEREAS, community banks, generally defined as banks with less than $10 billion in assets, provide safe and sound lending opportunities for their members and play a critical role in U.S. lending markets; and

WHEREAS, community banks account for more than 50% of all small business loans, and almost one out of every five U.S. counties have no other physical banking offices except those operated by community banks; and

WHEREAS, despite their major role in the U.S. economy and their minimal role in the 2008 financial crisis, one of the most significant problems community banks face is the sheer volume of banking regulations resulting from the enactment of the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), which established the Consumer Protection Financial Bureau (CFPB) whose authority is to administer, enforce, and otherwise implement federal consumer financial laws; and

WHEREAS, many of the regulations resulting from Dodd-Frank were intended to stop activities that larger institutions conducted in the run-up to the financial crises; and

WHEREAS, such regulations require a degree of categorization, recordkeeping, and reporting that can be particularly onerous for smaller institutions such as community banks which do not have large compliance staffs; and

WHEREAS, many community banks struggle with such unnecessary regulatory burdens, hindering their ability to fuel small business growth and job creation without enhancing consumer protections or improving the safety of the financial system; and

WHEREAS, the Government Accountability Office (GAO) has found that Dodd-Frank regulations have caused community based financial institutions to spend a tremendous amount of resources on compliance, thereby reducing the availability of credit to the communities they aim to serve; and

WHEREAS, while the CFPB does not have direct supervisory authority oversight over community banks, incongruously, the CFPB can still require community banks to submit reports, and can examine community banks at its discretion "on a sample basis…to assess compliance with the requirements of Federal consumer financial law," thereby sending a mixed message to community banks; and

WHEREAS, section 1022(b)(3)(a) of Dodd-Frank gives the CFPB the authority to adapt regulations by allowing it to exempt "any class" of entity from its rulemakings; and

NOW, THEREFORE, BE IT RESOLVED, that NCOIL supports the CFPB using such authority to create a regulatory environment for community banks that promotes their role as catalysts for entrepreneurship, economic growth, and job creation; and

NOW, THEREFORE, BE IT FURTHER RESOLVED, that the CFPB exempt community banks from all of its rulemakings pursuant to section 1022(b)(3)(a) of Dodd-Frank, and if the CFPB does not use its authority to exempt community banks from its rulemakings, then NCOIL urges Congress to amend Dodd-Frank accordingly so that community banks are exempt from all of the Act's provisions so that community banks can return to the effective regulatory scheme in place prior to July 21, 2010, thus freeing community banks to use their capital in productive ways; and

NOW, THEREFORE, BE IT FURTHER RESOLVED that NCOIL urges the Secretary of the Treasury, the Federal Reserve Board, the Comptroller of the Currency, and the Chairman of the Federal Deposit Insurance Corporation to take all steps within their authority consistent with this Resolution;

AND, BE IT FINALLY RESOLVED, that a copy of this Resolution shall be distributed to the Speaker and Minority Leader of the US House of Representatives; the Majority Leader and Minority Leader of the United States Senate; Chairman and Ranking Member of the US House Financial Services Committee; Chairman & Ranking Member of the Senate Banking Committee; Secretary of the Treasury; Director of the Consumer Financial Protection Bureau, Chairman of the Federal Reserve Board; Comptroller of the Currency; and, Chairman of the Federal Deposit Insurance Corporation.

ADDENDUM

Side-by-Side Comparison of

NAIC Health Benefit Plan Network Access and Adequacy Model Act (or "NAIC Network Adequacy Model Act")

NCOIL Proposed Model Act Regarding Network Adequacy and Use of Out-of-Network Providers (or "NCOIL Proposed Network Adequacy Model Act")

NCOIL Health Care Balance Billing Disclosure Model Act (or "NCOIL Balance Billing Model Act")

NAIC MODEL ACT PROVISIONS RELATED TO PROVIDER DIRECTORIES

As noted on page 21 of the side-by-side comparison document, portions of Sections 4A and 4B of the NCOIL Proposed Model Act Regarding Network Adequacy and Use of Out-of-Network Providers, and Section 6 C of the NCOIL Health Care Balance Billing Disclosure Model Act refer either directly or indirectly to the information provided in health plan provider directories. Section 9 of the NAIC Network Adequacy Model Act discusses provider directories in detail. In the interest of keeping the comparison document to as few pages as possible, the NAIC language has been shifted from the narrow center column of the comparison document and provided below.

Section 9A

(1)

a. A health carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions, as described herein.

b. In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2)

a. The health carrier shall update each network plan provider directory at least monthly.

b. The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.

Drafting Note: In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as participating providers who have not submitted claims within the past six months or other time frame a state feels is appropriate, to determine whether the provider still intends to be in network; and 2) closely monitoring consumer complaints.

Drafting Note: In situations in which a covered person receives covered services from a non-participating provider due to a material misrepresentation in the provider directory indicating

that the provider is a participating provider, state insurance regulators should refer the issue to their consumer complaint division for a resolution, such as requiring the health carrier to cover the benefit claim as if the services were obtained from a participating provider.

(3) A health carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described below, upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language in both the electronic and print directory, the following general information:
   (a) In plain language, a description of the criteria the carrier has used to build its provider network;
   (b) If applicable, in plain language, a description of the criteria the carrier has used to tier providers;
   (c) If applicable, in plain language, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and
   (d) If applicable, note that authorization or referral may be required to access some providers.

(5)
   (a) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

   (b) The health carrier shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

(6) For pieces of information required in a provider directory pertaining to a health care professional, a hospital or facility other than a hospital, the health carrier shall make available through the directory the source of the information and any limitations, if applicable.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

Section 9B

The health carrier shall make available through an electronic provider directory, for each network plan, the following information in a searchable format:

(1) For health care professionals:
   (a) Name;
   (b) Gender;
   (c) Participating office location(s);
   (d) Specialty, if applicable;
   (e) Medical group affiliations, if applicable;
   (f) Facility affiliations; if applicable;
   (g) Participating facility affiliations, if applicable;
   (h) Languages spoken other than English, if applicable; and
   (i) Whether accepting new patients.
(2) For hospitals:
   (a) Hospital name;
   (b) Hospital type (i.e., acute, rehabilitation, children's, cancer);
   (c) Participating hospital location; and
   (d) Hospital accreditation status; and

(3) For facilities, other than hospitals, by type:
    (a) Facility name;
    (b) Facility type;
    (c) Types of services performed; and
    (d) Participating facility location(s).

Section 9 C

For electronic provider directories, for each network plan, a health carrier shall make available the following information in addition to all of the information available under Subsection B:

(1) For health care professionals:
    (a) Contact information;
    (b) Board certification(s); and
    (c) Languages spoken other than English by clinical staff, if applicable.
(2) For hospitals: telephone number; and
(3) For facilities other than hospitals: telephone number.

Section 9D

(1) The health carrier shall make available in print, upon request, the following provider directory information for applicable network plan:

    (a) For health care professionals:
        (i) Name;
        (ii) Contact information;
        (iii) Participating office location(s);
        (iv) Specialty, if applicable;
        (v) Languages spoken other than English, if applicable, and
        (vi) Whether accepting new patients.
    (b) For hospitals:
        (i) Hospital name;
        (ii) Hospital type (i.e., acute, rehabilitation, children's, cancer); and
        (iii) Participating hospital location and telephone number; and
    (c) For facilities, other than hospitals, by type:
        (i) Facility name;
        (ii) Facility type;
        (iii) Types of services performed; and
        (iv) Participating facility location(s) and telephone number.

(2) The health carrier shall include a disclosure in the print directory that the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website or call [insert appropriate customer service phone number] to obtain current provider directory information.

    Drafting Note: In addition to the information required, health carriers may include or make available in their provider directories additional information, such as information concerning the structural accessibility, presence of accessible examination, and diagnostic equipment and availability of programmatic accessibility.

    Drafting Note: States should consider that the information included in electronic and print provider directories for limited scope dental and/or vision plans may have to differ from the information included in provider directories for major medical, comprehensive health benefit plans. For example, information on provider medical group affiliations and board certifications are not typically included in provider directories for limited scope dental and/or vision plans.

NAIC MODEL ACT LANGUAGE THAT DOES NOT DIRECTLY CORRESPOND TO LANGUAGE IN THE PROPOSED NCOIL NETWORK ADEQUACY MODEL BILL OR THE NCOIL BALANCE BILLING MODEL

The NAIC Health Benefit Plan Network Access and Adequacy Model Act is 32 pages long and addresses some topics not directly addressed in either the Proposed NCOIL Network Adequacy model bill or the NCOIL Balance Billing Model Act. To reduce the number of pages in this side-by-side comparison, we have moved that NAIC language from the middle column to this addendum.

In addition, some of the lengthier drafting notes from the NAIC model language shown below have been omitted but are available in the NAIC model (link provided **here** and in the column header at the top of each page of the side-by-side).

BALANCE BILLING REQUIREMENTS UNRELATED TO DISCLOSURES

Section 7E

(1) Health carriers shall develop a program for payment of non-participating facility-based provider bills submitted pursuant to this section.
(2) Health carriers may elect to pay non-participating facility-based provider bills as submitted or the health carrier may pay in accordance with the benchmark established in 7F below.
(3) Non-participating facility-based providers who object to the payment(s) made above may elect the Provider Mediation Process described in 7G.
(4) This section does not preclude a health carrier and an OON facility-based provider from agreeing to separate payment arrangements.

Section 7F
Payments to non-participating facility-based providers shall be presumed to be reasonable if it is based on the higher of the health carrier's contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area.

Drafting Note: This section proposes that states set a benchmark(s) for payments to non-participating facility-based providers. States can consider a number of options to use as the default reimbursement presumed to be reasonable, including, as provided above, using a percentage of the Medicare payment that a state considers appropriate to determine the rate for the same or similar services in the same geographic area. Others can include: a) some percentage of a public, independent, database of charges for the same or similar services in the same geographic area; or b) some percentage of the usual, customary, and reasonable (UCR) charges in the state, if defined in state law or regulation. In setting a benchmark(s), states should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility-based providers and health carriers to agree on a contract.

Section 7H

The rights and remedies provided under this section to covered persons shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

APPLICABILITY EXEMPTIONS

Section 4

The following provisions of this act shall not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope visions plans:

(1) Section 5A(2) of this Act. [Note: Covered person access to emergency services 24/7]
(2) Section 5F(7)(e), (8)(b) and (11) of this Act. [Note: A method for informing covered persons of the plan's procedures for covering and approving emergency, urgent, and specialty care; a system for ensuring the coordination and continuity of care for covered persons using ancillary services, including social services and other community resources and for ensuring appropriate discharge planning; and a process for monitoring access to physician specialist services in ERs, anesthesiology, radiology, hospitalist care and pathology/laboratory services at participating hospitals
(3) Section 6L(2)(a)(i)(I) and (III) and (c)(iii)(III) of this Act. [Note: An active course of treatment for ongoing course of treatment for a life-threatening condition; an active course of treatment for the second or third trimester of pregnancy and a continuity of care period for covered persons who are in their second or third trimester of pregnancy through the post-partum period]
(4) Section 8 of this Act [Note: Disclosure and notice requirements]
(5) Section 9B(2) and (3) of this Act [Note: Electronic provider directory information for hospitals or facilities other than hospitals]
(6) Section 9C(1)(a) and (b), (2) and (3) of this Act. [Note: Contact information and board certification within an electronic provider directory information for health care professionals; and phone numbers for hospitals and facilities within an electronic provider directory.

ACCESS PLAN

Section 5 E

(1) Beginning [insert effective date], a health carrier shall file with the commissioner [for review] [for approval] prior to or at the time it files a newly offered network, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act.
Drafting Note: States will establish different requirements for the access plan. The above paragraph provides for this by giving states the option to file and use the access plan, or to require prior approval before using the access plan. In states where prior approval is required, states may want to consider, for example, whether access to specific types of provider or health care services, geographic areas of the state, and other network issues with a past pattern of adequacy concerns require heightened review. Some states may also specify an agency other than the insurance department as the appropriate agency to review or approve access plans.

(2) The health carrier may request the commissioner to deem sections of the access plan as [proprietary, competitive or trade secret] information that shall not be made public. The health carrier shall make the access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request.

For purposes of this subsection, information is [proprietary or competitive or a trade secret] if revealing the information would cause the health carrier's competitors to obtain valuable business information.

Drafting Note: State insurance regulators should be aware that the intent of the above paragraphs is that the access plan be considered public information. Health carriers should not be permitted to request that the entire plan is proprietary, competitive or a trade information, and, as such no provision of the plan may be made public. State insurance regulators should review their open records laws in determining whether a particular provision, if any, of an access plan is proprietary, competitive or trade secret information and should not be made public based on information received from the health carrier supporting its request. State insurance regulators also should review their laws or regulations to determine which term is appropriate to use. State insurance regulators should rely on the state law or regulation that defines trade secret or proprietary.

(3) The health carrier shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner of any material change to any existing network plan within 15 business days after the change occurs. The carrier shall include in the notice to the commissioner a reasonable timeframe within which it will submit to the commissioner for approval or file with the commissioner, as appropriate, an update to an existing access plan.

Drafting Note: State insurance regulators may want to consider defining "material change" for purposes of Paragraph (3) above. **[Editor's Note: The drafting note goes on to provide examples of how a state could define the phrase.]**

Section 5F

The access plan shall describe or contain at least the following:

(1) The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable;
(2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;
(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;
(4) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;
(5) The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;
(6) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
(7) The health carrier's method of informing covered persons of the plan's covered services and features, including but not limited to:
    (a) The plan's grievance and appeals procedures;
    (b) Its process for choosing and changing providers;
    (c) Its process for updating its provider directories for each of its network plans;
    (d) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and
    (e) Its procedures for covering and approving emergency, urgent and specialty care, if applicable;

    Drafting Note: State insurance regulators should ensure that limited scope dental plans have provisions in their access plans or form filings, as appropriate, consistent with current practice to address situations where covered persons need urgent dental care.
    Drafting Note: Some states may have an existing definition of "urgent care." Those states with existing definitions may want to consider using the definition in this Act.

(8) The health carrier's system for ensuring the coordination and continuity of care:
    (a) For covered persons referred to specialty physicians; and
    (b) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(9) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;

(10) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations -

(a) The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner;

(11) The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals; and
Drafting Note: If a limited scope dental and/or vision plan uses hospitals and/or other types of facility in its provider network, then the limited scope dental and/or vision plan shall comply with the Act's requirements pertaining to hospitals and/or other type of facility

(12) Any other information required by the commissioner to determine compliance with the provisions of this Act.

Drafting Note: State insurance regulators may want to consider requiring that an access plan include information on the health carrier's efforts to ensure that its participating providers meet available and appropriate quality of care standards and health outcomes for network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.

Drafting Note: States should be aware that for dental network plans, some state insurance regulators may not require the preparation and submission of a so-called "access plan" for purposes of determining the sufficiency of a dental provider network. These states may require other documentation to be included in the form filings to accomplish this purpose in order to review and determine the sufficiency of a dental and/or vision provider network. State insurance regulators, however, should be aware that dental carriers seeking certification to offer limited scope dental plans on a health insurance Exchange use the term "access plan."

PROVIDER SELECTION AND TIERING

Section 6 F

(1) Health carrier selection standards for selecting and tiering, as applicable, of participating providers shall be developed for providers and each health care professional specialty.

(2)

(a) The standards shall be used in determining the selection [and tiering] of participating providers by the health carrier and its intermediaries with which it contracts.

(b) The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].

(3)

(a) Selection [and tiering] criteria shall not be established in a manner:

(i) That would allow a health carrier to discriminate against high-risk populations by excluding [and tiering] providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or

(ii) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization.

(b)

(i) In addition to subparagraph (a) of this paragraph, a health carrier's selection criteria may not discriminate with respect to participation under the health benefit plan against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations.

(ii) The provisions of Subparagraph (b)(i) shall not be construed to require a health carrier to contract with any provider willing to abide by the terms and conditions for participation established by the carrier.

(4) This shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this Act.

(5) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network.

Section 6G
A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner. A description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, shall be available to the public.

Drafting Note: State insurance regulators should review how a health carrier markets or represents its network plans to consumers particularly for those network plans that carriers market or represent to consumers as using quality as at least one method of assessing whether to include providers in the network. In addition, for such network plans, state insurance regulators also should review a health carrier's provider selection standards to ensure that quality is actually being used to assess whether to include providers in the network.

Drafting Note: The disclosure of a health carrier's selection standards to providers and consumers is an important issue to be considered by states and could be addressed in this Act or in another law.

Section 6H
A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuances of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

Section 6I
A health carrier shall not offer an inducement to a provider that would encourage or otherwise incent the provider to deliver less than medically necessary services to a covered person.

Section 6J
A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered person within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier or in accordance with any rights or remedies available under applicable state or federal law.

Section 6K

Every contract between a health carrier and a participating provider shall require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered persons' right to see, obtain copies of, or amend their medical and health records.

Section 6L

(1)

(a) A health carrier and a participating provider shall provide at least 60-days written notice to each other before the provider is removed or leaves the network without cause.

Drafting Note: In addition to when a provider is removed or leaves the network without cause, with respect to tiered network plans, states may want to consider the implications that consumers may face, including continuity of care and financial implications, when a participating provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements.

(b) The health carrier shall make a good faith effort to provide written notice of a provider's removal or leaving the network within 30 days of receipt or issuance of a notice provided to all covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether it is with or without cause.

(c) When the provider being removed or leaving the network is a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. When the provider either gives or receives the notice, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

(2)

(a) [See Definitions section above for definitions of "active course of treatment," "life threatening health condition" and "serious acute condition."]

(b) For purposes of subparagraph (a)(i), a covered person shall have been treated by the provider being removed or leaving the network on a regular basis to be considered an "active course of treatment."

(c)

(i) When a covered person's provider leaves or is removed from the network, a health carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.

(ii) The health carrier shall provide the notice required, and shall make available to the covered person a list of available participating providers in the same geographic area who are of the same provider type and information about how the covered person may request continuity of care as provided.

(iii) The procedure shall provide that:

I. Any request for continuity of care shall be made to the health carrier by the covered person or the covered person's authorized representative;

II. Requests for continuity of care shall be reviewed by the health carrier's medical director after consultation with the treating provider for patients who meet the criteria listed and are under the care of a provider who has not been removed or leaving the network for cause. Any decisions made with respect to a request for continuity of care shall be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;

III. The continuity of care period for covered persons who are in their 2nd or 3rd trimester of pregnancy shall extend through the postpartum period; and

IV. The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of;

a. The termination of the course of treatment by the covered person or the treating provider;
b. [90 days] unless the medical director determines that a longer period is necessary;
c. The data that care is successfully transitioned to a participating provider;
d. Benefit limitations under the plan are met or exceeded; or
e. Care is not medically necessary.

Drafting Note: The current accreditation standard for the length of the continuity of care period is 90 days. When determining the length of time for the continuity of care period, states should consider the number of providers, especially specialty providers who are available to treat serious health conditions in their states. States that have relatively few specialists or where consumers face significant wait times for appointments may want to adjust the continuity of care time frame.

(iv) In addition to the provisions of Item (iii)(IV), a continuity of care request may only be granted when:

I. The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract; and
II. The provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.

Drafting Note: In the event of a termination of a limited scope dental or vision plan participating provider, the commissioner may work with the plan's health carrier for approval of in-network benefits provided to the covered person until the episode of care is concluded.

Drafting Note: States may want to review other state laws and regulations and consider adding special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer's enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to have been a participating provider at the time of enrollment or when a participating provider was listed as accepting new patients, but was not accepting new patients at the time of enrollment.

Section 6M
The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by either party without the prior written consent of the other party.

Section 6N
A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

Section 6O
A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, co-payments or deductibles from covered persons pursuant to the evidence of coverage, or

of the providers' obligations, if any to notify covered persons of their personal financial obligations for non-covered services.

Section 6P
A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Section 6Q
A health carrier shall establish a mechanism by which participating providers may determine in a timely manner at the time services are provided, whether or not an individual is a covered person or is within a grace period for payment of premium during which the carrier may hold a claim for services pending receipt of payment of premium.

Drafting Note: There are situations that may arise when using the mechanism established when a participating provider has verified an individual's eligibility on the date of service, but later the provider learns that the individual was not actually eligible or has been terminated due to failure to pay premium or due to some other situation that may arise due to enrollment timing issues, and other issues under the ACA. Providers in this situation may bill the individual for payment of services provided. States may want to look at establishing possible protections for consumers in such situations when carriers have verified eligibility.

Section 6T

(1) At the time the contract is signed, a health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions and other documents incorporated by reference in the contract.

While the contract is in force, the carrier shall timely notify a participating provider of any changes to those provisions or documents that would result in material changes in the contract.

For purposes of this paragraph, the contract shall define what is to be considered timely notice and what is to be considered a material change.

Drafting Note: State insurance regulators may want to consider reviewing the sample contract forms filed with the commissioner under Section 11 in order to determine if the provisions in the contract defining what is to be considered time notice and what is to be considered a material change reflect fair contracting between the parties to the contract. Retroactive application of a change in the contract or in a document incorporated by reference will not be considered timely notice of the change. If the regulatory authority to review provider contracts lies with some state agency other than the insurance department, a state should consider adding language to this section, section 11, or some other section of the Act referencing that agency to ensure appropriate regulatory oversight of provider contracting issues.

(2) A health carrier shall timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider.

REGULATIONS

Section 7K

The commissioner and the [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general as indicated in section 7I] may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this section. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 14
The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

INTERMEDIARIES

Section 10

A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

A. Intermediaries and participating providers with whom they contract shall comply with all applicable requirements of Section 6 of this Act (requirements for health carriers and participating providers).
B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.
C. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.
D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon 20 days prior written notice from the health carrier.
E. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.
F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for [cite applicable statutory duration] in a manner that facilitates regulatory review.
G. An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance with this Act.
H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services. If a health carrier requires assignment, the health carrier shall remain obligated to pay the provider for furnishing covered services under the same terms and conditions as the intermediary prior to the insolvency.
I. Notwithstanding any other provision, to the extent the health carrier delegates its responsibilities to the intermediary, the carrier shall retain full responsibility for the intermediary's compliance with the requirements of this Act.

Drafting Note: States may want to consider requiring intermediaries to register with the state department of insurance, or other state agency as the state may feel is appropriate, or impose some other type of regulatory scheme on such entities, to ensure the state has the regulatory authority to regulate them and keep track of their activities.

FILING REQUIREMENTS AND STATE ADMINISTRATION

Section 11

A. At the time a health carrier files its access plan, the health carrier shall file [for approval] with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

Drafting Note: States may want to review their open records laws to determine whether the same contract forms filed are considered public information.

B. A health carrier shall submit material changes to a contract that would affect a provision required under this Act or implementing regulations to the commissioner [for approval] at least [cite period of time in the form approval statute] days prior to use.

Drafting Note: Subsections A and B provide for an option for states to require health carriers to file with the commissioner for informational purposes any material changes to a contract OR to require health carriers to file contracts and material changes for prior approval. A state should choose which option is appropriate for the state.

Drafting Note: States should consider that when health carriers make changes in contracted provider payment rates, coinsurance, co-payments or deductibles, or other plan benefit modifications, such changes could materially impact a covered person's access to covered benefits or timely access to participating providers; and as such, would be considered a material change to a contract subject to the requirement to file with the commissioner for informational purposes or filing for prior approval.

C. If the commissioner takes no action within 60 days after submission of a contract or a material change to a contract by a health carrier, the contract or change is deemed approved.

D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon 20 days prior written notice from the commissioner.

CONTRACTING

Section 12

A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.
B. All contracts shall be in writing and subject to review.

Drafting Note: Each state should add provisions that are consistent with that state's current regulatory requirements for the approval or disapproval of health carrier contracts, documents, or actions. For example, a state may want to add a provision requiring a health carrier to obtain prior approval of contracts, or requiring a health carrier to file a contract before using it, or requiring a health carrier to certify that all its contracts comply with this Act.

C. All contracts shall comply with applicable requirements of the law and applicable regulations.

EFFECTIVE DATE

Section 17

This Act shall be effective [insert date]. [If applicable:] The [insert year of adoption] amendments to this Act shall be effective [insert date].

A. All provider and intermediary contracts in effect on [insert effective date] shall comply with this Act no later than 18 months after [insert effective date]. The commissioner may extend the 18 months for an additional period not to exceed six months if the health carrier demonstrates good cause for an extension.
B. A new provider or intermediary contract that is issued or put in force on or after [insert a date that is six months after the effective date of this Act] shall comply with this Act.

C. A provider contract or intermediary contract not described above, shall comply with this Act no later than 18 months after [insert effective date].

D. Transition period for compliance with amended Section 5 of this Act.

Option 1: For states with access plan requirements comparable to the pre-2015 Act: No later than [12 months] after [insert effective date of amendments], each health carrier offering or renewing network plan in this state shall file revised access plans consistent with Section 5 of this Act, as amended, for all in-force network plans.

Option 2: For states without access plan requirements comparable to the pre-2015 Act: No later than [12 months] after [insert effective date of Act or effective date of amendments], each health carrier offering or renewing network plans in this state shall file access plans consistent with Section 5 of this Act for all in-force network plans.