TENTATIVE GENERAL SCHEDULE
NCOIL SUMMER MEETING
JULY 12-15, 2017

As of June 13, 2017, and Subject to Change

Intercontinental Chicago Magnificent Mile
Chicago, Illinois

NCOIL SUMMER MEETING
Chicago, Illinois
July 12 - 15, 2017
TENTATIVE SCHEDULE

WEDNESDAY, JULY 12TH

Welcome Reception	6:30 p.m.	-	7:30 p.m.

THURSDAY, JULY 13TH

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.
Workers Compensation Committee	10:15 a.m.	-	11:30 a.m.
Fundamentals of Insurance Session I (To run concurrent with committee hearings)	10:15 a.m.	-	11:45 a.m.
Health General Session	11:30 a.m.	-	12:45 p.m.
The Institutes Griffith Foundation Legislator Luncheon	12:45 p.m.	-	1:45 p.m.
Joint State-Federal Relations and International Insurance Issues Committees	2:00 p.m.	-	3:30 p.m.
Fundamentals of Insurance Session II (To run concurrent with committee hearings)	2:00 p.m.	-	3:30 p.m.
Networking Break	3:30 p.m.	-	3:45 p.m.

Innovation General Session	3:45 p.m.	-	4:45 p.m.
Budget Committee	4:45 p.m.	-	5:15 p.m.
CIP Reception	5:45 p.m.	-	6:45 p.m.

FRIDAY, JULY 14TH

Registration *Exhibits Open: 8:15 a.m. – 5:15 p.m.*	7:00 a.m.	-	5:30 p.m.
Health, Long Term Care & Health Retirement Issues Committee	9:00 a.m.	-	11:00 a.m.
Networking Break	11:00 a.m.	-	11:15 a.m.
NCOIL – NAIC Dialogue	11:15 a.m.	-	12:45 p.m.
Luncheon with Keynote Address	12:45 p.m.	-	2:15 p.m.
Legislative Micro Meetings	2:15 p.m.	-	2:45 p.m.
P&C General Session	2:45 p.m.	-	4:00 p.m.
Property & Casualty Committee	4:00 p.m.	-	6:00 p.m.
IEC Board Meeting	6:00 p.m.	-	6:30 p.m.

SATURDAY, JULY 15TH

Registration *Exhibits Open: 8:00 a.m. – 11:30 a.m.*	7:00 a.m.	-	11:00 a.m.
Air Ambulance Task Force	8:15 a.m.	-	9:00 a.m.
Life Insurance and Financial Planning Committee	9:00 a.m.	-	10:15 a.m.
Financial Services Committee	10:15 a.m.	-	11:15 a.m.
Networking Break	11:15 a.m.	-	11:30 a.m.
ILF Board Meeting	11:30 a.m.	-	11:45 a.m.

Business Planning Committee and Executive Committee	11:45 a.m.	-	12:45 p.m.

WEDNESDAY, JULY 12, 2017

Welcome Reception
July 12, 2017
6:30 p.m. – 7:30 p.m.

THURSDAY, JULY 13, 2017

Welcome Breakfast
July 13, 2017
8:30 a.m. – 10:00 a.m.

1. President Welcome
2. New member welcome
3. Comments from NCOIL CEO Commissioner Tom Considine
4. Presentation from Speaker
5. Adjournment

Workers' Compensation Insurance Committee
July 13, 2017
10:15 a.m. – 11:30 a.m.

1. Call to order/roll call/approval of March 4, 2017 committee meeting minutes
2. Discussion on Illinois workers' compensation reform efforts
3. Discussion on alternatives to workers' compensation for independent contractors
4. Introduction of impact of direct dispense programs on State workers' compensations systems
5. Adjournment

Fundamentals of Insurance Session I (To run concurrent with committee hearings)
July 13, 2017
10:15 a.m. – 11:45 a.m.

Health General Session
High Risk Pools - Is Everything Old New Again?
July 13, 2017
11:30 a.m. – 12:45 p.m.

The Institutes Griffith Foundation Legislator Luncheon
The Role of Rating Agencies in Insurance Markets: A Primer for Public Policymakers
July 13, 2017
12:45 p.m. – 1:45 p.m.

Joint State-Federal Relations and International Insurance Issues Committees
July 13, 2017
2:00 p.m. – 3:30 p.m.

1. Call to order/roll call/approval of March 5, 2017 committee meeting minutes
2. Update on Covered Agreement
3. Discussion on The Office of Independent Insurance Advocate - refocusing federal involvement in insurance
4. Update on Dodd-Frank and CFPB developments
5. Discussion on IAIS Initiatives
6. Discussion on draft legislation – "The International Insurance Standards Act of 2017"
7. Update on NCOIL Brussels Initiative
8. Adjournment

Fundamentals of Insurance Session II (To run concurrent with committee hearings)
July 13, 2017
2:00 p.m. – 3:30 p.m.

Networking Break
July 13, 2017
3:30 p.m. – 3:45 p.m.

Innovation General Session
Lemonade and Trov – Changing How We View Insurance
July 13, 2017
3:45 p.m. – 4:45 p.m.

Budget Committee
July 13, 2017
4:45 p.m. – 5:15 p.m.

CIP Reception
July 13, 2017
5:45 p.m. – 6:45 p.m.

FRIDAY, JULY 14, 2017

Health, Long Term Care and Health Retirement Issues Committee
July 14, 2017
9:00 a.m. – 11:00 a.m.

1. Call to order/roll call/approval of March 3, 2017 committee meeting minutes
2. Network adequacy/provider directories/balance billing discussion
3. Anatomy of a health insurance premium: Are Rx prices responsible for a disproportionate share of health insurance premiums?
4. Brief update on ACA repeal/reform efforts
5. Discussion on Air Ambulance Task Force activities
6. Re-adoption of Model Laws
    a. Healthcare Balance Billing Disclosure Model Act
7. Adjournment

Networking Break
July 14, 2017
11:00 a.m. – 11:15 a.m.

NCOIL – NAIC Dialogue
July 14, 2017
11:15 a.m. – 12:45 p.m.

1. Call to order/roll call/approval of March 3, 2017 committee meeting minutes
2. Discussion on NAIC Incorporation by Reference (IBR)
3. Discussion on NAIC Travel Insurance Working Group's efforts
4. Update on NAIC Insurance Data Security Model Law
5. Update on NAIC Unclaimed Property Model Working Group ceasing drafting efforts
6. Discussion on NAIC Innovation Task Force
7. Adjournment

Luncheon with Keynote Address
July 14, 2017
12:45 p.m. – 2:15 p.m.

Legislative Micro Meetings
July 14, 2017
2:15 p.m. – 2:45 p.m.

P&C General Session
The Future of Drones in the Insurance Industry
July 14, 2017
2:45 p.m. – 4:00 p.m.

Property & Casualty Committee
July 14, 2017
4:00 p.m. – 6:00 p.m.

1. Call to order/roll call/approval of March 5, 2017 committee meeting minutes and June 5, 2017 interim committee meeting minutes
2. Discussion on flood insurance market and NFIP reauthorization
3. Presentation from United Policyholders and Rutgers Center for Risk and Responsibility at Rutgers Law School: Essential Protections for Policyholders
4. Discussion on the use of Big Data and Autonomous Vehicles
5. Discussion on Model Towing Act
6. Update on American Law Institute (ALI) Restatement of the Law of Liability Insurance
7. Re-adoption of Model Laws:
    a. Certificates of Insurance Model Act
    b. Model Act Regarding Use of Insurance Binders as Evidence of Coverage
    c. Model State Uniform Building Code
    d. Auto Insurance Fraud Model Act
8. Adjournment

IEC Board Meeting
July 14, 2017
6:00 p.m. – 6:30 p.m.

SATURDAY, JULY 15, 2017

Air Ambulance Task Force
July 15, 2017
8:15 a.m. – 9:00 a.m.

Life Insurance & Financial Planning Committee
July 15, 2017
9:00 a.m. – 10:15 a.m.

1. Call to order/roll call/approval of March 4, 2017 committee meeting minutes
2. Update on DOL Fiduciary Rule
3. The John Hancock Vitality Program – An innovative life insurance solution that rewards healthy living
4. Consideration of Proposed Amendments to Secondary Addressee Model Act
5. Adjournment

Financial Services Committee
July 15, 2017
10:15 a.m. – 11:15 a.m.

1. Call to order/roll call/approval of March 3, 2017 committee meeting minutes
2. NY DFS Cybersecurity Regulations: A National Blueprint?
3. Continued Discussion on Resolution in Support of an Exemption for Community Banks from Onerous and Unnecessary Regulations

4. Update on Financial CHOICE Act of 2017
5. Adjournment

Networking Break
July 15, 2017
11:15 a.m. – 11:30 a.m.

ILF Board Meeting
July 15, 2017
11:30 a.m. – 11:45 a.m.

Business Planning Committee and Executive Committee
July 15, 2017
11:45 a.m.– 12:45 p.m.

1. Call to order/roll call/approval of March 5, 2017 committee meeting minutes
2. 2019 meeting locations
3. Recruitment of new member states
4. Administration
    a. Meeting Report
    b. Receipt of Financials
5. Non-controversial calendar
    a. Committee Reports including Model Laws adopted/re-adopted therein
6. Consideration of Model Act to Support State Regulation of Insurance Through More Informed Policymaking
7. Other Sessions
    a. Griffith Foundation Legislator Luncheon
    b. Fundamentals of Insurance Sessions
    c. Featured Speakers
8. Any other business
9. Adjournment

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

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.

Atlantic Corporate Center
2317 Route 34, Suite 2B
Manasquan, NJ 08736
732-201-4133
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, February 26, 2012, and March 4, 2017.
Proposed Amendments to be considered by the Life Insurance & Financial Planning Committee on July 15, 2017

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 **or if agreed to by the applicant, e-mailed or texted,** 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 **or if agreed to by the applicant, e-mailed or texted,** 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.

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 July 15, 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 _____

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

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***

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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).*

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

National Conference of Insurance Legislators (NCOIL)

DRAFT OUT-OF-NETWORK BALANCE BILLING TRANSPARENCY MODEL ACT

To be discussed by the Health, Long Term Care, and Health Retirement Issues Committee on July 14, 2017
Sponsored by Sen. James Seward (NY)

Section 1. Title

This Act shall be known as the Out-of-Network Balance Billing Transparency Act.

Section 2. Purpose

The purpose of this Act is to protect consumers from unexpected medical bills that result from their receiving care from out-of-network physicians. Improved disclosures by health benefit plans, providers, and facilities, and a procedure for appealing out-of-network referral denials will help consumers better navigate the insurance processes and reduce the incidence of costly, surprise bills.

Section 3. Applicability

A. Except as provided in subsection B, this Act applies to any health benefit plan, provider, and health care facility as defined in Section 4.

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

Section 4. Definitions

A. "Balance billing" means the practice by a provider, who does not participate in an enrollee's health benefit 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 required by the health benefit plan.

B. "Carrier" or "health 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. Carriers include a health insurance company, HMO, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

C. "Emergency services" includes any health care service provided in a health care 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. "Enrollee" means an individual who is eligible to receive medical care through a health benefit plan.

E. "Facility-based provider" means an individual or group of health care providers:
1. to whom the health care facility has granted clinical privileges; and
2. who provides services to patients treated at the health care facility under those clinical privileges.

F. "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, and/or behavioral] health care services.

G. "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing medical care, and which is licensed by [Insert appropriate state agency].

H. "Network" means the providers and health care facilities 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 (including an insurance company) that issues a health benefit plan.

I. “Network plan” means a health benefit plan that uses a network to provide services to enrollees.

J. “Out-of-network facility” means a health care facility that has not contracted with a carrier to provide services to enrollees of a health benefit plan.

K. “Out-of-network provider” means a health care provider who has not contracted with a carrier to provide services to enrollees of a health benefit plan.

L. “Out-of-network referral denial" means a denial by a health benefit plan of a request for an authorization or referral to an out-of-network provider on the basis that the health benefit plan has an in-network provider with appropriate training and experience to meet the particular health care needs of the enrollee and who is able to provide the requested health service.

M. “Provider” means an individual who is licensed to provide and provides medical care.

Section 5. Determination of Network Adequacy

A. A health benefit plan that contracts with a network of health care 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 by the health benefit plan.

B. The commissioner of [insert applicable state agency] 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.

C. To the extent that the network has been determined by the commissioner to meet the standards set forth in [insert applicable section law], such network shall be deemed adequate by the commissioner.

D. Nothing in this subsection shall limit the commissioner's authority to establish minimum standards for the form, content, and sale of health benefit plans, to require additional coverage options for out-of-network services, or to provide for standardization and simplification of coverage.

Section 6 Coverage Option Mandate

A. A carrier that issues a comprehensive group health benefit plan that covers services provided by out-of-network providers 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 service provided by an out-of-network provider after imposition of a deductible or any permissible benefit maximum.

B. If there is no coverage available pursuant to subparagraph (A) of this section in a rating region, then the commissioner may require a carrier issuing a comprehensive group health benefit plan 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 service provided by an out-of-network provider after imposition of any permissible deductible or benefit maximum. The commissioner may, after considering the public interest, permit a carrier to satisfy the requirements of this paragraph on behalf of another carrier, corporation, or health maintenance organization within the same holding company system. The commissioner may, upon written request, waive the requirement for coverage of services provided by out-of-network providers to be made available pursuant to this subsection if the commissioner determines that it would pose an undue hardship upon a carrier.

C. 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 a carrier.

D. This section shall not apply to emergency care services in health care facilities or pre-hospital emergency medical services as defined by [insert applicable section of state law].

E. Nothing in this subsection shall limit the commissioner's authority to establish minimum standards for the form, content, and sale of health benefit plans and

subscriber contracts, to require additional coverage options for services provided by out-of-network providers, or to provide for standardization and simplification of coverage.

Section 7. Emergency Services Provided by Out-of-Network Provider

A. When an enrollee in a health benefit plan that covers emergency services receives the services from an out-of-network provider, the health benefit plan shall ensure that the enrollee shall incur no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network provider.

Section 8. Health Benefit Plan Notice to Enrollees

A. Where applicable, and through its website, a health benefit plan must give to an enrollee:

1. notice
    a. that the enrollee may obtain a referral or preauthorization for services from an out-of-network provider when the health benefit plan does not have in its network a provider who is geographically accessible to the enrollee and has the appropriate training and experience to meet the particular health care needs of the enrollee; and
    b. the procedure for requesting and obtaining such referral or preauthorization;

2. notice
    a. that the enrollee with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and
    b. the procedure for requesting and obtaining such a standing referral;

3. notice
    a. that the enrollee with a life-threatening condition or disease, or 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 enrollee's medical care; and
    b. the procedure for requesting and obtaining such a specialist;

4. notice
    a. that the enrollee with a life-threatening condition or disease, or 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

b. the procedure for requesting and obtaining such access may be obtained;

5. notice that 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.

6. a listing of providers in the health plan network, pursuant to Section 14.

7. with respect to out-of-network coverage:

1. a clear description of the methodology used by the carrier to determine reimbursement for out-of-network health care services;

2. a description of the amount that the carrier 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

4. information that reasonably permits an enrollee 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 health benefit plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services

B. Upon request of an enrollee and no later than 48 hours after the enrollee has been pre-certified to receive non-emergency services at a facility, a health benefit plan shall provide by electronic or written correspondence, information on:

1. whether the enrollee's provider is a participating provider in the health benefit plan network;
2. whether proposed non-emergency medical care is covered by the health benefit plan;

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 9. Provider Notice to Enrollees

A. This section applies to the provision of non-emergency services only.

B. Verbally at the time an appointment is scheduled and in writing or through a website prior to providing services, a health care provider or the provider's representative shall disclose to the enrollee in writing or through an internet website, the health benefit plans in which the provider participates and the hospitals with which the provider is affiliated.

C. If a provider does not participate in the enrollee's health benefit plan network, the provider shall:

   1. prior to providing services, inform the enrollee that the amount or estimated amount the provider will bill the enrollee for health care services is available upon request; and

   2. Upon request, provide the enrollee with a written amount or estimated amount the provider anticipates billing the enrollee for planned services absent unforeseen medical circumstances that might arise when the services are provided.

D. When services rendered in a provider's office require referral to, or coordination with, an anesthesiologist, laboratory, pathologist, radiologist, and/or assistant surgeon, the provider or provider's representative initiating the referral or coordination shall give to the enrollee, the following information in writing about the aforementioned who will be providing services to the enrollee: (1) name, practice name, mailing address, telephone number, and (2) how to determine in which health benefit plan networks each participates. The information shall be provided to the enrollee at the time of the referral or commencement of the coordination of services.

E. At the time a provider or the provider's representative is scheduling an enrollee to receive services at a health care facility, that provider or provider's representative shall give to the enrollee, the following information in writing about any anesthesiologist, laboratory, pathologist, radiologist and/or assistant surgeon who will also be providing services to the enrollee: (1) name, practice name, mailing address, telephone number, and (2) how to determine in which health benefit plan networks each participates.

Section 10. Health Care Facility Notice to Enrollees

A. This section applies to the provision of non-emergency services only.

B. A health care facility shall establish, update and make public through posting on its website, to the extent required by federal guidelines, a list of the facility's standard charges for items and services provided by the facility, including for diagnosis-related groups established under section 1886(d)(4) of the federal Social Security Act.

C. A health care facility shall post on its website:

1. the networks in which the health care facility is a participating provider;

2. a statement that:

a. physician services provided in the health care facility are not included in the facility's charges;

b. physicians who provide services in the facility may or may not participate with the same health benefit plans as the facility;

c. if an enrollee in a health benefit plan receives services in the facility that is in that health benefit plan's network, but receives those services from a provider who is not in that network, the enrollee may be billed for the amount between what the provider charges and what the enrollee's health benefit plan pays that provider, including any co-pays, co-insurance, and/or deductibles that are the enrollee's responsibility; and

d. the enrollee should check with the provider arranging for the enrollee to receive services in the facility to determine whether that provider participates in the enrollee's health benefit plan~~s~~ network.

3. as applicable, the name, mailing address and telephone number of the facility-based providers and facility-based provider groups that the facility has employed or contracted with to provide services including anesthesiology, pathology, and/or radiology, and instructions about how to determine in which health benefit plan networks each participates.

D. In registration or admission materials provided in advance of non-emergency services, a health care facility shall:

~~1.~~ advise the enrollee to check with the physician arranging for the services to determine the name, practice name, mailing address and telephone number of any other physician who is reasonably anticipated to be providing services to the enrollee while in the health care facility, including but not limited to physicians employed by or contracting with the health care facility; and

2. inform the enrollee about how to timely determine in which health benefit plan networks the providers referenced in Section 10 C 3 participate.

E. Upon request, a facility shall provide the enrollee with a written amount or estimated amount that the facility anticipates billing the enrollee for planned services absent unforeseen medical circumstances that might arise when the services are provided.

Section 11. Balance Billing

A. If an out-of-network provider bills an enrollee for non-emergency medical care, 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 billing statement from that provider must contain:

1. an itemized listing of the non-emergency medical care provided along with the dates the services and supplies were provided;
2. a conspicuous, plain-language explanation that:
   a. the provider is not within the health plan 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's billed amount;

3. 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. a statement that the enrollee may call to discuss alternative payment arrangements;

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

6. a notice that if an enrollee owes more than $200 to the provider (over any applicable co-payments, co-insurance, or deductibles and insurance payments) and the enrollee agrees to a payment plan

    a. the provider will not furnish adverse information to a consumer reporting agency if the enrollee substantially complies with the terms of the payment plan (1) within six months of having received the medical services or (2) within 30 days of receiving the first billing statement that reflects all insurance payments and the final amount owed by the enrollee; and
    b. a patient may be considered by the 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.

Section 12. Out-of-Network Referral Denials

A. An out-of-network referral denial under this subsection does not constitute an adverse determination.

B. The notice of an out-of-network referral denial provided to an enrollee shall include information regarding how the enrollee can appeal the denial, including but not limited to what information must be submitted with the appeal.

C. Appeals

1. An enrollee or enrollee's designee may appeal an out-of-network referral denial by submitting a written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty appropriate to treat the enrollee for the health service sought, provided that:

    a. the in-network provider or providers recommended by the health benefit plan do not have the appropriate training and experience to meet the particular health care needs of the enrollee 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 enrollee, and who is able to provide the requested health service.

2. If an out-of-network referral denial has been upheld by the health benefit plan's internal appeals process and the enrollee wishes to pursue an external appeal, the external appeal agent shall

   a. review the utilization review agent's health benefit plan's final adverse determination; and
   b. make a determination as to whether the out-of-network referral shall be covered by the health benefit plan, provided that such determination shall:

      i. be conducted only by one or a greater odd number of clinical peer reviewers;
      ii. based upon review of the (1) training and experience of the in-network health care provider or providers proposed by the plan, (2) the training and experience of the requested out-of-network provider, (3) the clinical standards of the plan, (4) the information provided concerning the insured, (5) the attending physician's recommendation, (6) the insured's medical record, and (7) any other pertinent information; and

      iii. be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan;

      iv. be binding on the plan and the insured; and

      v. be admissible in any court proceeding.

   c. Upon reaching its decision, the external appeals agent shall submit to the enrollee and the health benefit plan, a written statement that:

      i. 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 that (1) 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 (2) 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

ii. the external appeal agent is upholding the health plan's denial of coverage.

Section 13. Prior Authorization

A. A health benefit plan shall make a utilization review determination involving health care services which require pre-authorization and provide notice of ~~a~~ that determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the information necessary to make the determination. To the extent practicable, such written notification to the enrollee and 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:

1. whether the services are considered in-network or out-of-network;

2. whether the enrollee will be responsible for any payment, other than any applicable co-payment, co-insurance or deductible;

3. as applicable, the dollar amount the health benefit plan will pay if the service is out-of-network; and

4. as applicable, information explaining how an enrollee can 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 benefit plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services

Section 14. Provider Directories

A. A carrier shall provide a provider directory on both the carrier's website and in print format.

1. The 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 insurance commissioner upon request.

2. The directory on the carrier's website and in print format shall contain the following general information in plain language for each network plan:

   a. a description of the criteria the carrier has used to build its network;

b. if applicable, a description of the criteria the carrier has used to tier providers;
c. if applicable, 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;
d. if applicable, a statement that authorization or referral may be required to access some providers;
e. 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;
f. a customer service email address and telephone number or electronic link that enrollees or the public may use to notify the carrier of inaccurate provider directory information.

B. Regarding the directory posted online, the carrier shall

1. update the provider directory at least monthly;

2. ensure that the 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;

3. make available in a searchable format the following information for each network plan:

    a. For health care professionals: name; gender; participating office location(s); specialty, if applicable; medical group affiliations, if applicable; facility affiliations; if applicable; participating facility affiliations, if applicable; languages spoken other than English, if applicable; and whether the provider is accepting new patients.
    b. For hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); participating hospital location; and hospital accreditation status; and
    c. For facilities, other than hospitals, by type: facility name; facility type; types of services performed; and participating facility location(s).

4. make available the following information in addition to the information available under Subsection B 3:

    a. for health care professionals: contact information; board certification(s); and languages spoken other than English by clinical staff, if applicable;
    b. for hospitals: telephone number; and
    c. for facilities other than hospitals: telephone number.

C. Regarding the provider directory in print format, the carrier shall include a disclosure that the directory is accurate as of the date of printing and that enrollees and prospective enrollees 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.

D. Upon request of an enrollee or a prospective enrollee, the carrier shall make available in print format, the following provider directory information for the applicable network plan:

   a. for health care professionals: name; contact information; participating office location(s); specialty, if applicable; languages spoken other than English, if applicable; and whether the provider is accepting new patients;

   b. for hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); and participating hospital location and telephone number; and

   c. for facilities, other than hospitals, by type: facility name; facility type; types of services performed; and participating facility location(s) and telephone number.

Section 15. Effective Date

This Act shall take effect on [insert months] following enactment.

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

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS

Certificates of Insurance Model Act

Adopted by the NCOIL Property-Casualty Insurance and Executive Committees on November 18, 2012. **Sponsored by Rep. Steve Riggs (KY)**
To be considered for re-adoption at the NCOIL Summer Meeting, July 2017

Section 1. Short Title

This Act shall be known as the “Certificates of Insurance Model Act.”

Section 2. Definitions

For purposes of this Act:

A. “Certificate of insurance" means a document or instrument, regardless of how titled or described, that is prepared or issued by an insurer or insurance producer as evidence of property or casualty insurance coverage. The term does not include a policy of insurance, insurance binder, policy endorsement, or automobile insurance identification or information card.

B. “Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate property or casualty insurance.

C. “Insurer" means any organization that issues property or casualty insurance.

D. “Person” means any individual, partnership, corporation, association, or other legal entity, including any government or governmental subdivision or agency.

Section 3. Certificate Forms

A. A person may not prepare, issue, or request or require the issuance of a certificate of insurance on property, operations, or risks located in this state unless the certificate of insurance form has been filed with the commissioner by or on behalf of an insurer.

B. The commissioner of insurance shall prohibit the use of a certificate of insurance form if the form:

(1) Is unfair, misleading, or deceptive, or violates public policy; or

(2) Violates any law, including any regulation promulgated by the commissioner of insurance.

C. The current edition of standard certificate of insurance forms promulgated and filed with the commissioner by the Association for Cooperative Operations Research and Development (ACORD), the American Association of Insurance Services (AAIS), the Insurance Services Office (ISO) are not required to be filed by individual insurers. Additionally, certificate of insurance forms whose specific content and wording are established by Federal law or regulation, or any law or regulation of this State, are not required to be filed by individual insurers.

D. A certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to any person new or additional rights beyond what the referenced policy of insurance expressly provides.

Section 4. Limitations on Use

A. A person may not:

(1) Alter or modify a certificate of insurance form filed with the commissioner;

(2) Prepare, issue, or request or require the issuance of a certificate of insurance that contains any false or misleading information concerning the policy of insurance to which the certificate of insurance makes reference; or

(3) Prepare, issue, or request or require the issuance of a certificate of insurance that purports to affirmatively or negatively alter, amend, or extend the coverage provided by the policy of insurance to which the certificate of insurance makes reference.

B. A certificate of insurance may not warrant that the policy of insurance referenced in the certificate comply with the insurance or indemnification requirements of a contract and the inclusion of a contract number or description within a certificate of insurance may not be interpreted as doing such.

Section 5. Notice Requirements

A person is entitled to notice of cancellation, nonrenewal, or any material change, and to any similar notice concerning a policy of insurance only if the person has such notice rights under the terms of the policy of insurance or any endorsement to the policy. The terms and conditions of the notice are governed by the policy of insurance or endorsement and may not be altered by a certificate of insurance.

Section 6. Applicability

A. The provisions of this Act shall apply to all certificates of insurance issued in connection with property, operations, or risks located in this state, regardless of where

the policyholder, insurer, insurance producer, or person requesting or requiring the issuance of a certificate of insurance is located.

B. A certificate of insurance or any other document or correspondence prepared, issued, requested, or required in violation of this Act shall be null and void.

Section 7. Enforcement and Penalties

A. The commissioner of insurance shall have the power to examine and investigate the activities of any person that the commissioner reasonably believes has been or is engaged in an act or practice prohibited by this Act.

B. The commissioner of insurance shall have the power to enforce the provisions of this Act, including the authority to issue orders to cease and desist and to impose a fine of up to [insert amount] per violation against any person who violates this Act up to [insert amount] per violation.

C. The commissioner of insurance may adopt reasonable rules and regulations as are necessary or proper to carry out the provisions of this Act.

Section 8. 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

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

Auto Insurance Fraud Model Act

Adopted by the NCOIL Executive Committee on July 22, 2006. Readopted by the Executive Committee on February 26, 2012. **Sponsored by Sen. Neil Breslin (NY), Sen. William J. Larkin (NY), and Assem. Ivan Lafayette (NY)**
To be considered for re-adoption at the NCOIL Summer Meeting, July 2017

TITLE I – ANTI-RUNNER (1)

1. Definitions

As used in this section, the following terms have the meanings given.

(a) "Provider" means an attorney, health care professional, owner of a health care practice or facility, or any person employed or acting on behalf of any of the aforementioned persons.

(b) "Public Media" means telephone directories, professional directories, newspapers and other periodicals, radio and television, billboards, and mailed or electronically transmitted written communications that do not involve in-person contact with a specific prospective client.

(c) "Runner," "capper," or "steerer" means a person who for pecuniary benefit, whether directly or indirectly, or in cash or in kind, procures or attempts to procure a client, patient or customer at the direction of, request of, or in cooperation with a Provider whose intent is to seek to obtain benefits under a contract of insurance or to assert a claim against an insured or an insurer for providing services to the client, patient or customer. The term does not include a person who procures clients, patients or customers through the use of Public Media.

2. Whoever employs, uses, or acts as a Runner, Capper, or Steerer with the intent to falsely or fraudulently obtain benefits under a contract of insurance or to falsely or fraudulently assert a claim against an insured or an insurer for providing services to the client, patient or customer is guilty of a felony and may be sentenced to _____ and to a payment of a fine of not more than $_____.

Drafting Note:
A state may wish to include a definition of "insurer" in order to correspond to the

state's insurance code or insurance fraud law, assuring that there is symmetry between the anti-runner law, the insurance fraud law, and the state insurance code.

<u>TITLE II</u> – STAGED ACCIDENTS (2)

A person may not organize, plan, or knowingly participate in an intentional motor vehicle crash or a scheme to create documentation of a motor vehicle crash that did not occur for the purpose of making motor vehicle claims or claims for personal injury protection (PIP) benefits. Any person who violates this title commits a felony of the second degree. A person who is convicted of a violation of this title shall be sentenced to a minimum term of imprisonment of two (2) years.

<u>TITLE III</u> – RESTRICTION ON ACCESS TO ACCIDENT REPORTS (3)

1. Crash reports that reveal the identity, home or employment telephone number or home or employment address of, or other personal information concerning the parties involved in the crash and that are held by any agency that regularly receives or prepares information from or concerning the parties to motor vehicle crashes are confidential and exempt for a period of 60 days after the date the report is filed.

2. (a) Crash reports held by an agency under Section 1 may be made immediately available to the parties involved in the crash; their legal representatives; their licensed insurance agents; their insurers or insurers to which they have applied for coverage; persons under contract with such insurers to provide claims or underwriting information; prosecutorial authorities; victim services programs; radio and television stations licensed by the Federal Communications Commission; newspapers qualified to publish legal notices; and free newspapers of general circulation, published once a week or more often, available and of interest to the public generally for the dissemination of news.

(b) For the purposes of this section, the following products or publications are not newspapers as referred to in this section: those intended primarily for members of a particular profession or occupational group; those with the primary purpose of distributing advertising; and those with the primary purpose of publishing names and other personal identifying information concerning parties to motor vehicle crashes.

3. Any local, state, or federal agency that is authorized to have access to crash reports by any provision of law shall be granted such access in the furtherance of the agency's statutory duties.

4. (a) As a condition precedent to accessing a crash report within 60 days after the date the report is filed, a person must present a valid driver's license or other photographic identification, proof of status, or identification that demonstrates his or her qualifications to access that information, and file a written sworn statement with the state or local agency in possession of the information stating that information from a crash report made confidential and exempt by this title will not be used for any commercial solicitation of accident victims, or knowingly disclosed to any third party for the purpose of such solicitation, during the period of time that the information remains confidential and exempt.

(b) In lieu of requiring the written sworn statement, an agency may provide crash reports by electronic means to third-party vendors under contract with one or more insurers, but only when such contract states that information from a crash report made confidential and exempt by this title will not be used for any commercial solicitation of accident victims by the vendors, or knowingly disclosed by the vendors to any third party for the purpose of such solicitation, during the period of time that the information remains confidential and exempt, and only when a copy of such contract is furnished to the agency as proof of the vendor's claimed status.

5. This section does not prevent the dissemination or publication of news to the general public by any legitimate media entitled to access confidential and exempt information pursuant to this section.

6. (a) Any employee of a state or local agency in possession of information made confidential and exempt by this title who knowingly discloses such information under this section is guilty of a felony of the third degree.

(b) Any person, knowing that he or she is not entitled to obtain information made confidential and exempt by this title, who obtains or attempts to obtain such information is guilty of a felony of the third degree.

(c) Any person who knowingly uses confidential and exempt information in violation of a filed written sworn statement or contractual agreement required by this title commits a felony of the third degree.

<u>TITLE IV</u> – DRIVER'S LICENSE SUSPENSION (4)

1. Any person convicted of the crime of insurance fraud while using a motor vehicle, or adjudicated as a juvenile delinquent or youthful offender that otherwise would be defined as insurance fraud if committed by an adult while using a motor vehicle, may have their license or registration suspended for one year.

2. Any fee to reinstate a driver's license or registration on account of a violation of Section 1 of this title shall be double that of the normal and regular fees charged for the reinstatement of any license or registration.

*1 Known separately as the Coalition Against Insurance Fraud/NCOIL Model Anti-Runners Fraud Bill.
*2 Based on Florida statute and New York State Senate bill.
*3 Based on Florida statute.
*4 Based on Florida and New York statutes.

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

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

Model State Uniform Building Code

Readopted by the NCOIL Executive Committee on July 15, 2012, and by the Property-Casualty Insurance Committee on July 13, 2012. First adopted by the Executive Committee on March 3, 2007, and by the P-C Insurance Committee on March 2, 2007.
Sponsored by Rep. George Keiser (ND)
To be considered for re-adoption at the NCOIL Summer Meeting, July 2017

Section 1: Purpose

A. This Act provides for the adoption, updating, amendment, interpretation, and enforcement of a single, unified state building code that applies to the design, construction, erection, alteration, modification, repair, or demolition of public or private buildings, structures, or facilities in this state to provide effective and reasonable protection for public safety, health, and general welfare at reasonable costs, and establishes a Building Code Commission to effect those ends.

B. This Act establishes statewide building standards that would take effect one (1) year after enactment. For hurricane, flood, and seismic exposure areas in the state, the Act requires that such high-hazard areas implement those standards no later than 90 days following enactment.

C. This Act is intended to permit the fullest use of modern technical methods, devices, and improvements; encourage the use of standardized construction practices, methods, equipment, materials, and techniques; and eliminate restrictive, obsolete, conflicting, and unnecessary building regulations.

D. This Act provides that local governments shall have the authority to enforce the [insert state] Uniform Building Code.

Section 2: State Building Code Commission

A. A Building Code Commission shall be established in the [insert appropriate state agency] to perform the following functions in establishing and administering the state's Uniform Building Code program:

1. review, modify, update, and promulgate the building codes referenced below in

accordance with provisions of this Act and the Administrative Procedures Act of this state

2. promulgate rules and regulations to modify portions of the [insert state] Uniform Building Code as provided by this Act

3. review and update the [insert state] Uniform Building Code at least every three (3) years

4. establish qualifications for personnel responsible for inspection and enforcement of the [insert state] Uniform Building Code

5. adopt rules and regulations prescribing minimum standards for administration and enforcement of the [insert state] Uniform Building Code

6. assist counties and municipalities in establishing programs to ensure consistent, effective, and efficient administration and enforcement of the [insert state] Uniform Building Code

7. develop, and in conjunction with counties and municipalities, disseminate training and education programs for code officials and contractors and programs to raise homeowners' awareness of steps that they may take to enhance the safety, comfort, value, and livability of buildings

8. review all requests from municipalities or counties for variation from the [insert state] Uniform Building Code to determine which variations, if any, are justified by local conditions and may be enacted after a finding on the record that modification does not diminish structural integrity or stability to affect the public health, safety, and welfare

9. provide interpretations of contested provisions of the [insert state] Uniform Building Code

10. in conjunction with appropriate state, municipal, or county government agencies, resolve requirements of those agencies that conflict with the application or enforcement of the state Uniform Building Code

Section 3: Commission Membership

A. The Building Code Commission shall consist of 16 members appointed by the governor, subject to Senate confirmation, who each will serve for a period of four (4) years. Members shall be appointed within 15 days of the effective date of this Act. Initial appointments shall be staggered, with six (6) appointments for a two (2) year period; six (6) appointments for a three (3) year period; and three (3) appointments for a four (4) year period. Vacancies shall be filled for the remainder of an unexpired term.

B. The Commission shall consist of:

1. an architect licensed in this state

2. a structural engineer licensed in this state

3. a mechanical or electrical engineer licensed in this state

4. a general contractor doing business in this state
5. a residential contractor doing business in this state

6. a municipal administrator, manager, or elected official

7. a county administrator, manager, or elected official

8. a representative of the State Fire Marshall

9. a certified code enforcement official

10. a representative of the plumbing industry doing business in this state

11. a representative of the electrical industry doing business in this state

12. a representative of the mechanical or gas industry doing business in this state

13. a representative of the manufactured housing industry

14. a disabled person

15. a representative of the property-casualty insurance industry

16. a representative of the general public

Section 4: Commission Administration

A. The Commission shall:

1. convene within 45 days of the effective date of this Act

2. elect from its members a chairman

3. meet at least four (4) times a year

a. at the call of the chair

b. at the request of a majority of its membership

c. at the request of the [insert appropriate state agency]

d. or at such times as may be prescribed by the Commission's rules

B. Members shall be notified in writing of the time and place of a regular or special meeting at least seven (7) days in advance of the meeting. A majority of members of the Commission shall constitute a quorum.

C. The Commission and its members shall be immune from personal liability for actions taken in good faith in the discharge of their responsibilities. The state shall hold the Commission and its members harmless from all costs, damages, and attorney fees arising from claims and suits against them with respect to matter to which immunity applies.

D. Members of the Commission shall receive per diem or other compensation for their duties on the Commission, as determined by state policy.

Section 5: State Uniform Building Code

A. The Commission, pursuant to the State Administrative Procedures Act, shall adopt a State Uniform Building Code to take effect within one (1) year of the effective date of this Act.

B. The State Uniform Building Code shall contain or incorporate all laws and rules that pertain to and govern the design, construction, erection, alteration, modification, repair, and demolition of public and private buildings, structures, and facilities and the enforcement of such laws and rules, except as otherwise provided in this Section.

C. The provisions of this Act shall not apply to structures that are constructed on a farm, other than residences or structures attached to them.

D. The Commission shall adopt a State Uniform Building Code by reference to the latest editions of the following nationally recognized codes and the standards for the regulation of construction within this State: building, residential, existing buildings, gas, plumbing, mechanical, electrical, fire, and energy codes as promulgated, published, or made available by the International Code Council, Inc. and the National Electrical Code as published by the National Fire Protection Association. The appendices of the codes provided in this Section may be adopted as needed, but the specific appendix or appendices must be referenced by name or letter designation at the time of adoption.

E. The Commission may modify the selected model codes and standards as needed to accommodate the specific needs of this state provided that modifications do not diminish structural integrity or stability to affect the public health, safety, and welfare.

F. Counties and municipalities, upon review and approval by the Commission, may adopt

amendments to the technical provisions of the State Uniform Building Code that apply solely within their jurisdictions and that provide for more stringent requirements than those specified in the State Uniform Building Code.

G. The Commission shall review and update the State Uniform Building Code at least every three (3) years.

H. To the extent that federal regulations preempt state and local laws, nothing in this chapter shall conflict with the federal Department of Housing and Urban Development (HUD) regulations regarding manufactured housing construction and installation.

Section 6: State Building Code Provisions Addressing Catastrophic Hazards—Wind, Flood, and Seismic

A. Wind and flood mitigation requirements prescribed by the 2006 or later International Building Code and 2006 or later International Residential Code are adopted by this Act and shall apply within [insert appropriate areas of state] and seismic requirements by the 2006 or later International Building Code and the 2006 or later International Residential Code shall apply within [insert appropriate areas of state].

B. Wind, flood, and seismic code provisions shall be enforced no later than 90 days from the effective date of this Act. If counties or municipalities are unable to enforce the provisions of this Section, the [insert appropriate state agency] shall enforce the provisions.

C. The [state agency] may establish contract agreements with counties, municipalities, and third-party providers in order to provide enforcement of this Section.

Section 7: Enforcement

A. Notwithstanding any other law to the contrary, all counties and municipalities in this state shall enforce only the State Uniform Building Code as provided for in this Act, including enforcing any more stringent county or municipal standards as authorized under Section 5(F).

B. The Commission shall promulgate rules and regulations prescribing minimum standards for administration and enforcement of the State Uniform Building Code.

C. Such rules and regulations shall address the nature and quality of enforcement and shall include, but not be limited to, the frequency of inspections; number and qualifications of staff, including qualifications required for inspectors; required minimum fees for administration and enforcement; adequacy of inspections; adequacy of means for insuring compliance with the Uniform Code; and procedures whereby any provision or requirement of the State Uniform Building Code may be varied or modified, subject to requirements of this Act.

D. Municipalities and counties may establish agreements with other governmental entities of the state to issue permits and enforce building codes in order to provide the services required by this Act.

E. The Commission may assist in arranging for municipalities, counties, or consultants to provide the services required by this Act to other municipalities or counties if a written request from the governing body of such municipality or county seeking assistance is submitted to the Commission.

Section 8: Penalties

Should any building or structure be maintained, erected, constructed, reconstructed, or its purpose altered, so that it becomes in violation of the State Uniform Building Code, either the county or municipal enforcement officer or the [insert appropriate state agency] may, in addition to other remedies, institute any appropriate action or proceeding in order to:

A. prevent the unlawful maintenance, erection, construction, reconstruction, or alteration of the building/structure's purpose, or to prevent overcrowding

B. restrain, correct, or abate the violation, or

C. prevent the occupancy or use of the building, structure, or land until the violation is corrected

Section 9: Effective Date

This Act shall take effect upon enactment.

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

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding Use of Insurance Binders as Evidence of Coverage

Adopted by the NCOIL Executive and Property-Casualty Insurance Committees on July 15, 2012. **Model sponsored by Rep. Matt Lehman (IN)**
To be considered for re-adoption at the NCOIL Summer Meeting, July 2017

Section 1. Short Title

This Act shall be known as the "Model Act Regarding Use of Insurance Binders as Evidence of Coverage."

Section 2. Purpose

This Act establishes that insurance binders obligate coverage until a policy is issued or cancelled.

Section 3. Definitions

A. "Insurance binder" means a written temporary contract of insurance authorized by an insurer issued prior to the insurance policy that includes:

1. the name and address of the insured and any additional named insureds, mortgagees, or lienholders

2. a description of the property insured

3. a description of the nature and amount of coverage that shall be deemed to include the terms of the insurance policy except as conspicuously noted on the binder

4. the identity of the insurer and of the authorized representative executing the binder

5. the effective date of coverage

6. the binder number or the policy number where applicable to a policy extension

B. “Insurance policy” means a contract of insurance describing the term, coverage, premiums, and deductibles.

C. “Insured” means the person, group, or property for which an insurance policy is issued.

D. “Insurer" means any organization that issues property or casualty insurance.

E. “Lender” means an individual, partnership, corporation, association, or other entity, or loan servicer acting on behalf of such party, who lends money and receives or otherwise acquires a mortgage, a lien, a deed of trust, or any other security interest in or on any real or personal property as security for the loan.

Section 4. Insurer Obligations

A. An insurer that provides an insurance binder is obligated to provide the coverage according to the terms of such binder until the insurer issues the insurance policy or cancels the binder.

B. An insurer shall only cancel an insurance binder in accordance with the minimum cancellation provisions included in the insurance policy and in accordance with [insert appropriate state law on insurance policy cancellations].

Section 5. Penalties

Any person who violates this Act may be fined up to [insert amount] per violation.

Section 6. 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

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

Asbestos Bankruptcy Trust Claims Transparency Model Act

Adopted by the NCOIL Property & Casualty Committee on June 5, 2017
To be considered by the NCOIL Executive Committee on July 15, 2017
Sponsored by Sen. Jerry Klein (ND) and Sen. Bob Hackett (OH)

Section 1. Short Title

This Act shall be known as the Asbestos Bankruptcy Trust Claims Transparency Model Act.

Section 2. Findings and purpose

(a) The 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) Over 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 and the civil court systems has resulted in the suppression of evidence in asbestos actions and potential fraud; and

(8) 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 Act 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.

Section 3. Definitions

As used in this Act:

(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.

(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.

Section 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 Act shall constitute grounds for the court to extend the trial date in an asbestos action.

Section 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.

Section 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 Act within one hundred twenty days prior to the trial date.

(b) If, in the disclosures required by section four of this Act, 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.

Section 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.

Section 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.

Section 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.

Section 10. Failure to provide information; sanctions

A plaintiff who fails to provide all of the information required under this Act is subject to sanctions as provided in the Rules of Civil Procedure and any other relief for the defendants that the court considers just and proper.

Section 11. Application

The provisions of this Act apply to all asbestos actions filed on or after the effective date of this Act.

Section 12. Effective Date

This Act shall take effect immediately.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
FINANCIAL SERVICES AND INVESTMENT PRODUCTS COMMITTEE
NEW ORLEANS, LOUISIANA
MARCH 4, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Financial Services and Investment Products Committee met at the New Orleans Downtown Marriott on Saturday, March 4, 2017 at 8:15 a.m.

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

Other members of the Committee present were:

Rep. Sam Kito, AK
Sen. Jason Rapert, AR
Sen. Travis Holdman, IN
Rep. Joseph Fischer, KY
Rep. Jeff Greer KY
Rep. George Keiser, ND
Asm. Will Barclay, NY
Sen. James Seward, NY

Other legislators present were:

Rep. Steve Riggs, KY
Rep. Matt Lehman, IN
Rep. Lois Delmore, ND
Sen. Nellie Pou, NJ
Asm. Kevin Cahill, 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 November 17, 2016 meeting in Las Vegas, Nevada.

UPDATE ON NAIC INSURANCE DATA SECURITY MODEL LAW

Birny Birnbaum from the Center for Economic Justice (CEJ) stated that CEJ thinks it is extremely important for NAIC to draft this Model because it strives to set out basic goals and requirements for insurers regarding data security which is fundamental for consumer protection and financial regulation. It is an integral part of monitoring the company's solvency because the data security issues relate to the company's operations and data breaches can have a significant financial impact on the company. The first part of the Model deals with financial regulation issues such as what kind of requirements companies have for data security and what kind of responsibilities they have in terms of monitoring those responsibilities. The second part of the Model deals with market regulation and consumer protection issues such as defining what a data breach is, and defining what to do in the event of a data breach.

One contentious issue from CEJ's perspective is that there is great flexibility in the Model given to financial regulators in terms of how they apply the various standards but when it comes to the consumer protection aspects of the Model, the insurers and licensees have been demanding total uniformity with low consumer protections. Mr. Birnbaum stated that CEJ believes that a fundamental consumer protection is notifying consumers if their personal information has been lost or stolen and the argument that notifications to consumers will lose their "power" if consumers are inundated with them does not hold merit – if your information is lost or stolen, your only tool to protect yourself is to be alerted in the first place. Accordingly, CEJ is opposed to the "harm trigger" in the Model that gives the insurance company/licensee discretion to decide what will or won't harm the consumer. CEJ believes there is no way that insurance companies and licensees can know the particular circumstances of when a consumer is harmed. CEJ asked for examples of data breaches that did not harm consumers and the examples were all instances where the data was not actually breached – information was sent to the wrong lab or released to the wrong agency and then recovered without use/distribution by that third party. CEJ suggested that if you can demonstrate that the lost data was recovered without further distribution, that is not a data breach. Mr. Birnbaum stated that the current draft of the Model is nowhere near being a finished product but urged NCOIL to support it going forward.

Frank O'Brien from the Property Casualty Insurers Association of America (PCI) stated that yesterday's NCOIL – NAIC Dialogue was very instructive in that we heard doubts from Commissioners regarding the effectiveness of the Model drafting efforts thus far. These are constantly evolving issues, made more interesting by the recent issuance of the New York Department of Financial Services Cybersecurity Regulations. Mr. O'Brien stated that where NAIC and the industry ends up with the Model is open to debate. Sen. Hackett agreed and stated that he is part of a cybersecurity task force in Ohio and there are so many competing interests to deal with. Rep. Lehman stated that it is hard to deal with these issues without actuarial data and how the standards in the Model can be applied to other industries. Mr. Birnbaum stated that the Model isn't about developing cyber liability policies, it's about protecting data and protecting consumers in the event of a data breach. The issue of developing cyber liability policies and promoting a cybersecurity market is vitally important but separate from the Model. Rep. Lehman agreed but stated that the adoption of the Model creates a need because if the Model is adopted, a carrier or agent will realize that if they don't comply they can experience a loss and will therefore go to the market to see what there is to fill gaps. Sen. Hackett agreed.

Kate Kiernan from the American Council of Life Insurers (ACLI) stated that ACLI supports the NAIC's drafting efforts primarily because of the need for uniformity - the 47 different State data breach requirements is not workable. At the Federal level, there has been a lack of movement due to competing interests. Due to that lack of movement, it was thought that starting with the NAIC, because of the members' knowledge and expertise in the industry, would be prudent. In response to one of Mr. Birnbaum's earlier comments, Ms. Kiernan stated that ACLI is not pushing for a lower consumer notification standard – ACLI wants any notification to be meaningful so that consumers take it seriously.

Eric Cioppa, Superintendent of the Maine Bureau of Insurance, stated that Maine is heavily involved with efforts in trying to improve the Model. Supt. Cioppa stated that drafting has proved difficult because of the competing interests but he is optimistic of the

drafting efforts moving forward. Supt. Cioppa welcomed a call with NCOIL to review the current draft and noted that States need to monitor very closely what insurers are writing and what the amounts are for cyber liability policies.

Joe Thesing from the National Association of Mutual Insurance Companies (NAMIC) stated that NAMIC believes that the recent draft of the Model is headed in the wrong direction. Regarding the harm trigger, in the current draft of the Model, if there was a breach to my auto insurance policy and the only thing exposed was my home address, that would trigger all of the notice provisions of the Model, and not just for him but for all the policyholders in the company – that is concerning.

Wes Bissett from the Independent Insurance Agents and Brokers of America (IIABA) stated that the Model is very broad in that it applies to insurance companies and also to insurance agents and brokers. On the other hand, it is very narrow in that it only applies to the insurance industry. The Model has two main components: a set of data security standards that outline how to protect data; and what happens if you think or find out there was a breach. The latter is controversial. Mr. Bissett stated that if the Model were to be enacted, most agents would have to hire an outside vendor to help them develop the data security requirements, and would also have to purchase a cyber liability policy – those costs are significant. There is an inherent tension in the Model: on one hand, it's insurance specific and on the other hand NAIC wants the Model to expand to relationships insurers have with third parties. Mr. Bissett asked how can small agents compel much larger third party vendors to do anything? IIABA has suggested that third parties should have direct obligations but that would broaden the scope of the Model and not make it insurance-specific. The Model also makes an independent agent responsible to investigate after a company breach – that is impractical. IIABA has suggested that the NAIC narrow its focus on the first part of the Model – the set of data security standards, since 47 States already have data breach notification standards. In fact, Supt. Cioppa's Financial Condition Committee has recommended that approach. That is what New York did – it adopted regulations that did two core things: it addressed information security standards and then addressed a regulatory gap in that most States don't require licensees to notify regulators when there has been a breach. IIABA believes those two components together could form a strong Model that it could support.

Rep. Joseph Fischer (KY) asked if the Model is adopted, do we need to preempt existing cybersecurity laws applicable to companies? Mr. Birnbaum stated that is an issue that has been discussed extensively. The industry position is yes, it has to preempt everything else and the consumer perspective is that it should be a minimum standard – if a State has a higher standard, that higher standard applies. Mr. Birnbaum also stated that the Model is important because if an all-industry Model is drafted, that may work on the consumer protection side but not on the regulator side – regulators need industry specific data security requirements because the insurance industry is different from other industries. Ms. Kiernan agreed. Rep. Fischer asked, under current law, who has standing to enforce the laws and who has standing to enforce the Model? Mr. Bissett stated that the insurance department would enforce the Model and Attorney Generals typically enforce other laws. Rep. Fischer asked if there is a private cause of action accounted for in the Model? Mr. Bissett noted that the Model states that if a private cause of action existed prior to the Model, then it would continue to apply. Mr. Birnbaum stated that CEJ proposed there should not be a private cause of action for any financial regulation related issues but there should be one for the consumer protection aspects, particularly if there is a harm trigger.

DISCUSSION ON RESOLUTION IN SUPPORT OF AN EXEMPTION FOR COMMUNITY BANKS FROM ONEROUS AND UNNECESSARY REGULATIONS

Sen. Travis Holdman (IN) stated that in today's financial world, small banks are completely overwhelmed by Dodd-Frank compliance and that has led to more and more consolidation in the market. Community banks are the heart of what goes on in most communities around the country. Accordingly, the Resolution asks for community banks (less than $10 billion in assets) to be exempt from the onerous and unnecessary CFPB regulations. Sen. Holdman stated that he hopes the CFPB is abolished but if not, community banks should be exempt from its regulations in order to thrive and benefit local communities.

Sen. Hackett agreed and stated that community banks have suffered from the costs of compliance. Sen. Hackett asked if there were any new developments in D.C. about Dodd-Frank reform? Kevin McKechnie from the American Bankers Association (ABA) stated that he supports Sen. Holdman's Resolution and that consolidation is an economic enemy. There are more people trying to enforce rules than there are trying to lend and create credit – that is not going to grow the economy. One Federal development is the Financial CHOICE Act which contains meaningful changes but the question remains whether it will become law.

Rep. Steve Riggs (KY) stated that he never understood why Dodd-Frank applies to all banks because it was only the large banks that engaged in the risky practices such as credit default swaps. Rep. Riggs asked why $10 billion is the "trigger" in the Resolution - why can't the trigger be the specific activities the bank conducts. Sen. Holdman stated that under industry standards, less than $10 billion in assets is regarded as the point which you are considered to be a community bank. Commissioner Tom Considine, NCOIL CEO, stated that the $10 billion trigger also comes out of Dodd-Frank. There is an exemption in Dodd-Frank at the $10 billion level and the CFPB has a "no-exam" rule at the $10 billion level. Cmsr. Considine further stated that community bankers were and are told by CFPB examiners: "don't worry about the regulations, we won't examine you." However, being responsible business people, community bankers nevertheless hire expensive compliance officers.

Mr. Birnbaum stated that CEJ opposes the Resolution. First, compliance for community banks isn't completely a result of the CFPB – increased compliance is mostly due to their specific regulators. Second, the decline in the number of community banks is a long-term trend not necessarily associated with Dodd-Frank/CFPB. Third, the Resolution is too broad and it would be anti-consumer to prohibit a consumer protection agency from regulating community banks. Lastly, Mr. Birnbaum stated that the CFPB has done great things for consumers and has a lot of value. Sen. Holdman disagreed and stated that we don't know how well community banks could have performed due to the all the regulations and associated compliance costs. Also, another issue that arose from Dodd-Frank is that of capital requirements. Unnecessarily raising capital requirements means that banks have less money out in their communities loaned to those seeking to start a business, buy a home, or buy a car. Sen. Holdman also agreed with Cmsr. Considine's earlier comments and requested that the Committee not vote on the Resolution so it can be further discussed at the Summer Meeting in Chicago. Sen. Jason Rapert (AR) asked Mr. Birnbaum what has the CFPB actually done and stated that he has frequently been told by community bankers in Arkansas that the CFPB tells

them to ignore standards and write-off bad loans. That does not seem like consumer protection. Mr. Birnbaum first stated that the CFPB is the wrong target of this Resolution and then stated that he can't speak to specific instances in Arkansas, but that the CFPB has recovered billions of dollars for consumers from unfair and deceptive practices.

DISCUSSION ON NEW YORK, OTHER STATE, AND FEDERAL CYBERSECURITY DEVELOPMENTS

Aaron Tantelff, Esq., Foley & Lardner, LLP, stated that the New York regulations became effective on March 1, 2017, and that covered entities must comply with most requirements by August 28, 2017. The regulations have a broad applicability despite the exemptions contained therein. The exemptions only exempt certain provisions such as penetration testing, audit trial, encryption, and incident response plan rules. Mr. Tantleff noted that he thought the incident response plan exemption was strange. Rep. George Keiser (ND) asked if there was a lot of discussion from small employers regarding the "less than 10 employees or less than $5 million in gross annual revenue" exemption. Mr. Tantleff stated that there were several comments on that issue but he got the impression that the NY DFS simply stated "thank you for your comment, but we are moving forward." Mr. Tantleff further stated that the initial draft was a one-size-fits-all approach, and that he thinks the exemptions are extremely narrow.

Mr. Tantleff stated that when he works with companies in trying to figure out how to comply with these regulations, there are some concerns. For instance, in Section 500.06, audit logs must be designed to "reconstruct material financial transactions sufficient to support normal operations and obligations of the Covered Entity." The questions become: what does that mean? who determines what that includes? And the same section requires the logs to be designed to "detect and response to cybersecurity events that have a reasonable likelihood of materially arming any material part of the normal operations of the covered entity." Those sections represent a double-materiality standard and make compliance difficult. Additionally, section 500.12 requires multi-factor authentication which is a great idea in theory but has proven to be difficult to comply with. Additionally, the requirements in Section 500.13 regarding data retention make it difficult to have adequate fraud detection. The double notification trigger under Section 500.17(b) is also very difficult to understand. Section 500.18 regarding confidentiality also raises concerns about making disclosures about vulnerabilities of an organization.

The regulations also require the CISO to report in writing at least annually to the board of directors or its equivalent. Under the NAIC Model, there is no indication as to where the report goes. Mr. Tantleff noted that the 72-hour notice requirement in the New York regulations is difficult to comply with, because of the time limit and because of deciphering what "reasonable likelihood of materially harming any material part of the normal operations" means. Regarding third-party service providers, Mr. Tantleff stated that he thinks they play a huge role in terms of risk to the organization. The companies need to be required to do their due-diligence before contracting with them and the third-party service providers need to be held accountable as well. Mr. Tantleff then noted some differences between the New York regulations, the Gramm-Leach-Bliley Act, and the Federal Financial Intuitions Examination Council such as notification requirements, encryption, and covered information. Mr. Tantleff closed with saying that he supports uniformity in cybersecurity/data breach requirements and acknowledged there is a lot of work to do.

Ron Jackson of the American Insurance Association (AIA) stated that the New York regulations represent a persistent problem – lack of uniformity. Mr. Thesing stated that its important to note that what New York did are regulations, not legislation. Accordingly, legislators didn't debate and weigh in on them. NAMIC opposed their efforts. Ms. Kiernan stated that ACLI is concerned about the notice requirements in the New York regulations and that in 2017, ACLI is tracking 17 pieces of State cybersecurity legislation. It seems that the "patchwork" of requirements relating to cybersecurity will continue to grow and ACLI supports a uniform standard. Mr. McKechnie stated that he will be delivering a PowerPoint presentation in Ohio that he would be happy to make available to this Committee. Mr. McKechnie further stated that passing regulations without an understanding of the technology at issue is a bad way to handle this. Lastly, he stated that State legislators need to find a way to get security clearances because as it stands, none can get the briefings required to understand what really is going on with cybersecurity.

ADJOURNMENT

There being no further business, the Committee adjourned at 9:45 a.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
SPECIAL EXECUTIVE COMMITTEE SESSION
NEW ORLEANS, LOUISIANA
MARCH 3, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Executive Committee met at the New Orleans Downtown Marriott on Friday, March 3, 2017 at 10:00 a.m.

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

Other members of the Committee present were:

Asm. Ken Cooley, CA
Sen. Jason Rapert, AR
Rep. Sam Kito, AK
Rep. Deborah Ferguson, AR
Rep. Matt Lehman, IN
Sen. Dan "Blade" Morrish, LA
Rep. George Keiser, ND
Asm. Will Barclay, NY
Asm. Kevin Cahill, NY
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Marguerite Quinn, PA

Other legislators present were:

Rep. Lois Landgraf, CO
Rep. Justin Hill, MO
Rep. John Wiemann, MO
Rep. Lois Delmore, ND
Sen. Nellie Pou, NJ
Asm. Andrew Garbarino, NY
Rep. Lewis Moore, 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

PRELIMINARY CONSIDERATION OF MODEL ACT TO SUPPORT STATE REGULATION OF INSURANCE THROUGH MORE INFORMED POLICYMAKING

NCOIL President, Rep. Steve Riggs (KY) thanked Asm. Ken Cooley (CA) for his participation in NCOIL thus far and stated that he is looking forward to more California legislators participating. Rep. Riggs stated that it is in everyone's interest for State lawmakers to be up to date and educated on the complex issues that are discussed at NCOIL meetings. There needs to be a system in place that can improve and ensure a State appropriation for NCOIL membership dues and the travel expenses to attend NCOIL conferences. Asm. Cooley's proposed Model Act is designed to alleviate the concerns NCOIL recruitment targets have when they say "I can't get the money to go to the conference." Rep. Riggs stated that the other two branches of government don't seem to have the same problem– the legislative branch seems to be more into self-flagellation than others.

Asm. Cooley (CA) stated that he sees his proposed Model as in line with the notion that, in generations past, lawmakers have passed statutes conferring great authority to the National Association of Insurance Commissioners (NAIC) to bring forward ideas relevant to the regulation of state-based insurance regulation, and yet now we have lawmakers who have not served for many years and might not know the backstory on some of the NAIC authority. Asm. Cooley stated that he once tried to invite NAIC representatives to come to California and provide a briefing to the Senate Insurance Committee on the work of the NAIC because he knew that a lot of its work product is incorporated by reference into State law and that many of his colleagues were not familiar with that. However, the chief California insurance regulator said no, and nothing ever came of it. Asm. Cooley stated that struck him as anomalous since the executive branch wants the legislative branch to defer its lawmaking power, but would not agree to make educational presentations about its processes.

Asm. Cooley further stated that he has attended NAIC meetings for quite some time and is aware of how it functions. There are robust internal discussions about its work product, but there are members who have taken an oath of office while certain staff members have not and they are involved in policy discussions. And now we've seen the emergence of similar conversations on the international level over what are the right transparency principles with insurance. Accordingly, Asm. Cooley stated that this Model represents the idea that insurance departments should, by some means through the budget process, provide not just a financial process to participate at the NAIC but to make it easier for legislators to participate at NCOIL. Given the nature of the inherent complexity in the legislative and regulatory marketplace in the modern world, this is a timely idea. There are details to be worked out, but there is no doubt that a more educated legislative body would benefit everyone. And there is no comparable entity to NCOIL so this is the best forum for the Model.

Joe Thesing from the National Association of Mutual Insurance Companies (NAMIC) agreed with Asm. Cooley's assertion that insurance is very complex and that NAMIC spends a considerable amount of time trying to educate legislators on the industry and its continuous developments. NCOIL also plays a very vital role in doing so. NAMIC is extremely supportive of Asm. Cooley's Model but would offer a couple of amendments for the industry's and NCOIL's protection. One is that NCOIL is unrelated to the market conduct exam power so it would make more sense to have the funding provisions located in the insurance department's general budget provisions. Second, the language about the funds going towards NCOIL dues and travel expenses needs to be tightened and clarified so that the industry doesn't interpret the language as an open checkbook. For example, language such as "in an amount not to exceed…." could be included. Rep. Riggs asked Mr. Thesing why NAMIC would want "not to exceed" language in that section but not in section 2(C)(ii) dealing with the department of insurance funding NAIC member assessments. Mr. Thesing said that NAMIC had not thought about that but thinks that is worthy of conversation.

Frank O'Brien of the Property Casualty Insurers Association of America (PCI) stated that PCI supports the Model and agrees with NAMIC's comments. PCI looks forward to working on the Model with NCOIL.

Sen. Jason Rapert (AR) stated that in Arkansas, both the Senate and House Insurance Committees Chairs have the authority to approve travel but noted that is not the case in every State. Sen. Rapert supports the Model and stated that there is no question that

the Arkansas Insurance Committees would function better if there were more members participating at NCOIL. Mr. Thesing agreed with Sen. Rapert's statement that one of the big problems is lack of uniformity as to how States fund NCOIL – this Model is a great solution.

Rep. George Keiser (ND) complemented Asm. Cooley in addressing a longstanding problem of NCOIL – stable funding. However, Rep. Keiser stated that he would not support the Model because the issue of NCOIL funding is a State decision. The Model would never pass in North Dakota because many years ago, the Insurance Department had the scenario/language that is set forth in the Model. But the Department made the decision that because the insurance department is basically an enterprise fund, which the revenues generated within the department are used to fund that agency, and the balance is appropriated to the general fund, the appropriations committee has a lot of interest in those dollars. A conscious decision was made that the legislative management level, not the department level, should manage all association expenses - NCSL, CSG, NCOIL, etc. The bottom line is that North Dakota had what is in the Model already and therefore won't introduce something it already opposes.

Rep. Lois Landgraf (CO) stated that she does not know if the Model would pass in Colorado but she supports it. Rep. Landgraf also stated that if nothing else it would bring awareness to NCOIL.

Mr. Thesing asked Rep. Keiser if there is State oversight in North Dakota on joining and participating in the NAIC? Rep. Keiser stated that basically what's in the Model is in North Dakota's code regarding the NAIC. But the NAIC is not guaranteed funding out of their department, it's in the department budget which is approved by the legislature.

Rep. Matt Lehman (IN) stated that he agreed with Rep. Keiser's statement that some States will not adopt this Model, but also noted that some States may be looking for a mandate like this. Rep. Lehman also stated that NCOIL dues ($10,000) are "budget dust" comparted to those for NCSL, CSG, etc.

Birny Birnbaum from the Center for Economic Justice (CEJ) stated that CEJ strongly supports NCOIL's involvement with NAIC and vice versa. Accordingly, CEJ supports proper State funding of both organizations. Mr. Birnbaum stated, however, that the issue of Incorporation by Reference (IBR) needs to be addressed more directly, not through this Model. Mr. Birnbaum stated that the Model also blurs the line between the executive and legislative branches. He asked why can't the legislature budget funds for NCOIL involvement directly? The Model seems like NCOIL is asking an administrative agency to fund the legislative's policy work. A better way to raise awareness of NCOIL funding might be a Model or Resolution that simply states State legislatures should/need to budget for NCOIL dues/expenses. Asm. Cooley stated that in the realm of insurance regulation, the intertwined nature of the legislative and executive branches is arguably in a class by itself. Mr. Birnbaum asked how about asking NAIC to fund NCOIL's participation in a more robust manner? Asm. Cooley said that is not a bad idea and views this special Executive Committee session as the beginning of a broader discussion on NCOIL funding.

Sen. James Seward (NY) stated that Mr. Birnbaum's suggestion of asking the NAIC for funding is intriguing. Sen. Seward supports the Model despite reservations of it passing in New York because it is a good backstop to maintain ongoing involvement of State

legislators with NCOIL. It makes sense to have the funding come out of the Department's budgets which are funded by industry assessments because it's in the industry's interest to have sound State insurance legislation.

Rep. Riggs stated that if the purpose is to secure more informed legislative oversight, then in section 2(C)(iii), instead of "seek appropriation" it should say "make appropriation." Asm. Cooley did not have a problem with that suggestion. Rep. Riggs also stated that at NAIC meetings, there are several people sent by State executive and legislative branches – some States send 5 or 10 people. This Model only considers expenses for the Chairmen and Ranking Members of the Insurance Committees so perhaps that language should be broader. Asm. Cooley agreed and was open to considering a revised draft either during an interim committee conference call or at the Summer Meeting in Chicago. Rep. Keiser agreed with seeking broader language to have people attend NCOIL besides those mentioned in the Model, particularly a legislator from the Appropriations Committee. Rep. Justin Hill (MO) and Asm. Cooley agreed.

ADJOURNMENT

There being no further business, the Committee adjourned at 10:45 a.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE
NEW ORLEANS, LOUISIANA
MARCH 3, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at the New Orleans Downtown Marriott on Friday, March 3, 2017 at 3:45 p.m.

NCOIL Vice President, Senator Jason Rapert of Arkansas, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Sam Kito, AK
Asm. Ken Cooley, CA
Sen. Travis Holdman, IN
Rep. Matt Lehman, IN
Rep. George Keiser, ND
Sen. James Seward, NY
Sen. Bob Hackett, OH

Other legislators present were:

Rep. Deborah Ferguson, AR
Rep. Steve Riggs, KY
Rep. Justin Hill, MO
Sen. Nellie Pou, NJ
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 November 17, 2016 meeting in Las Vegas, Nevada.

NAIC INCORPORATION BY REFERENCE (IBR)

NCOIL Vice President, Senator Jason Rapert (AR), began by asking for feedback on the presentation made during the Welcome Breakfast from Rutgers Constitutional Law Professor Robert F. Williams, and asked if the presentation accurately outlined the constitutional limits on IBR. James Donelon, Louisiana Insurance Commissioner, stated that he thought the presentation was great but that he respectfully disagreed with it.

NAIC thinks its IBR process is constitutionally sufficient, obviously efficient, and provides for exhaustive opportunity for outsiders/interested parties/legislators to share their concerns. Cmsr. Donelon stated he is not categorially opposed to external review and noted that the issue of whether NAIC is a public or private entity is an ongoing discussion, is his mind at least, inside and outside the NAIC. If NAIC is deemed private, Cmsr. Donelon stated that he thinks NCOIL would be deemed private as well and if we

went down the path of external review of IBR, other entities would have to do the external review.

Cmsr. Donelon also noted that NAIC IBR has never been challenged and that IBR is in the interest of uniformity and the ability to regulate the insurance industry at the State level on a national basis – that necessitates some sort of uniformity in things such as handbooks and manuals. Cmsr. Donelon further stated that NAIC is not aware of any issues that have been involved in the IBR process that would constitute legislating in a substantive manner – everything has been technical in nature and everything has been done in a transparent manner. Sen. Rapert asked Cmsr. Donelon to comment on his own (Louisiana's) proposal regarding oversight of the IBR process. Cmsr. Donelon stated that he remains open to the idea but that it hasn't gained a lot of traction at NAIC. Cmsr. Donleon said he strongly believes that the NAIC is a public entity and should act in all regards like it is one. Sen. Rapert noted that the greatest threat to the state-based regulation of insurance and the transparency of such is on the federal level and thinks that NCOIL and NAIC can work together to reach a solution on this issue.

Jim Ridling, Alabama Insurance Commissioner, stated that as Chair of the NAIC Governance Review Task Force, one thing that needs to be discussed is how open the NAIC is in every deliberation – the only time doors are closed is when the commissioners are educated by NAIC staff on an issue. Mike Chaney, Mississippi Insurance Commissioner, agreed and said NAIC is a public entity and they vet everything they do extensively. Cmsr. Ridling noted that Alabama issues regulations for IBR-related changes, such as changes to a handbook or manual – there is no hiding it. Cmsr. Chaney also stated that if States were to eliminate IBR statutes and regulations it would result in destabilizing the insurance market which is a market where predictability and stability is essential in order to regulate properly. Additionally, Cmsr. Chaney stated that he is concerned that if an outside oversight process is set up for IBR, special interest groups would end up "running the show."

Sen. Travis Holdman (IN) stated that organizations like NCSL, CSG, ALEC, etc. do not hold the power that NAIC does – its highly organized, asset-rich, and regulates its respective industry in a way like no other. Sen. Holdman also stated that he was concerned that NCOIL's proposal to serve as an outside overseer/clearinghouse for IBR changes was dismissed without consideration. Cmsr. Donelon disagreed and said it was put on the agenda and considered during a NAIC Governance Review Task Force conference call meeting. Cmsr. Donelon also stated that he thinks there is tremendous value in the relationship between NCOIL and NAIC but has not seen any examples of NAIC going outside its IBR authority and venturing into substantive lawmaking that would warrant NCOIL serving as a third-party overseer.

Rep. George Keiser (ND) stated that he is glad this discussion is taking place and hopes it's a starting point for a discussion on what exactly is technical and what is substantive in the realm of the IBR process. Cmsr. Chaney asked what the main problem is with the IBR process. Asm. Ken Cooley (CA) stated that he views this is a constitutional issue. The power to enact laws is given to the legislature; and more so than the issue of a technical change vs. a substantive change is the issue of changes being made to State law without ever being seen by legislators. Asm. Cooley stated that such concerns also apply to the NAIC's efforts on the international level. Cmsr. Ridling disagreed and stated that the NAIC has not issued anything that would affect State legislators.

NCOIL President, Rep. Steve Riggs (KY) stated that the IBR process changes State law whether its technical or not and that NCOIL could be a great tool in serving as the clearinghouse for such changes. That would protect NAIC and further what the NAIC Governance Review Task Force is trying to do in improving its administrative due process.

Commissioner Tom Considine, NCOIL CEO, stated that the technical vs. substantive issue is undoubtedly "blurry" and depends on where you stand and where you sit. However, what leapt off the page was the creation of the law of Corporate Governance in the insurance industry. It was done entirely through IBR and that appears to be substantive in nature. Cmsr. Considine also stated that NCOIL was not married to its clearinghouse proposal. In fact, NCOIL agrees with the method of States issuing regulations for IBR changes that Cmsr. Ridling mentioned. Cmsr. Donelon closed by saying that he hopes to discuss this further at the NAIC Spring Meeting in Denver and that he agreed with Cmsr. Considine's comment on corporate governance blurring the line between technical vs. substantive.

UPDATE ON NAIC INSURANCE DATA SECURITY MODEL LAW

Cmsr. Ridling questioned whether there has been success in NAIC drafting efforts with this Model and expressed concerns about having industry specific Models for cybersecurity. Sen. Rapert agreed and noted that NCOIL has frequently stated that 70 of the 99 State legislative bodies across the country combine insurance with other financial industries such as banking, commerce, and financial services. Cmsr. Donelon stated that NAIC is happy to hold another NCOIL specific conference call to review the latest draft of the Model. Cmsr. Donelson further stated that during this past year's drafting efforts on the Model a problem he encountered is that Attorney Generals deem this area to be their turf.

Rep. Keiser complemented the NAIC on its drafting efforts but stated that the Model is terrible. One example is the definition of "data breach" – it 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. Rep. Keiser stated that under that definition, he can steal it and give it to Rep. Riggs who has the key – under that scenario Rep. Keiser hasn't violated the Model but Rep. Riggs has. Rep. Keiser encouraged the NAIC to continue its work because the current draft is nowhere near ready for introduction to States. Cmsr. Chaney stated that adoption of the Model is a long way away and stated that he would vote "no" on the current draft.

Rep. Matt Lehman (IN) stated that one thing that has not been determined in this area is, what is a loss? In the world of insurance, you must prove your loss. With Anthem, they lost a lot of money trying to recreate what happened – Anthem's clients lost nothing. It was discovered that the data was stolen not to access client's data but rather to access the software Anthem was using. It's therefore hard to draft cyber insurance policies/cyber models when no one really knows what the exposure is. Cmsr. Ridling stated that in his earlier comments, he did not mean to degrade the drafting process – he just wanted to convey that the Model is a very long way away from being close to a an acceptable product and thinks that it might be better to have a communal discussion on these topics rather than trying to draft industry specific Models. Rep. Lehman agreed and stated that if you look at the big breaches that have occurred, they haven't dealt with insurance companies – we should focus on the big picture. Sen. Rapert stated that the

largest data breaches have dealt with the federal government and agreed that focus should be on gathering all industries to perhaps establish best practices.

DISCUSSION ON THE FUTURE OF THE ACA AND DODD-FRANK

Cmsr. Donleon stated that his biggest criticism of the ACA was that it was rushed out "half-baked" with the expectation it could be fixed on the fly with regulations – that did not happen. A good aspect of the ACA was guaranteed issue which is here to stay. Double digit increases in premiums obviously was not a good aspect. The system is in meltdown, is dysfunctional, and needs to be reformed. High-risk pools and phasing out Medicaid expansion do not seem like effective ideas. Sen. Rapert stated that in Arkansas, high-risk pools were phased out. Cmsr. Donelon stated that Louisiana did the same. Cmsr. Chaney said that Mississippi kept theirs and he thinks that for the States that did not expand Medicaid, they will be issued funds from the federal government to operate high-risk pools for those between 100% and 138% below the poverty line. The States will have the option to go to 100% below the poverty line for Medicaid but he does not think that will happen so there will still be a gap for a lot of people. The issue for regulators is being able to react quickly enough to whatever happens with repeal/reform efforts.

Cmsr. Ridling stated that Alabama recommended to the Trump Administration that high-risk pools need to be created that are funded by premiums from the industry and hopefully reinsured by the federal government. The federal government needs to figure out how to subsidize the high-risk pools so that the industry is competing for healthy people and the un-healthy are taken care of through a subsidized program that gives them the same quality of care. Sen. Rapert stated that Arkansas' private option is similar. Cmsr. Chaney stated that he doesn't agree with Cmsrs. Ridling and Donleon and thinks that we need to figure out how to control healthcare costs – health insurance is not the issue. Cmsr. Ridling agreed and stated that when he served on a hospital board he learned that hospitals make their money through procedures which is doctor-driven and substantial change could be effectuated through drug industry reform. Cmsr. Chaney stated that 30% of insurance premiums are caused by the cost of pharmaceutical drugs – they are the driving cost of increased healthcare costs. Regulators can do things to help prevent healthcare costs like prevent balance billing, and adopting the CDC's recommendations on opioids.

NAIC STANCE ON ELIMINATION OF FIO

Cmsr. Ridling stated that the FIO essentially doesn't do anything. The Treasury has a role in international negotiations on things affecting insurance – we did not need and do not need the FIO as a part of Treasury to do that. Sen. Rapert stated that timing is everything and that if the FIO is to be abolished or reformed, now is the time to reach out to the Trump Administration and voice concerns.

ADJOURNMENT

There being no further business, the Committee adjourned at 5:00 p.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE & RETIREMENT ISSUES COMMITTEE
NEW ORLEANS, LOUISIANA
MARCH 3, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long Term Care & Retirement Issues Committee met at the New Orleans Downtown Marriott on Friday, March 3, 2017 at 11:00 a.m.

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

Other members of the Committee present were:

Rep. Sam Kito, AK
Sen. Jason Rapert, AR
Rep. Justin Hill, MO
Rep. John Wiemann, MO
Rep. George Keiser, ND
Asm. Will Barclay, NY
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Marguerite Quinn, PA

Other legislators present were:

Rep. Lois Landgraf, CO
Rep. Lois Delmore, ND
Sen. Nellie Pou, NJ
Asm. Andrew Garbarino, NY
Rep. Lewis Moore, 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 second, the Committee unanimously approved the minutes of its November 19, 2016 meeting in Las Vegas, Nevada, and the minutes of its January 27, 2017 interim conference call meeting.

NETWORK ADEQUACY/PROVIDER DIRECTORIES/BALANCE BILLING DISCUSSION

Dianne Bricker of America's Health Insurance Plans (AHIP) stated that the chart prepared by AHIP summarizes the provisions set forth in: a.) Sen. James Seward's (NY) Proposed Model Act Regarding Network Adequacy and Use of Out-of-Network Providers, b.) the NAIC's Health Benefit Plan Network Access and Adequacy Model Act, and c.) the NCOIL Healthcare Balance Billing Disclosure Model Act.

Sen. Seward thanked Ms. Bricker and AHIP for preparing the chart and said at this juncture the Committee's options are: a.) continue working on his proposed Model, b.) adopt the NAIC Model and/or suggest amendments to improve it, or c.) draft a Model that combines the best provisions of each Model. Sen. Seward recommended the third approach. Sen. Seward also noted that NCOIL staff may want to look to the American

Medical Association (AMA) draft Models and offered his staff's assistance when NCOIL staff begins the research/drafting process. Rep. George Keiser (ND) stated that there are very good parts in each of the Models mentioned and agreed with Sen. Seward – we should take the time to do this right with the end result being a comprehensive NCOIL Model.

Rep. Lewis Moore (OK) asked what the marketplace is doing in response to the surprise balance billing issue. Asm. Cahill stated that there are different approaches in different places and one of the things that the AHIP chart points out is that it is treated different on the regulatory and legislative levels – hopefully a comprehensive NCOIL Model can create uniformity. Rep. Moore stated that since the overall healthcare industry is in freefall right now, NCOIL has a great opportunity to provide leadership in the discussions. Rep. Justin Hill (MO) stated that he thinks networks are going to be a large part of repeal and replace and it is important to be careful of that during any drafting efforts. Rep. John Wiemann (MO) agreed and also stated that we should not be trying to micromanage the network adequacy of providers. Sen. Seward stated that after the Committee reviews the AHIP chart, please send any comments to either his staff or NCOIL staff.

DISCUSSION ON VALUE BASED INSURANCE DESIGN

Connecticut State Comptroller Kevin Lembo stated that the Health Enhancement Program in CT is a value based insurance design. What that means is that CT is driving its state employed population toward behavior that is better for them and better for the plan. CT took some of the academic information that was out there as well as some corporate experience in an effort to engage state employees in their own healthcare. Some ways of doing that were by reducing premiums, deductibles and copays for participants who opted-in to the plan. Focus was also given to five chronic diseases because they were known to be the main cost-drivers in the system – asthma, chronic obstructive pulmonary disease, diabetes, hypertension, and hyperlipidemia. There was 95% enrollment in the plan in the first year and in the second year there was a 90% compliance rate. Some criticized the plan design as a give-away and it is important for States who think about implementing this design to be prepared for those criticisms. For background purposes, TPA's operate the plan – Anthem, Blue Cross & Blue Shield, United on the health side, United and Cigna on the dental side, and CVS Health on the pharmacy side.

Compt. Lembo stated that as part of the CT design, the chronically ill population is required to engage meaningfully in their care – that means take your meds, see your doctor, and engage in some level of education about your disease and how you can improve your condition. That requirement can be satisfied in a number of ways: visiting nurse educators that are engaged with the plan, on-line education, and direct education from providers. A third party manager was hired to put nurses on the phone, engage with people when they show up in the emergency department, and handle things of that nature. Rep. George Keiser (ND) asked who the population is. Compt. Lembo clarified that it is CT state employee retirees and it is important to recognize the differences between those employees and others. State-employees tend to stay with the State, municipality, etc. so there is a great opportunity to review long-term data. Compt. Lembo stated that at the end of the year, if employees met all the requirements they received $100 which proved to be very motivating for employees.

CT engaged with Healthcore for help to analyze how the program was doing. Healthcore performed a study with 2012 data (the current data wont' be available until the fall) which showed that it was working well. There were increases in: colorectal cancer screenings, cervical cancer screenings, breast cancer screenings, cholesterol screenings; and decreases in emergency room use and overall medical costs. For non-chronically ill employees, all they really need to do to be in the plan is to get the age-appropriate screenings. CT saved about $60 million in year one of the plan, $30 million in year two, and $30 million in year three. A reduction of absenteeism in the work place has also occurred. Compt. Lembo noted that State legislators have a critical opportunity to, at the very least, force a discussion on designs like this in their respective States.

Asm. Cahill asked what was the specific resistance from labor groups? Compt. Lembo stated that it was mostly complaints from the healthy employees (non-chronically ill) who didn't like the requirements to get screenings and things of that nature. Compt. Lembo stated that there are numerous stories of those same employees who complained and then called the office directly to thank them after they or their spouse had something discovered and taken care of during a screening. Asm. Cahill asked if CT had done an analysis of the relative pharmaceutical cost increases vs. other costs of delivering healthcare. Compt. Lembo stated a study had not been done but it is something that CT is looking at along with several other States. Asm. Cahill asked what is an appropriate window of study when looking at designs like this? Compt. Lembo stated that he thinks five years is sufficient.

Sen. Bob Hackett (OH) asked if there was any thought about dis-incentivizing people who don't meet the design requirements? Compt. Lembo stated that due to other laws and regulations, it had to be structured by way of setting the prices and then setting the incentives – it couldn't just be penalties for not meeting requirements. But it is important to know that once someone has reached full-compliance, if they don't continue to meet all the requirements, they are out of the plan and are accordingly subject to the higher prices in the market. It is also important to note that an important design feature is that those "kicked out" can get back in and they don't have to wait a year – they can get back in for the portion of the next coverage year after meeting requirements.

Rep. Keiser stated that in ND a medical home program which is very similar to CT's program was enacted. The providers had to opt-in and it was for a larger population. After seven years, the data shows positive effects but the program is being eliminated because of provider fatigue. Rep. Keiser asked if CT was seeing any of the same fatigue. Compt. Lembo said no, but noted that not as much pressure is put on providers in the CT program as in ND. Rep. Wiemann asked what was the annual increase in CT healthcare costs prior to implementation of the program. Compt. Lembo said it was double digits and afterwards, on average, it's been about half of that.

Rep. Moore asked what kind of leverage does CT use when working with vendors to lower costs and increase utilization. Compt. Lembo stated CT pushes everyone hard that is involved but the hardest "push" was setting up the arrangements with third parties to get all the accurate data. Rep. Moore asked if CT uses pharma code genetic DNA testing or anything like that. Compt. Lembo said no. Rep. Moore asked if CT uses some sort of constant-contact system for overall wellness or those with chronic diseases. Compt. Lembo stated that there is direct contact on a regular basis for things such as a deadline reminders to checking on compliance.

Asm. Cahill asked how CT handled the data ownership issue because NY is considering how to do so. Compt. Lembo stated that in CT the data ownership issue was limited to this specific self-insured plan and ultimately it was a condition in contracts. Asm. Cahill asked if there was any discussion about doing it by statute. Compt. Lembo said that he was not aware of any such discussions.

DISCUSSION ON ACA REPEAL/REFORM EFFORTS

Claire McAndrew, Director of Campaign Strategy at Families USA, stated that consumers who benefitted from the ACA are looking towards their elected officials to ensure that any efforts surrounding the ACA moving forward at the State or Federal level will provide at least the same quality of coverage, including the same level of benefits, at least as much cost protections, to at least as many people as the ACA did. And for people who had coverage they liked even before the ACA, they also want to make sure that any changes to the ACA do not make them any worse-off. Families USA is concerned about many of the provisions set forth in the draft bill that was released last week.

The bill provides for a flat tax credit that varies based on age, not income. Also, if you're under 250% below the poverty line, under the ACA you would get help with deductibles and cost-sharing – the draft bill wholly eliminates that. For those in favor of this type of tax-credit system, Ms. McAndrew recommended that you inquire with federal counterparts as to how it will be paid for because the draft bill removes all of the financing mechanisms that are currently in place for tax-credits – the employer mandate penalties, the individual mandate penalties, the health insurer tax, the medical device tax, the tanning bed tax, etc. The one financing mechanism the bill includes is a tax mechanism on employer health plans that fall in the 90th percentile of premiums starting in 2019. After 2019, the tax is adjusted on general inflation, not healthcare inflation which raises a concern that tax could expand. Other provisions that would be eliminated under the bill are the essential health benefits (EHB's) and the Medicaid expansion program which is very concerning. Something that is not in the bill but is rumored to be included in the future is a provision to allow for selling across State lines. Ms. McAndrew also voiced concerns over provisions regarding high-risk pools and health savings accounts (HSA's). Ms. McAndrew stressed to the Committee that consumers do not care whether what's in their health plans comes from the State or Federal government – they want healthcare that works for them. The debate on Medicaid has shown that State legislators and Governors speaking up on behalf of those they represent is making a difference.

Chris Condeluci of CC Law & Policy began by reviewing the ways which the ACA can be repealed. One is through the normal legislative process, which the Republicans currently don't have enough votes to do, and the other is through the budget reconciliation process which essentially affords passage of legislation by a simple majority in the Senate. But in order to be afforded that "luxury," the reconciliation bill can only impact taxes or spending. Therefore, through the reconciliation process, the ACA Medicaid expansion can be repealed along with premium subsidies and taxes, but the insurance market reforms like guaranteed issue, the pre-existing conditions rule, the rule for covering adult children up to age 26, cannot be repealed. Regarding the draft repeal bill, Mr. Condeluci noted the three-year transition periods involved with repealing Medicaid expansion and premium subsidies which indicate the practical and moral desire to avoiding immediately harming people who relied on ACA coverage. Mr.

Condeluci also noted that the individual mandate penalty will be repealed by way of reducing the penalty to $0, and clarified that the news that was circulated about the Trump Administration not enforcing the individual mandate is not true. Also, regarding the Cadillac Tax, Mr. Condeluci stated that it is essentially the same thing as the 90th percentile tax that Ms. McAndrew mentioned.

Mr. Condeluci then discussed some ideas about what the replacements for those portions of the ACA repealed will look like. Regarding the premium subsidy structure: increasing subsidy payments for younger consumers and decreasing payments for older consumers; making subsidies available for off-Exchange plans "non-advanceable"; making subsidies available for ACA-defined "catastrophic plans." Regarding Medicaid, it is a moving target and is the biggest issue/stumbling block in negotiations. It could be replaced with a per-capita cap that States would have to adhere to, but there is also some discussion about allowing States that have already expanded to continue such expansion at pre-ACA FMAP levels.

Regarding opportunities for the State legislators in this process, "State innovation grants" will be included in repeal/replace legislation and States have the flexibility on how to spend those funds. States could set up high-risk pools, a reinsurance program, or other programs designed to reduce premiums and promote health. Additionally, States may have flexibility to limit the "categories" of coverage under a specified EHB in an effort to balance cost with coverage mandates. Defining what a "state-approved" plan is and the use of 1115 and 1332 waivers are also opportunities for States.

Mike Chaney, Mississippi Insurance Commissioner cautioned State legislators about altering EHB's and stated that he does not foresee a lot of changes to EHB's. Cmsr. Chaney also noted that the news of transitional relief afforded to grandfathered health policies is extremely beneficial. Cmsr. Chaney further stated that he thinks that the States that did not expand Medicaid will probably receive substantial benefits to set up high-risk pools but is skeptical of such pools functioning properly under what the Administration has proposed thus far. James Donelon, Louisiana Insurance Commissioner, stated that there are several concerns with the proposals set forth thus far by the Trump Administration, particularly with those involving "writing" across State lines. Cmsr. Donelon recommended that everyone read the NAIC publication on that issue.

RE-ADOPTION OF MODEL LAWS

Upon a motion made and seconded, the Committee unanimously adopted the Model Act Banning Fee Schedules for Uncovered Dental Services, the Patient Safety Model Act, and the Rental Network Contract Arrangements Model Act. Sen. Seward recommended that due to the Model Law drafting efforts mentioned earlier in the Committee, the re-adoption of the Healthcare Balance Billing Disclosure Model Act should be deferred to the Summer Meeting in Chicago. The Committee agreed.

ADJOURNMENT

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

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY COMMITTEE
NEW ORLEANS, LOUISIANA
MARCH 5, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Property & Casualty Committee met at the New Orleans Downtown Marriott on Sunday, March 5, 2017 at 8:00 a.m.

Assemblyman Ken Cooley of California, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR
Rep. Matt Lehman, IN
Rep. Joseph Fischer, KY
Sen. Dorsey Ridley, KY
Rep. Steve Riggs, KY
Rep. Greg Cromer, LA
Sen. Dan "Blade" Morrish, LA
Rep. Michael Webber, MI
Asm. Will Barclay, NY
Sen. Bob Hackett, OH
Rep. Michael Henne, OH

Other legislators present were:

Rep. Sam Kito, AK
Rep. Deborah Ferguson, AR
Rep. Robin Lundstrum, AR
Rep. John Wiemann, MO
Asm. Andrew Garbarino, NY
Rep. Lewis Moore, 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 November 17, 2016 meeting in Las Vegas, Nevada.

DETAILED DISCUSSION/CONSIDERATION OF AMENDMENTS TO LIMITED LINES TRAVEL INSURANCE MODEL LAW

Rep. Matt Lehman (IN) began by notifying the Committee of three (3) amendments to the Model in addition to what has already been proposed:
1.) strike section 2.C. because the language is vague;
2.) amend the definition of "Travel Insurance" in Section 3 by adding the following at the end of the definition after the word "deployed" – "or any other product that requires a specific insurance producer license." The concern is that the scope of a limited lines license shouldn't be expanded beyond what a limited lines producer can do. Because contained within the definition is "but not limited to," it could be interpreted as allowing

the writing of auto liability in conjunction with someone's planned travel since auto is not one of the coverages listed;
3.) strike section 13.C. because the amount of the fine and enforcement language should come from the Commissioners' ability to take action in their respective States.

James Donelon, Louisiana Insurance Commissioner, stated that the NAIC formed its Travel Insurance Working Group in 2015 and it is charged with considering the development of a Model law or guidelines to establish appropriate regulatory standards for the travel and tourism industry. The Working Group began its work in the Spring of 2016 by considering three items: a.) refunds to consumers under free-look periods and whether such periods should be mandatory for travel insurance products. A model law or guideline could be drafted that promotes a consistent interpretation and treatment of that requirement; b.) Un-licensed producer activity. It does appear that current licensing laws across the country are relatively clear. However, given the variance in State laws regarding limited lines travel insurance licensing for producers, and variance in compliance with such laws, the Working Group in coordination with the producer licensing Working Group plan to review NAIC uniform producer licensing standards for limited lines travel insurance and the travel insurance limited lines law that have been enacted in the States and possibly recommend a Model that would make these laws consistent across all States; c.) travel insurance companies self-funding certain benefits without holding an insurer license.

The plan was to research and if necessary provide clarity regarding whether certain products are insurance and should be written through licensed insurers only or are other benefits being offered such as "cancel for any reason" coverage which may not constitute insurance and therefore not require a license to sell and payment of premium taxes. Further, the Working Group could address the packaging with other benefits that do not require a license to sell. Finally, it was expected that this determination would provide clarity as to the payment of premium taxes overall. In its first conference call last June, the Working Group members agreed that it would be helpful to first get more information regarding travel products. The members wanted to better understand what products are typically offered, what business and distribution models look like, and what part of the product is considered insurance. Various stakeholders including industry, trade organizations, and consumer representatives made presentations during subsequent conference calls and during the NAIC Summer and Fall Meetings. Prior to the Fall Meeting, the Working Group chair became aware of NCOIL efforts on these issues. Comments were received from industry, trade organizations, and consumer representatives on the NCOIL proposed amendments to its Limited Lines Travel Insurance Model and Commissioner Tom Considine, NCOIL CEO, made a presentation last week to the Working Group to further explain the amendments. Cmsr. Donelon stated that NAIC looks forward to working with NCOIL to use the proposed amendments as a starting point to discuss the unique features of the travel insurance industry and to further efforts to form a clear regulatory structure with strong consumer protections.

John Fielding, Steptoe & Johnson, representing the U.S. Travel Insurance Association ("UStiA") began by explaining that a travel protection plan is a single product comprised of insurance and non-insurance services. Insurance reimburses trip costs if the trip is canceled for a covered reason and also covers other personal risks incident to travel such as lost baggage and lost costs/expenses due to travel delay. Non-insurance services include things such as concierge services, ID theft, and crisis management.

Brad Finkle, President and CEO of Trip Mate, Inc., stated that the travel protection plans today bear no resemblance to those that existed prior to 1985. Prior to 1985, consumer demand focused on air flight accidental death insurance and baggage coverage. Medical benefits were an afterthought and 24 hour travel assistant services didn't exist. During the 1970's when the tourism and cruise industries began to boom, there was a rise in pre-departure cancellation fee waivers. Around 1985, travel protection plans began to expand due to another increase in tourism, particularly international travel. Consumers wanted a simpler way to purchase travel insurance and travel assistant services rather than on an a la carte basis as was then customary. The modern period of travel protection plans, post-2001, has seen a consolidation of independently owned travel agencies into large travel agency networks, the rapid rise of online travel agencies, and insurance aggregator sites. We've also seen a rise in a different type of traveler who seeks more independent travel to more unique and remote locations. In response to that, travel protection plans have expanded coverage and services. Mr. Finkle stated that given all of these complex developments, the industry does not understand why regulators want to revert back to earlier practices that would make it tougher and more complex for consumers – it doesn't make sense.

Caren Alvarado, Vice President of Regulatory Affairs and Compliance at Crum & Forster, told a hypothetical story of a married couple's trip to Rome in order to illustrate the differences between travel insurance and travel assistance services, and why it benefits consumers to have them bundled into a travel protection plan. Ms. Alvarado stated that travel protection plans are a market-driven product that is highly valued by consumers. The travel industry has grown, and an industry doesn't grow unless its consumer are happy with the product. Industry survival depends on providing products that consumers want at a value they expect. Additionally, the products are a highly discretionary purchase that must prove value to each customer, each time. There are also very low consumer complaint ratios. In 2014 there was a UStiA study that showed that less than one-quarter of 1% of consumers complained about the product.

Jose Menendez, Executive Vice President, Generali U.S. Branch, provided some examples of how travel protection plans function and how they have benefitted consumers. Mr. Menendez stated that the plans are structured to provide complete protection that people want, need and expect.

Greg Mitchell, Frost Brown Todd LLC, stated that what is being sought today is similar to what was sought when NCOIL originally adopted its Limited Lines Travel Insurance Model in 2012. Prior to its adoption, there was a lack of clarity and regulatory structure in the marketplace and the Model helped tremendously.

Rep. Greg Comer (LA) asked how the plans interact with medical destination insurance. Mr. Finkle stated that there would be no interaction – there are specific exclusions for that in all policies.

Sen. Travis Holdman (IN) asked where is the entry point to sell travel insurance. Mr. Finkle stated that there are several: the airline; aggregator sites; travel insurance websites; travel agents. Sen. Holdman asked what the travel insurance that an airline typically offers him when he purchases tickets covers. Ms. Alvarado stated that there are numerous plan designs depending on what the consumer wants. Rep. Lehman agreed and stated that from his experience and those that he has interacted with, those who purchase the plans and use them are very happy with them.

A Motion was then made and seconded to waive the quorum requirement.

Wes Bissett of the Independent Insurance Agents and Brokers of America (IIABA) stated that IIABA does not object to the goals of the Model but feels that it needs some work. One concern is which particular State law would apply in an insurance sale. If you buy a Delta airline fare, what State disclosure requirements would apply. Another concern is some of the carve-outs in the Model relating to the Unfair Trade Practices Act. IIABA also has concerns over the timing of disclosure obligations. IIABA also urges the Model to address more thoroughly the problems with opt-out provisions. Mr. Bissett further stated that the Model does not properly address who the responsible party is and their licensing requirements when supervising travel agents. Asm. Cooley then asked Mr. Bissett, in the interest of time, to please memorialize all thoughts and concerns with the Model and send them to NCOIL staff and the Committee.

Birny Birnbaum of the Center for Economic Justice (CEJ) stated that he is speaking on behalf of CEJ, the Consumer Federation of America, and the U.S. Public interest Research Group. Mr. Birnbaum stated that travel insurance is an important product but the issue is how best to provide the regulation that industry wants and how best to encourage consistent and uniform regulation and consumer protection. Mr. Birnbaum stated that regulators should be provided an opportunity to weigh in on the Model, particularly since there are some ongoing examinations involving travel insurance. Mr. Birnbaum stated that the part of the Model that states the travel insurance industry is competitive unless the Commissioner determines otherwise is an old feature that has been traditionally oriented towards the kind of products that are State-specific like auto and homeowners' insurance. Additionally, the Model sets forth provisions for filing and rate review but then declares travel insurance as an inland-marine product – that is contradictory. In response to Sen. Holdman's earlier question, Mr. Birnbaum stated that when you go to the Delta website it doesn't tell the consumer that they can buy travel insurance from anyone they want. Mr. Birnbaum stated that is not representative of a competitive market and is similar to consumer credit insurance. Mr. Birnbaum further stated that without knowing what the travel insurance market loss-ratios and market shares are, information that he has requested but has not been given, you can't determine if a market is competitive.

Mr. Birnbaum stated that bundling travel insurance and travel assistance services to form a travel protection plan does not exist in any other line of insurance. Mr. Birnbaum asserted it is important to recognize that consumers have specific rights when purchasing insurance that they don't have with other services/products. Separating travel insurance from assistance services and giving the consumer the option to purchase what they want is also beneficial to regulators because they can easily identify what products they must oversee and which are subject to premium tax. Mr. Birnbaum also stated that the competitive market section in the Model should be deleted and welcomes working with NCOIL to improve the Model.

Rep. Lehman stated that consumers need to be given some credit in that they don't always need to be shown a list, as Mr. Birnbaum suggested, of other places to purchase travel insurance. A consumer that goes to Walmart.com doesn't need to be told that they can purchase a hammer at Lowe's, Home Depot, etc. Some consumers might also like the ease of doing business by simply having an extra $30 added to their ticket price when on Delta.com rather than spending time searching for other prices and coverages.

Regarding the issue of bundling, Rep. Lehman stated that it already exists in other lines of insurance such as auto insurance - services such as emergency road side service and rental car coverage are commonly included. Rep. Lehman closed by saying it is important to recognize that when drafting a large Model law like this one, the focus should be on whether what's in the Model is the appropriate general framework and States can then tweak it to their liking. Mr. Birnbaum disagreed with Rep. Lehman and stated that a consumer shopping at Walmart knows that they can get a hammer somewhere else but that's not the case with travel insurance. Mr. Birnbaum also stated that the bundling examples Rep. Lehman provided are incorrect and urged the Committee to not adopt the Model at this time so regulators can provide feedback.

NCOIL President Rep. Steve Riggs (KY) stated that bundling is when you offer two products for one price such as auto and homeowners insurance. With travel protection plans, the marketing and promotion is bundled but travel insurance and travel assistance services are separate. NCOIL Vice President Sen. Jason Rapert (AR) disagreed with Mr. Birnbaum's comments and stated that legislators and regulators shouldn't be required to make decisions for consumers from "cradle to grave." Sen. Rapert stated that all consumer need to do is google "travel insurance" and they will be presented dozens of options. Mr. Birnbaum stated that he supports making travel insurance available to consumers because it is a good product and again expressed concern over the competitive market section in the Model. Asm. Cooley stated that the section is important because it effects how rating law is applied. Rep. Lehman stated that he agreed with Mr. Birnbaum and Mr. Bissett that it is important to have proper regulatory review, and that is in fact why the Model has been presented – there were and are unnecessary regulatory actions taken against the travel insurance industry because of the lack of a regulatory framework.

Jack Zemp, Vice President and Deputy General Counsel, Allianz Global Assistance, stated that there is no doubt that the travel insurance market is competitive. Rates have been the same for past 20 years, coverage has expanded, and consumer complaints have been low. The industry has responded to the fact that consumers don't care whether what they purchase is insurance or not – they just want help and they don't want surprises when they travel.

Ed Schwartz, Steptoe and Johnson, stated that the concept of bundling comes out of anti-trust law where it has been recognized as typically pro-consumer. Bundling in anti-trust law has been discussed for decades, including at the Supreme Court. The first and most important question that a judge asks when analyzing a bundled product is: is there a competitive market? Put another way – does the supplier have market power? If the answer is no, then judges will typically approve the bundled product because they recognize the free market is working. All the data in the travel insurance market shows that it is competitive.

Terry Dale, President and CEO of the U.S. Tour Operators Association stated that the Model is a big step forward for the industry because it provides clarity, consistency, continuity, and compliance. When those things can be packaged together, the consumer always benefits.

Melinda Bourgeois, Travel Central and American Society of Travel Agents, supports the Model and stated that it is very important for travel agents to have a regulatory

framework to work with. Ms. Bourgeois also stated that bundling is extremely pro-consumer.

Rep. Joseph Fischer (KY) asked, given how competitive the market is and the low number of complaints, why is this regulatory framework needed? Mr. Zemp stated that over the past few years, some regulators began interpreting laws in a new fashion which led to an investigation of the industry in an effort to "transform" it. Accordingly, clarity and understanding of the regulatory environment is needed. Commissioner Tom Considine, NCOIL CEO, stated that when in conflict with State unfair trade practice law, the Model would govern. That is necessary because unfair trade practice law is extremely general which has led to travel insurance companies being the target of market conduct exams due to, in essence, a difference of interpretation and the lack of a clear regulatory structure for the industry.

Sen. Bob Hackett (OH) asked if there was any discussion between NCOIL and NAIC to work together on this Model. Cmsr. Considine stated that the NAIC has indicated that they want to draft their own Model using parts of ours and information from market conduct exams. Sen. Holdman stated that NCOIL and NAIC need to do a better job of working together on Model laws.

The Committee then unanimously voted to adopt the Model as amended earlier in the Committee proceedings.

REBATES, REFERRALS AND REWARDS – WHAT'S OK AND WHAT'S NOT?

Former Massachusetts Insurance Commissioner Joe Murphy and current Chief Operating Officer at Coverys stated that the NAIC Model Unfair Trade Practices Act (Act) has been adopted in 48 States. Cmsr. Murphy stated that during his time as Massachusetts Insurance Commissioner, the issue of how rebates, referrals and rewards were viewed by that Act constantly arose. Most of the issues arose from complaints filed by companies against a competitor company/agent, not from consumers.

Cmsr. Murphy stated that under the Act approves any coverage or benefit including rebate of premium or dividend opportunity, provided it is specified in the insurance policy. The Act disapproves something of value offered/given to sell a policy, if the item of value is not provided in the policy itself. For example: cash, refund of all or part of an agent or broker's commission, services, gifts, contributions, payment of premiums – anything of value; and any special advantage over other applicants or insureds in dividends, profits, or other benefit to sell a policy, if it is not provided in the policy itself. Cmsr. Murphy noted that some States like Washington and Georgia have set dollar thresholds/bright-lines. Washington (RCWA 48.30.140(4)): "This section shall not apply to advertising or promotional programs conducted b insurers or insurance producers whereby prizes, goods, wares, gift cards, gift certificates, or merchandise, not exceeding one hundred dollars in value per person in the aggregate in any twelve month period, are given to all insureds or prospective insureds under similar qualifying circumstances." Maine is considering raising its statutory exemption and allowing the insurance department to increase the value through regulation.

Regarding referrals, Cmsr. Murphy stated that most if not all States provide that only licensed persons can receive compensation for insurance business placed. Sharing

commissions with a licensed person is ok, but not with unlicensed persons. Unlicensed persons may be compensated for potential business referrals, provided that compensation is not tied to actual business written. Regarding rewards, items given to consumers for promotional purposes, if given at "de minimis" value, a reward can be ok and not considered a rebate. For example, trade show trinkets and offering cash for a quote may be ok if it is offered for a quote and not the result of a quote, i.e. not tied to purchase. Cmsr. Murphy closed by stating that more uniformity and clarification is needed on these issues and looks forward to working with NCOIL in the future. Rep. Lehman stated that he hopes NCOIL continues consideration of these issues since there are some grey areas.

DISCUSSION ON ASBESTOS CLAIMS TRANSPARENCY MODEL LAW

Cmsr. Considine stated that when drafting a Model law, NCOIL staff will look to the West Virginia law on this issue given the bi-partisan support it received. Cmsr. Considine recommended that the Committee, in addition to the presentation it heard at the Annual Meeting in Las Vegas and the one it will hear today, familiarize themselves with the West Virginia law and the issue in general between now and the Summer Meeting in Chicago.

Former U.S. Congressman Barry Goldwater, Jr. from Goldwater-Taplin stated that asbestos litigation is a very serious issue and supports the Committees efforts in considering adoption of an Asbestos Claims Transparency Model Law.

Mark Behrens, Esq., Shook, Hardy & Bacon, LLP, stated that the culpable asbestos companies were largely forced into bankruptcy but reorganized and are immune from personal injury lawsuits. As a result of those bankruptcies, privately managed trusts were created that collectively hold about $37 billion dollars available to those exposed to and harmed from asbestos. But the litigation did not stop there – plaintiff's lawyers got creative about bringing in new, peripheral defendants in litigation. Plaintiffs today have two different sources of recovery: the trust system, and the tort system. But by waiting to file trust claims until after the tort case is resolved, the jury in the tort case is misinformed about all of the plaintiff's exposures. Eight States have passed, and other States are considering, legislation to bring the two sources of recovery together by allowing the juries to hear about all of the plaintiff's asbestos exposures. Mr. Behrens recommended that the Committee read the "Garlock" case to gain a better understanding of the issues. Sen. Rapert said that Arkansas is considering this issue and supports NCOIL Model drafting efforts.

ADJOURNMENT

There being no further business, the Committee adjourned at 9:45 a.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
NEW ORLEANS, LOUISIANA
MARCH 4, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the New Orleans Downtown Marriott on March 4, 2017 at 1:15 pm.

Representative Joseph Fischer of Kentucky, presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR
Asm. Ken Cooley, CA
Sen. Travis Holdman, IN
Rep. Jeff Greer, KY
Rep. Steve Riggs, KY
Rep. Michael Webber, MI
Rep. John Wiemann, MO
Rep. George Keiser, ND
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Marguerite Quinn, PA

Other legislators present:

Rep. Lois Delmore, ND
Rep. Deborah Ferguson, AR

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 November 18, 2016 meeting in Las Vegas, Nevada.

UPDATE ON DOL FIDUCIARY RULE

Sen. Jason Rapert (AR) expressed his appreciation to the committee for discussing and working on his Resolution opposing the Rule which he stated was brought to a halt earlier this year. Sen. Rapert said some of the largest firms have already changed business models and that it was an interesting dynamic. Some of them refused to change their models and he went on to say that they listen to the industry and organizations like NCOIL.

Kate Kiernan from the American Council of Life Insurers (ACLI) stated that the DOL has delayed the rule until April and ACLI is hopeful to have the rule further delayed. Ms. Kiernan reported account minimums were raised and the rule limit choices. Currently the ACLI seeks to replace, not repeal this rule and is looking forward to working with the Administration on this.

Sen. Rapert stated that in talking to advisors in the industry, the rule has presented an ethical dilemma. Many advisors are considering leaving firms because they reject the notion that client accounts that they have in a good situation and have been managing for the past 20 years will have costs raised without a change in investment approach. Sen. Rapert stated that he has read the rule will result in $15-17 billion dollars in extra costs that ultimately will be passed on to consumers.

Rep. Joseph Fischer (KY) asked if the moratorium has impacted the ongoing court cases. Ms. Kiernan responded yes, it has, and that the ACLI is at a pause to wait and see what happens before moving further.

Birny Birnbaum from the Center for Economic Justice (CEJ) stated four courts have upheld the rule and those are courts selected by industry to pursue these challenges. The courts have found that the multi-year process and deliberations regarding the rule was done appropriately and fully within the DOL's authority and responsibility to workers. He stated that many advisers were already adhering to the fiduciary standard and many more have pledged to do so regardless of the outcome of legal challenges, and that consumers need and deserve retirement investment advice from advisors who put the clients interest first. Hundreds of consumer, worker and adviser organizations have and continue to support his rule and dozens of editorials across the country have urged support of the rule. More than ever, the opposition to the rule is coming from organizations selling the higher-cost products. Mr. Birnbaum also stated that the mere prospect of the rule has already increased reasonable options for small investors.

Mr. Birnbaum stated that another issue is the federal government acting because states haven't. States could have pre-empted the DOL rule by addressing the issue of conflicted advice – either by mandating a fiduciary standard for insurance producers or even by addressing the compensation schemes used by insurers which fail to align the interests of consumers with producers. He suggested that state legislatures and regulators work on those issues to broaden consumer protection beyond retirement investments and to render the rule unnecessary.

DISCUSSION ON THE USE OF BIG DATA IN LIFE INSURANCE UNDERWRITING

Mary Bahna-Nolan, MAAA, FSA, CERA, Executive Vice President, Head of Life R&D at SCOR Global Life, stated that from a customer perspective, underwriting has been perceived as the major obstacle on the customer's pathway to purchase. Consumers find it to be a complex, time consuming and lengthy experience. Many consumers do not understand the purpose of underwriting or the process. Enhanced and accelerated underwriting techniques remove the perceived barrier to the insurance application process. Accelerated underwriting (AUW) is a process by which non-medical and medical information gathering may be customized to the individual applicant. The information gathered on two applicants for the same product, at the same face amounts, and for the same gender, age, and smoking status may be different. The impact on the retail premium is not expected to be significantly different from the impact of traditional fully underwritten processes as we know them today. The result of AUW processes can be less invasive.

AUW may look like an expanded simplified issue process but with mortality that aligns more closely with fully underwritten business. AUW is often modeled using predictive modeling and complex algorithms. Ms. Bahna-Nolan stated that AUW may include traditional underwriting sources collected through different means such as Medical Information Bureau (MIB), Motor Vehicle Record (MVR), criminal history, pharma data/prescription history, electronic lab data, health records, expanded application and tele-interview process, non-traditional data such as clinical lab data, credit profiles, facial analytics, and in many cases it excludes extraction of blood and urine.

Ms. Bahna-Nolan further stated that the number of companies with AUW programs is increasing at a rapid rate. In a Society of Actuaries survey of 27 respondents:10 have implemented in some form; 10 working on implementing; 3 currently evaluating. The majority of applicants through age 55 or 60 can be fully underwritten towards "Standard Mortality", including preferred, without exam/fluids, using combinations of alternate information sources. This can be achieved by, knowing and appreciating the degree and power of appropriate pipeline selection and carefully stratifying applicants suitable for "no fluid" selection by using other favorable parameters that can be obtained non-intrusively, (Rx check, MIB, MVR, credit profiles, enhanced application, detailed questioning, etc.) Use of other data sources, smarter applications and tele-interviews are replacing the traditional underwriting process for certain ages and face amounts. Ms. Bahna-Nolan stated that new data sources include enhanced applications with use of behavioral economics, predictive models, credit profiles, Rx risk scores/algorithms, electronic health records, electronic clinical lab records, smoker propensity, APS summaries, applicant candor, use of wearable devices, facial analytics, criminal history and other emerging technologies.

Ms. Bahna-Nolan also noted that all companies are using e-data sources of some sort and there is a false presumption that today's underwriting approach appropriately classifies all the risks. Use of new data sources and predictive modeling can lead to more consistent risk selection and can better segment profiling with re-classification of risk. The execution of AUW strategy varies widely amongst companies but often utilizes a combination of traditional and new data sources. Company motivations for AUW also vary and often drive the approaches taken. Motivations may include: attract new customers; an aging underwriter workforce; an aging distribution network; reduce expenses; improve the customer experience; and improve risk selection and add constancy.

The mortality outcome for any underwriting regime is a factor of many selection levers. While the more favorable scores have a greater percentage of higher incomes, all income ranges include all possible scores and vice versa. Ms. Bahna-Nolan stated that the use of risk scores via single or combined data sources is becoming common in AUW programs. Unlike legacy UW approaches, selection by risk score can be finely tailored towards a specific target across a wide range of possible scenarios. Common risk scores are credit profiles, prescription scores, and lab scores. As less favorable (by score) are 'removed' from the group, the mortality of the remaining applicants improves in predictable fashion.

Rep. George Keiser (ND) asked if companies are setting ceiling limits for a benefit above which you would not use the AUW and if so what is that limit. Ms. Bahna-Nolan responded yes, companies today are entering that market carefully. Ms. Nolan also reported that some companies are considering expanding to higher base amounts. As companies are learning and getting more experienced they are looking into expanding those limits.

Rep. Keiser stated that in ND they have run into a recent problem where they have three primary health care providers. All three were providing medical data in about ten days. They then suddenly arbitrarily made the decision that it will now be thirty-one working days before the medical data will be made available. That creates a problem for health and life insurance companies. The consumers want the policy now. Ms. Bahna-Nolan reported not seeing this as a problem although her focus has been primarily on the life insurance side and she could not really comment on the health insurance side of this issue. Ms. Bahna-Nolan did state that insurance companies are trying to utilize health records and electronic health records would be the gold standard. Ms. Nolan also stated that as of now that is not accessible as an instant format. Rep. Keiser then pointed out the electronic health record is available but they are not transferring it. Ms. Bahna-Nolan stated it is not available in a data format that can easily be implemented.

Rep. John Weiman (MO) commented that it looks like life insurance companies are going through the transformational period that the auto insurance companies did about fifteen years ago. Auto insurers refrained from using the word “credit scoring” and they used the “insurance score”, where they take data information from your credit, driving record etc. to create a score that they would then use for their pricing models. Then they would put you into various rate classes. Rep. Wiemann went on to state that it is his understanding that is what the life insurance companies are on the cusp of doing right now and asked if life insurance rating scores are being created based on credit and health status to help speed up the underwriting? Ms. Bahna-Nolan stated there is a fair correlation as to what is being done. There are differences though, as life insurers cannot change the rating once the policy is issued. There is a combination of traditional and new data sources to be considered. But she answered yes as far as the credit attributes, criminal history and motor vehicle records are concerned. Some of these things have always been used. They are just being used in a smarter way. Rep. Wiemann asked if companies are using an external third-party agency to create those profiles or internally, within companies? Ms. Nolan stated they use Nexus Lexus and Trans Union for the credit profiles.

Sen. Travis Holdman (IN) asked if companies consider things like magazine subscriptions, credit card purchases and health club memberships. Ms. Bahan-Nolan stated that consumer purchases and social media are not utilized “today”; however, Ms. Bahna-Nolan that she can’t speak as to what companies might use in the future.

Professor Brenda Cude, PH.D., University of Georgia, stated that she is in a department of consumers and economists and that most do not know what underwriting is. Some consumer concerns with underwriting relate to privacy, unintended consequences and transparency. Consumers are concerned with insurers accessibility to their privacy via Facebook as that may be a misrepresentation as a life insurance consumer. Consumers also want decisional (freedom from interference in personal choices) and informational

(ability to restrict access to and control the flow of his/her own personal information) privacy. In the U.S. today, we don't really own our privacy. Some examples given were wearable data, cameras on the streets, credit card purchases as well as stolen information. Prof. Cude also reported that different consumers are likely to view privacy differently. She went on to say that she teaches college students and they have a very different view on what is private and what is not. Her guess is that they are less resistant but perhaps it is because they have no understanding of what is happening. One of the main problems for consumers is that they have no idea how much their information is worth. For example, how much is my cholesterol level to a life insurer worth? How much is my interest in basketball and gardening worth?

Prof. Cude also stated that there may be unintended consequences of companies using so much data in underwriting. Will prospective parents forgo genetic testing to apply for life insurance? Individuals also may not apply for life insurance because of a genetic condition. Prof. Cude also raised the following questions: Will the consumer know what information is being used? What information is being used? By Whom? For what purpose? Does the consumer have opportunity to contest some information? There are also problems associated with "group" profiling where data patterns suggest new associations about people which may or may not be true. For example, Target had sent a young woman pregnancy information based on her purchases. Prof. Cude stated that a lot of this boils down to transparency – will the consumer know what information is being used, by whom, and for what purpose. And will the consumer have the ability to contest inaccurate information. Prof. Cude also noted that by moving further away from traditional underwriting, we've made producer's jobs very difficult. Some of the information used with AUW can only be understood by statisticians.

Prof. Cude stated that consumers want to understand how factors relate to risk; want to understand what information is considered in underwriting; and want to understand how behavior change can make a difference in cost. NCOIL President Rep. Steve Riggs (KY) stated that privacy concerns have to be tempered with what consumers want. When you want someone to write a million dollar check when you die, to expect you don't have to give up some private information is not realistic. As you are signing a contract, you are making an agreement with somebody and they are agreeing to pay out $1,000,000.00, therefore, privacy concerns need to be tempered with what coverage you are looking for. Prof. Cude agreed but thinks that the connection to the specific information provided and the risk assumed needs to be better understood and explained by all.

Mr. Birnbaum stated that when filling out a paper application, I know exactly what information I am giving to the insurance company. Therefore, I can look at this and decide whether I do or do not want to apply. The issue with AUW and big data is that consumers aren't disclosing the data that is being used. Insurance companies are gathering information without disclosing it to the consumer so the consumer does not have the same option as they do with a paper application.

Rep. Keiser stated that a lot of these issues arose from the Gramm Leach Bliley Act (GLB) and interstate banking. State legislators were told that financial institutions must be allowed to sell and share information. However, there is a provision in GLB that says you

can opt-out. ND was the only state that said you must notify us when you share financial information and despite fears that it would disrupt the economy, ND is doing very well. Accordingly, big data was created by government policy and the way to cure concerns about it is to go to an opt-in/opt-out system on the State level. Ms. Bahna-Nolan stated that there is disclosure on all applications but whether the consumer is aware of it or understands it is another issue. Ms. Kiernan stated that since life insurance is not mandated coverage, innovative methods to create and sell the product are extremely important.

Sen. James Seward (NY) stated that a big part of the problem is financial literacy and there needs to be a greater understanding about what underwriting is all about. That would lead to a better process done in a more expeditious manner. Prof. Cude agreed and encouraged State legislators to review their State education requirements on financial literacy - part of the problem is finding unbiased and lucid financial literacy education.

UPDATE ON NAIC UNCLAIMED PROPERTY MODEL

James Donelon, Louisiana Insurance Commissioner, state that the current draft's provisions are mixed with provisions from the lead states draft model act and the NCOIL Model. Cmsr. Donelon complimented NCOIL for its leadership in this area having approximately two dozen states adopting its model act. The current draft NAIC model requires a look back period of 18 months for any lapsed policy and requires an additional search semi-annually for policies that might have lapsed during that time frame. The NAIC draft also contains a provision that gives the commissioner the discretion to exempt an insurer from having to perform DMF comparisons if the insurer can demonstrate financial hardship or that conducting such comparison would not be cost effective[1]. This provision also gives the commissioner the discretion to phase-in the DMF comparison requirements. While state legislators, industry, and consumer reps may have different views on how to most effectively address this issue, the NAIC remains committed to exploring different avenues in an open and transparent process.

Mr. Birnbaum stated that CEJ is concerned and troubled by the NAIC efforts developing a model in this area for several reasons. First, while regulators may have some new insights as a result of investigations and audits, it is unclear why those insights could not be provided as revisions or updates to the NCOIL model. Second, the regulators are split on key aspects of the model, most notably whether the model applies to all policies or only to policies issued on or after the effective date. Third, CEJ is "stunned" that many regulators will not support the application of the unclaimed benefits model to all life insurance policies, as legislators have done with the NCOIL model. The current draft of the model provides a choice of so-called retroactive or prospective applications – that is a terrible consumer protection approach and it undermines the NCOIL Model and undermines those States that have said all consumers should be protected.

UPDATE ON NAIC LOST LIFE INSURANCE POLICY LOCATOR

[1] Note: Just 2 days after adjournment of the NCOIL Spring 2017 National Meeting, the NAIC suspended work on its Unclaimed Property Model Act.

Eric Cioppa, Superintendent of the Maine Bureau of Insurance, stated that about 15 States had such a program but now it is truly national. It is designed to assist individuals in locating individual annuity contracts and individual life insurance policies after the death of an insured. Consumers are entitled to these benefits and this is a great opportunity for NCOIL and NAIC to work together to let them know this program exists.

RE-ADOPTION OF MODEL LAWS

Joe Thesing from the National Association of Mutual Insurance Companies (NAMIC) strongly encouraged the committee to re-adopt the Insurance Compliance Self-Evaluation Privilege Model Act. The model currently has been adopted in twelve states and all indications are that the law is working well. The whole idea behind the model is that it promotes self-evaluation. The idea is that an insurer, without fear of retribution, has the opportunity to examine their internal processes to identify problems and if they identify any problems, they correct them. It is worth noting if the insurer starts using the self-evaluation privilege and is not moving towards compliance, that privilege does not stay in place. Indications from regulators are that the laws are working well and are meeting the intention of promoting self-evaluation. NAMIC will continue to encourage other states to pass legislation in other states.

Rep. Keiser stated that he originally voted for the Model but will not vote for its re-adoption because in Section 1(b)(1), it states that an insurance compliance self-evaluative audit document is privileged information and is not discoverable, or admissible as evidence in any legal action in any civil, criminal, or administrative proceeding.[2] Rep. Keiser made a motion to strike "criminal." Mr. Thesing stated that he can't speak to that without checking with some of the insurance companies but noted that ND has adopted the Model and encouraged Rep. Keiser to speak to ND regulators to see if any problems exist. There was no second to Rep. Keiser's Motion.

Mr. Birnbaum stated the model is biased against consumers and towards insurers because it allows the insurer to use the self-evaluative privilege when helpful, and allows the insurer to assert privilege when it would be helpful to consumers to address unfair treatment. Mr. Birnbaum also stated that the Model is premised on the fact that it will encourage voluntary compliance and improve market conduct quality of insurers. He went on to say that he is not aware of any empirical evidence or study produced over the past 20 years supporting this assertion. It seemed reasonable for NCOIL to require some evidence relating this privilege to improved market conduct quality before re-adopting this model. Mr. Thesing stated that it was Mr. Birnbaum's obligation to come up with evidence that it was not working well, and NAMIC has not heard about any complaints from regulators.

A motion was then made and seconded to re-adopt the Model. All committee members voted to re-adopt except Rep. Keiser.

[2] Note: There are exceptions for criminal proceedings after an *in camera* review in other sections of the Model.

Mr. Birnbaum stated that CEJ is supportive of the Secondary Addressee Model Act but noted that it is limited to consumers aged 64 and over and urged NCOIL to amend the model to apply to all consumers.

Upon a motion made and seconded, the committee unanimously voted to re-adopt the Model.

ADJOURNMENT

There being no additional business the Life Insurance and Financial Committee meeting was adjourned at 2:15 p.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
STATE-FEDERAL RELATIONS COMMITTEE AND INTERNATIONAL INSURANCE ISSUES COMMITTEE
NEW ORLEANS, LOUISIANA
MARCH 5, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) State-Federal Relations Committee and International Insurance Issues Committee met jointly at the New Orleans Downtown Marriott on Sunday, March 5, 2017 at 9:30 a.m.

Representative Joseph Fischer of Kentucky, Chair of the International Insurance Issues Committee, presided.

Other members of the Committee present were:

Rep. Sam Kito, AK
Sen. Jason Rapert, AR
Asm. Ken Cooley, CA
Sen. Travis Holdman, IN
Rep. Matt Lehman, IN
Rep. Steve Riggs, KY
Rep. Greg Cromer, LA
Sen. Dan "Blade" Morrish, LA
Rep. Michael Webber, MI
Asm. Will Barclay, NY
Sen. Bob Hackett, OH

Other legislators present were:

Rep. Deborah Ferguson, AR

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 November 18, 2016 meeting in Las Vegas, Nevada.

DISCUSSION ON IMPACT OF COVERED AGREEMENT

Dave Snyder of the Property Casualty Association of America (PCI) stated that pursuant to Dodd-Frank, a period of 90 calendar days following the date of submission of the final text of the covered agreement to Congress must expire before the covered agreement is effective. At the end of 90 days, without Congressional action or revocation from the Trump Administration, the agreement goes into effect. That is different from a traditional trade agreement which requires a Congressional vote to go into effect. On February 16, 2017, a hearing was held on the covered agreement before the House Financial Services Subcommittee on Housing and Insurance during which the NAIC opposed the agreement and called for re-negotiation. Industry and legislators are divided on supporting the agreement. On February 24, 2017, a letter was sent to Treasury Secretary Mnuchin from Subcommittee Chairs Duffy and Ross that laid out several

procedural and technical questions about the covered agreement, and requested a response by March 10, 2017.

Eric Cioppa, Superintendent of the Maine Bureau of Insurance, stated that NAIC has urged a transparent re-negotiation of the covered agreement. While the NAIC recognizes that the U.S. received some benefits under the agreement, such as the elimination of local presence requirements, it doesn't provide for full equivalence or recognition of the U.S. regulatory system. Supt. Cioppa stated that the agreement places certain conditions on the ability of regulators to obtain information and to take certain actions currently authorized by State law. In addition to concerns with the substance of the agreement, Supt. Cioppa stated that the NAIC is concerned with how the negotiation process unfolded. Unlike a traditional trade agreement, there were no formal consultations with U.S. stakeholders and despite assurances to the contrary, the few in the negotiation room were merely observers subject to strict confidentiality requirements.

Joe Thesing from the National Association of Mutual Insurance Companies (NAMIC) stated that the covered agreement is a result of a simple lobbying job: European insurance companies did a great job convincing international regulators to come to the U.S. and fight for a regulatory regime that benefits them so that they can gain more market share to make more money. The problem is that the U.S. domestic marketplace loses because of that, particularly smaller U.S. insurers. Regarding reinsurance collateral, if the covered agreement goes into effect it will eliminate all collateral requirements for European reinsurers. The agreement says that U.S. companies can negotiate collateral requirements but the fact of the matter is that smaller U.S. insurers don't have the negotiating power to do so. Mr. Thesing also stated that for a State that hasn't adopted the NAIC Credit for Reinsurance Model Law, such as Texas, if the covered agreement goes into effect, collateral requirements will be zero because of the covered agreement provisions allowing for preemption of State law. Mr. Thesing urged NCOIL to voice its concerns about the covered agreement to Congress and offered assistance in doing so.

Ron Jackson from the American Insurance Association (AIA) stated that AIA agrees that the negotiation process in any future agreements needs to be improved and above all, more transparent. However, AIA believes the covered agreement provides critical protection for U.S. companies doing business in the E.U. that have suffered discriminatory treatment. Mr. Snyder stated that another key feature of the covered agreement is that it creates a joint committee for further work in analyzing the issues raised by the agreement and the committee will therefore be very important going forward. Mr. Snyder urged NCOIL to consult with the committee if in fact the covered agreement goes into effect. Rep. Joseph Fischer (KY) asked if the agreement goes into effect, is it self-executing against the States. Mr. Thesing stated that no one knows for sure.

NCOIL President Rep. Steve Riggs (KY) stated that the lack of transparency in the negotiation process was a big problem and asked Mr. Jackson if AIA agrees. Mr. Jackson agreed and stated that AIA supports H.R. 5143. Rep. Riggs asked if AIA could adopt a resolution or statement supporting transparency in future agreement negotiations. Mr. Jackson said that should not be a problem. Mr. Snyder stated that there are serious issues with transparency in other international settings as well such as the International Association of Insurance Supervisors (IAIS). Mr. Thesing stated that

the U.S. needs to simply say no to European micro-managing in the U.S. insurance regulatory regime. State legislators can help by putting pressure on their federal colleagues.

Rep. Fischer asked Supt. Cioppa if the NAIC has done an analysis as to which State laws could be preempted by the covered agreement. Supt. Cioppa stated that is an ongoing process and also stated that if the States don't modify their reinsurance agreements within four years, there is going to be preemption of State reinsurance laws. Supt. Cioppa also stated that there are many ambiguous provisions in the covered agreement and a lot of unanswered questions. He urged all to read it carefully and voice their concerns.

Dennis Burke of the Reinsurance Association of America (RAA) agreed with Mr. Jackson's statements. U.S. companies were prohibited from doing business in several E.U. countries and there was a danger that if the covered agreement was not reached, U.S. companies would see more barriers to operating in Europe. Mr. Burke stated that the agreement can be re-negotiated while in place and it also has a termination provision in it. Mr. Burke further stated that RAA agrees that the negotiating process was flawed and needs more transparency. Rep. Fischer asked who has the authority to cancel the agreement. Mr. Burke said he is not sure but he knows the States do not. Mr. Snyder closed by saying: due to the short turnaround (90 days from submission of the agreement to Congress), NCOIL needs to move quickly if it wants to be involved; that U.S. companies have reported that the discrimination has ceased since the covered agreement was reached; and PCI is willing to provide to NCOIL its legal analysis of the covered agreement.

DISCUSSION ON IAIS INITIATIVES

Mr. Snyder stated that the IAIS continues to work on its insurance capital standards and unfortunately, many at the IAIS continue to maintain a hard line that there should be a single standard. Mr. Snyder stated that standard is not reflective of how the U.S. operates.

Mr. Snyder then noted that there are many other international insurance regulation developments ranging from governance, market conduct, resolution, the role of technology, systematic risk and enhanced supervision, and cyber discussions. This past Friday, IAIS issued over 150 pages of material on several issues and a lack of transparency continues to be a problem. Mr. Snyder stated that one example of the direction the IAIS is headed is reflected in the issue of suitability – the notion that members of the board, CEO's, key people that control various government functions, as well as company owners, are not only subject to review in terms of "did they do anything bad in the past", but under the IAIS standards, the regulator has the authority to determine whether he or she thinks a board member/CEO is competent. That is typically left to the free market and that is one example of the intrusive nature of some of the IAIS standards and their lack of providing things like due process, transparent regulatory provisions, and the role of the judiciary. Such actions blur the line between the regulator and the regulated entity. Mr. Snyder noted that the Trump Administration has issued core principles for financial services regulation that fit well with Organization for Economic Cooperation and Development (OECD) recommendations on how best to regulate financial services. Mr. Snyder urged NCOIL to stay involved on international

insurance developments and assured the Committee that its involvement makes a real difference.

FIO/FACI ACTIVITY

Mr. Thesing stated that NAMIC supports elimination of the FIO and believes it has not provided any value during its existence. Commissioner Tom Considine, NCOIL CEO, stated that NCOIL does not support elimination of the FIO at this time. We might be arriving at a time of "new Federalism" and it would be shortsighted to call for its elimination because the current temperature of the new Administration and Congress and its respect towards State rights might lead to someone leading the FIO who internationally advocates for the state-based regulation of insurance.

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

Mr. Thesing stated that NAMIC supports the Resolution and that the study didn't look at any loss costs and cost drivers that you need to look at to determine in any sort of accurate way whether a product is affordable or not. What's interesting about the study is that it said 91% of those considered to be low-income individuals find auto insurance to be affordable. Mr. Thesing stated that FIO essentially used its bully pulpit to promote a half-baked study that is not accurate.

A motion was then made and seconded to waive the quorum requirement.

Sen. Dan "Blade" Morrish stated that, in the interest of time, he would not thoroughly discuss the Resolution but urged the Committee to focus on the fifth and final action the Resolution calls for: "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."

Birny Birnbaum of the Center for Economic Justice (CEJ) stated that CEJ thinks the Resolution is counterproductive. Mr. Birnbaum stated that this would resurrect an issue that long ago "died" and asked why NCOIL would ask the Federal government to do more work on this issue when NCOIL thinks FIO shouldn't be collecting data from insurers – that is contradictory. Mr. Birnbaum stated that NCOIL should ask State regulators to perform the study and offered help in doing so.

Upon a motion made and seconded, the Committee unanimously adopted the Resolution.

ADJOURNMENT

There being no further business, the Committee adjourned at 10:45 a.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
WORKERS COMPENSATION INSURANCE COMMITTEE
NCOIL SPRING MEETING, NEW ORLEANS, LOUISIANA
SATURDAY, MARCH 4, 2017
11:00 A.M. - 12:00 P.M.

The National Conference of Insurance Legislators (NCOIL) Workers' Compensation Committee met at the New Orleans Downtown Marriot on Saturday, March 4, 2017 at 11:00 am.

Representative Marguerite Quinn of Pennsylvania, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR
Asm. Ken Cooley, CA
Rep. Martin Carbaugh, IN
Rep. Matt Lehman, IN
Rep. Joseph Fischer, KY
Rep. Steve Riggs, KY
Rep. Greg Cromer, LA
Rep. Michael Webber, MI
Rep. George Keiser, ND
Sen. James Seward, NY
Rep. Michael Henne, OH

Other legislators present:

Rep. Deborah Ferguson, AR
Rep. Lois Landgraf, CO
Sen. Dan "Blade" Morrish, LA
Sen. David Robertson, MI
Rep. Lana Theis, MI
Rep. Lois Delmore, ND
Sen. Nellie Pou, NJ
Asm. Will Barclay, NY
Asm. Kevin Cahill, 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 November 19, 2016 meeting in Las Vegas, Nevada.

PRESENTATION ON WORKERS COMPENSATION PREMIUM FRAUD

Howard Goldblatt, Director of Government Affairs for the Coalition Against Insurance Fraud (Coalition) provided some background on the Coalition and stated that it is hard to measure the cost of fraud. He stated that he can't necessarily quantify the exact dollar amount of insurance fraud in the nation or in a State but he knows that there is a large amount that goes undetected and what they know about is the tip of the iceberg. Fraud affects everyone on a daily basis. It affects the ability of businesses and States to expand and to hire people. It affects individuals spending money because they are spending more on insurance. On workers' compensation, there are several different schemes to avoid

paying the proper premium. The employee leasing scheme is one where the employer basically says the worker is a lease employee and not a salary employee and, therefore, not covered under workers' compensation laws. This is a misrepresentation. Mr. Goldblatt stated that misclassification also occurs when an employer states his or her work force is comprised of independent contractors and not employees. A recently published article stated that there were high paying jobs being removed from payroll to avoid paying workers' comp premiums as well as state and local taxes. Layers of insurance coverage are created between employers and the workforce and this has been going on for the past few years, especially in the construction industry.

Mr. Goldblatt stated that specifically, premium fraud occurs when employers fail or avoid paying the adequate amount of premium which puts their work force at a disadvantage if they get injured or, from a state or local perspective, are not paying the proper amount of taxes to the jurisdiction based on their workers. One way to approach this issue is through insurer-audits to verify work force coverage. One of the obstacles with that is that most of those audits are after the fact and in essence, you end up having given the business an interest-free loan because the insurer may go back to the business saying you should have been paying "x" amount workers' comp and you paid "y" amount so you owe us the difference between "x" and "y". For that year, that business had that extra money to do things with whether to invest it or put it in their own pocket but either way the workers' comp insurer wasn't getting the proper premium. A company can also be fined for lack of insurance. It is seen all the time where the insurance departments or workers' comp department commissions fine a business, per day, or they issue cease and desist orders to halt the non-compliance. The problem with cease and desist orders is that it puts the honest work force that is being used by that cheating employer out of a job. So, cease and desist could harm individuals who had nothing to do with the premium avoidance.

Mr. Goldblatt stated that another problem with premium avoidance is that, especially in the construction industry or where you have contracts, you end up having a process where the dishonest business can undercut the honest businesses in bidding for a contract because they know they will not be paying workers' comp coverage. That puts the honest business in a precarious position - do they continue on the honest path or do they join their competitor by avoiding paying the adequate workers' comp for their workers just so that they are able to compete for those contracts. The contractors are, in many cases, government contractors.

Mr. Goldblatt went on to say that Indiana has pending legislation that creates a payroll fraud task force. The task force would investigate what's going on with avoiding workers' comp and therefore state and local taxes. As of now, the bill is still in committee. In North Carolina, news reports in 2012 estimated 30,000 businesses didn't have coverage. The recent audit from the NC state workers' comp commission in 2013 brought 1,300 businesses into compliance since the news stories broke in 2012.

Mr. Goldblatt suggested some solutions: Florida cracked down on businesses using check cashing facilities for payment of payroll because the discovery was businesses that were avoiding paying workers' comp were paying their employees in such a way that they had to go to check cashing facilities to get paid. There are strict regulations on what a check cashing facility can be used for to avoid the workers' comp scam. The Coalition believes that there should be a sharing of payroll data between tax agencies and workers' compensation insurers that collect business taxes so that the workers' comp insurer could compare how much that business is saying they pay and what they tell the workers' comp

insurer. The odds are that businesses are not going to be cheating the tax revenue, but they are going to be cheating the workers' compensation board. The odds are that you are getting the proper number of payroll for your information business taxes - they are cooking the books when it comes time to share with workers' comp coverage.

Mr. Goldblatt stated that there needs to be a wide range of solutions involving strict regulations targeting the fraud, because the bottom line is the people who are being harmed are the honest workers who don't have the coverage and who are being used to shift their work place injuries to their health insurance where the odds are there are deductibles to be met or co-pays, and so you are asking a worker who is legitimately injured in a work accident to pay more out of pocket or recovery then they would have if the business had proper workers' comp coverage. Additionally, the Coalition thinks that workers groups, organized labor and the insurance industry need to work together better to identify the problems in the individual states and notify State legislators. They are not necessarily natural allies but it helps everyone in the system if everyone was paying their fair share so that everyone could be properly covered.

Rep. Quinn asked to what extent are the workers aware that they do not have proper coverage - do they find out upon having injury? Mr. Goldblatt responded that in most cases, workers do not know and even if they did know, it puts their jobs at jeopardy because if they go to the employer and ask if they are paying for workers' comp insurance, that employee may be out of work the next day. Rep. Quinn then asked if there has been a whistle blower component with this issue in any states. Mr. Goldblatt stated he was not aware of any.

Rep. Keiser asked if the Coalition had done any kind of analysis of the different approaches among States to stop these problems. Mr. Goldblatt replied no but there should be an analysis done. Rep. Keiser also stated that tax agencies have a lot of problems and ND has found that if you are going to lie to job services, you are going to lie on taxes. Rep. Keiser further stated that with regards to shifting costs to medical claims, what they're also avoiding is the responsibility for wage replacement and vocational education.

Rep. Henne asked doesn't the audit with the independent contractors identify the fraud because with a general liability policy, you have to have a certificate proving the independent contractor has their own insurance. Mr. Goldblatt responded that presumably, it should, but it has been known that some these companies will fake those certificates.

Sen. Seward. asked Mr. Goldblatt how he would assess where the states are in terms of fraud from the employee side. Mr. Goldblatt stated most, if not all states, have laws targeting the specifics of workers' comp claims fraud. In some cases, some states have to beef that up to do more work on that and target certain practices. He continued by saying that he also sees States not giving as much attention to the premium fraud on the employer side. Sen. Seward stated that in New York, the companies that write auto insurance have special units that fight fraud - is that the case with workers' compensation carriers. Mr. Goldblatt stated that most workers' comp carriers do have the same type of anti-fraud effort that you see on the property/casualty or the health side.

Rep. Henne asked if more specific misclassification such as classifying workers in less-dangerous job categories is a problem as well. Mr. Goldblatt acknowledged that is indeed

a problem in addition to what he has stated.

DISCUSSION ON FLORIDA WORKERS COMPENSATION REFORM AND ITS IMPACT ON OTHER STATES

Ron Jackson of the American Insurance Association (AIA) stated that the Florida Supreme Court (*Castellanos v. Next Door Company)* recently struck down the statutory attorney fee schedule. The court held that the strict schedule, and no means by which the schedule can be varied from, was unconstitutional. Interestingly, the majority in their opinion stated that a reasonable attorney's fee had always been the lynch pin of the workers' compensation system which, if you think about it, is fairly astounding. Most people would say the lynch pin of the workers compensation system is quickly, efficiently, and cost effectively treating injured workers for work place injuries, getting them back to work as soon as possible and to the extent possible, avoiding ligation. Mr. Jackson stated that attorney's fees and incentives matter and that is why the attorney fee schedule had been so effective in improving the Florida market and other states by providing some limitation and removing the incentive to litigate which is not the purpose of the workers' compensation system.

Mr. Jackson stated that AIA has been working with others in industry and the employer community how to respond to the Florida Supreme Court decision. Mr. Jackson further stated that since the decision, we are already seeing a return to the "battle days" where the fee schedule is supposed to be the starting point but the administrative law judge can look at that particular case and determine whether fees in excess of that fee schedule are to be awarded and invariably the judges are awarding fees in excess of the fee schedule. AIA believes the appropriate policy response is for Florida to join the majority of states' policy, which is that claimant's attorney fees are paid from the award. That addresses the incentive for needless litigation. If there's nothing that's going to be paid by the claimants, they and particularly their attorneys, have every incentive in the world to take small disputes or manufactured disputes and get them out of the system and into the court. Mr. Jackson noted that NCCI in their rate hearing recently, before the Office of Insurance Regulation, noted that although only 6% of all workers compensation claims in the State of Florida involve attorneys, that 6% of claims represents over 40% of the system-wide cost and that should tell you a lot about the hugely negative impact that can occur when you're sending the wrong incentives and encouraging and really allowing litigation to occur. Mr. Jackson closed by urging the Committee members to not follow the Florida approach in their respective States.

DISCUSSION ON LOUISIANA WORKERS COMPENSATION SYSTEM

Kristin Wall, President and CEO of the Louisiana Workers Compensation Corporation (LWCC) stated that the LWCC was created by statute in 1992. The Louisiana workers comp system had imploded and all the carriers had left the system. After looking at all the different states LA decided it wanted to create a state fund. She stated that there are 23 state funds across the country and she said that they are all very different. Ms. Wall stated that LWCC was created as a private, non-profit mutual insurance company. Mutual carriers can take a long term view when they are looking at things. She said that they feel the market of last resort and that they are the residual market, and they are also a competitive market. That gives them the opportunity to operate like a business. There is no worry that people won't be covered in LA because LWCC will cover all employers. LWCC has several missions. One is solvency - a broke insurance company is not a good

insurance company and solvency is about keeping your promises. Providing workers' comp at the lowest feasible cost is a mission as well. LWCC is very sensitive about how much it charges to employers. She added that they are also very sensitive and careful about the treatment of the injured workers. She stated that they have a balancing act that's going on all the time at LWCC and that safety is extremely important - it is the heart and soul of workers' compensation.

To illustrate that LWCC is not focused on trying to do the cheapest possible thing for injured workers but rather, is focused on giving the best care it can. Ms. Wall told a story about an injured worker who suffered a traumatic brain injury. He's been able to stay out of nursing home care. A lot of that is certainly about his dedication to getting better but it is also about taking care of injured workers the right away. LWCC has paid $2.5 million with several more million dollars in the future. So, when you think about things that can happen to people and the need for solvency and the need for a long-term view, he's going to need them.

Ms. Wall stated that incidents of injury have decreased across the country and that is a credit to the insurance industry and employers who really invested in technology. She stated that LWCC has brought its rates down by almost 60% for policy holders. She added that if you look across the region and country, you could see LA is a high cost state but it doesn't pay as much as it used too and each State has different needs.

Sen. Rapert asked Ms. Wall for her thoughts on the Arkansas workers compensation system. Ms. Wall stated that each State has a lot of things to balance - people representing injured workers' that say they're not getting the care they need; policy holders saying it's unaffordable. Part of the Arkansas story might be that it's trying to attract businesses and that when you're trying to do that, they're looking for a lower cost state and it's not likely if workers' comps is going to be part of their cost. Ms. Wall stated that Louisiana is a wage loss state so as long as there is wage loss, we're likely to keep them on comp and to be on comp, they need to be treated for medical so you can see how that gets a little more expensive. Arkansas is a schedule state. There's a period of time were benefits are off and not necessarily medical benefits but the wage benefits. So, she stated that you can see that's a less generous approach to the way things are done in other places. Fraud, attorney involvement and things like that could run the cost of the state up or it can bring it back down. Ms. Wall also noted the issue of choice of physician -- if you say, I'm only going to allow you to go to the physician of the insurance company or a panel of doctors, your costs would be a lot less and there are a lot of people in Louisiana who would like to see that happen but LWCC doesn't take that approach.

Sen. Rapert asked if LWCC had a cap for the number of weeks people can be paid. Ms. Wall responded that Louisiana does not and that they are a wage loss state but Arkansas is in the majority in that it has a schedule so they're going to cap it at some point and say that's it. That makes a huge difference in the cost of the system. She stated that it was a delicate balance. She added that there are many parties with interests and added that reducing costs might have unintended consequences. It might be at the expense of someone else. Ms. Wall stated that the main point of this is that State legislators are in control. Ultimately, LWCC is not a policymaker and is not an advocate. It doesn't go to legislators and lobby those things. It tries to say that if "this" happens "this" is more than likely going to be the outcome.

Sen. Seward asked who specifically manages the care of the injured workers. Ms. Wall

responded that LWCC does and that in serious cases like the one mentioned earlier they have a specialist claims person on it. They also interface with LWCC nurses and they hire external case managers who build plans. Ultimately, there are physicians involved and they do not have a staff of physicians but they do have a physician in their office that helps look at things and to talk to the other physicians. Ms. Wall noted that the more you turn things over to others, it becomes more impersonal.

Rep. Quinn stated that according to the June, 2016 Workers' Compensation Research Institute on the use of opioids, Louisiana is the highest in the nation for opioids use per claim. Rep. Quinn asked what LWCC was doing to try to stop that and asked if it was a matter of higher intensity/level of severity of injuries that led to that ranking. Ms. Wall responded by saying that it is a terrible problem and that it is an epidemic across the country. She continued by saying that physicians are over-prescribing opioids. Part of the reason is that it is the path of least resistance. When people come in hurting, then you want to solve their problem if you are a physician. She stated that LWCC has a successful and focused workers' comp pharmaceutical benefits manager tracking each and every claim, and each and every prescription and it will push back and go back to the doctors and say "this is not right." She emphasized that they are not winning the war, and Louisiana is really trying to work on something and she thinks more needs to be done. She concluded by saying that, now, the CDC was coming in and doing some things too that is going to help but ultimately, it is going to take people getting sued to solve the problem.

Rep. Cromer thanked Ms. Wall for all of LWCC's efforts and stated that it has done tremendous work for injured workers in the state.

ADJOURNMENT

There being no further business, the Committee adjourned at 12:00 p.m.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
BUSINESS PLANNING AND EXECUTIVE COMMITTEE
NEW ORLEANS, LOUISIANA
MARCH 5, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Business Planning and Executive Committees met at the New Orleans Downtown Marriott on Sunday, March 5, 2017 at 11:00 a.m.

Chair of the Committee, Rep. Steve Riggs, presided.

Members of the Committee Present:

KY Rep. Steve Riggs, Chair
AR Sen. Jason Rapert, Vice-Chair
Rep. Deborah Ferguson, AR
Asm. Ken Cooley, CA
Rep. Joe Fischer, KY
Sen. Dan "Blade" Morrish, LA
Rep. Greg Cromer, LA
Asm. Will Barclay, NY
Sen. Bob Hackett, OH

Other Legislator Present:

Asm. Andrew Garbarino, NY

Also Present:

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

Rep. Riggs, Chair of the Committee presided over the meeting.

MINUTES

Sen. Rapert made a motion to accept the minutes of the Business Planning and Executive Committee Meeting from November 20, 2016 at the Paris Las Vegas. Sen Morrish seconded and motion carried.

SWITCH TO 2 MEETINGS BEGINNING IN 2019

Commissioner Considine raised the prospect of moving from 3 meetings a year to two meetings, beginning in 2019 and replacing the traditional spring meeting with a one-day session held either immediately prior to or after the spring NAIC meeting in that same hotel. The thought is the NCOIL spring meeting has the fewest attendees and much of the decision making is deferred until the summer and annual meeting.

Rep. Cromer likes the idea to go to 2 full meetings and also likes the concept of co-locating a shorter spring meeting with the NAIC.

The sense of the was that it was a good idea to eliminate the full 2019 spring meeting and move to a one day spring seminar in conjunction with the NAIC. Rep. Riggs asked

that everyone think about it and there will be further discussion and a decision at the Summer Meeting.

Commissioner Considine asked Chara Bradstreet from the NAIC for the 2019 meeting dates and she stated they were April 5 – 8 in Orlando, FL; August 2 – 6 in New York City, NY and December 6 – 9 in Austin, TX. Commissioner Considne noted that it would be possible to have a seminar in Orlando and we would begin discussions with the NAIC.

RECRUITMENT

Rep. Riggs stated that NCOIL Chairs and Vice Chairs need to be recruitment leaders. He tasked chairs and vice chairs to identify legislators in assigned non-contributing states to identify and recruit. The legislators will partner with industry and interested parties in their assigned states.

Rep. Riggs pointed out the Assemblymen Cahill and Barclay sent a joint bipartisan letter. NCOIL staff will publish a box score to show everyone's progress.

MEETING REPORT

Commissioner Considine reported there were 233 total attendees, including 43 legislators, 10 of which were new legislators; 4 scholarships were given; 8 regulators from 6 jurisdictions.

REVENUE REPORT

Mr. Penna reported that the unaudited 2016 financials for NCOIL were revenue of $746,048.71 and expenses of $838,193.52 for an operating deficit of $92,144.81.

The first two months of 2017 show an operating revenue of $195,758.15 and expenses of $118,182.80 for excess revenue of $77,575.35.

Sen. Rapert asked what the total amount in all NCOIL accounts were and Commissioner Considine reported that as of 1/31 there was $323,9056.53 and ILF, which is separate, had a total balance of $117,456.76.

MODELS

Asm. Cooley discussed his model to ensure legislator education and fund NCOIL. Lawmakers develop laws. This proposal ensures that insurance departments secure sponsorship and funding for key legislators to attend and NCOIL meeting. It was a productive first discussion. We will fine tune the language for consideration in Chicago. Rep. Riggs stated the model as drafted called for chair and ranking member. He suggested that

Asm. Cooley consider a change so it is not limited to just those two.

Upon a motion from Sen. Morrish that was seconded by Sen. Hackett, the following models were re-adopted:

Model Act Banning Fee Schedules for Uncovered Dental Services
Patient Safety Model Act
Rental Network Contract Arrangements Model Act
Insurance Compliance Self-Evaluative Privilege Model Act
Secondary Address Model Act

The Healthcare Balance Billing Model, which was tabled in committee, will be addressed at the Summer Meeting.

The amendments to the Limited Lines Travel Insurance Model New model was approved in committee. Rep. Cromer made a motion to accept the amended model and it was seconded by Asm. Cooley. The motion carried.

No committee chairs wanted to report.

OTHER PRESENTATIONS

Rep. Riggs discussed both the Griffith programming and Governor Edwards address as great and well attended. He also stated that the foray into banking was interesting and there was positive feedback about MS DAG Wiggins presentation.

Sen. Rapert thanked Sen. Morrish and LA delegation. Stated that getting the governor was very helpful and this was one of our better meetings.

Rep. Riggs echoed Sen. Rapert's statement.

Rep. Cromer & Sen. Morrish thanked everyone for coming to New Orleans.

Rep. Riggs stated that Sen Holdman stated concern about non-collaborative work between NCOIL and NAIC and the need to work together. When NCOIL has a model that 43 states adopted and needs to be revised then NAIC should work with us to change it and not create a whole new duplicative effort. He asked Ms. Bradstreet to take that back to the NAIC leadership.

A motion was made and seconded, and passed, to add Rep. Joe Fischer added to executive committee.

Rep. Riggs stated that he added Rep. Cromer to the Air Ambulance Task Force

Sen. Rapert stated that NCOIL should look at all aspects of marijuana legalization in the states.

They are grappling with it in Arkansas and all of the elements from insurance issues to employment and NCOIL should explore a future symposium and how we deal with it.

A motion to adjourn was made by Asm. Cooley and Rep. Cromer seconded.
Being no other business the committee adjourned at 11:30.

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

National Conference of Insurance Legislators (NCOIL)

Resolution Urging the United States Congress to Take Legislative Action and Exempt Matters Properly Governed by the McCarran-Ferguson Act from the Scope of the Airline Deregulation Act of 1978 to Authorize States to Regulate Air Ambulance Billing

To be discussed by the NCOIL Health Long Term Care and Health Retirement Issues Committee on July 14, 2017

Sponsored by Assemblyman Kevin Cahill, New York

WHEREAS, air ambulance services are being used more frequently to transport patients to faraway hospitals; and

WHEREAS, many states are reporting that some air ambulance providers are not affiliated with a hospital and do not contract with an insurance carrier; and

WHEREAS, this creates numerous situations in which air ambulances are being called to airlift individuals in both emergency and non-emergency situations and are billing these individuals for out-of-network charges; and

WHEREAS, these charges can cost patients tens of thousands of dollars in out-of-pocket expenses when companies do not accept a patient's insurance; and

WHEREAS, emergency patients rarely are in a position, or have the capacity, to choose their own air ambulance carrier; and

WHEREAS, some air ambulance carriers refuse to reveal actual costs to insurers, and some insurers are unwilling to pay billed charges for the service; and

WHEREAS, Medicare reimbursements cover only a small portion of the actual cost of an air ambulance, forcing air ambulances to charge patients more; and

WHEREAS, the air ambulance industry has high fixed costs, including aircraft, pilots, and trained medical staff; and

WHEREAS, increased competition forces these costs to be recouped from a smaller number of flights per provider, leading to higher prices; and

WHEREAS, the Airline Deregulation Act of 1978 declared that "States may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier"; and

WHEREAS, various states have attempted to pass laws to protect consumers from out-of-network air ambulance bills, but courts have determined that these laws are preempted by the Airline Deregulation Act of 1978; and

NOW, THEREFORE, BE IT RESOLVED, that NCOIL urges the U.S. Congress to take legislative action by exempting matters properly governed by the McCarran-Ferguson Act, specifically matters central to the business of insurance that are related to health insurance network participation, reimbursement, balance billing, and/or transparency, from the scope of the Airline Deregulation Act of 1978, thereby permitting States to regulate air ambulance billing in an effort to protect consumers from crippling and often life-altering out-of-network air ambulance bills; and

AND, BE IT FINALLY RESOLVED, that a copy of this Resolution be sent to the U.S. Senate Majority Leader, the U.S. Senate Minority Leader, the Speaker of the House, the House Minority Leader, the members of the U.S. Senate Committee on Commerce, Science, and Transportation, Federal and State insurance legislators and regulators, and other interested parties.

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

National Conference of Insurance Legislators (NCOIL)

Guiding Principles on State Regulation of Air Ambulance Balance Billing Practices

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To be discussed by the NCOIL Health Long Term Care and Health Retirement Issues Committee on July 14, 2017

1.) Air ambulance services are being used more frequently to transport patients to faraway hospitals.

2.) The problem of air ambulances not being affiliated with hospitals and not in an insurer's network has become increasingly apparent.

3.) This has led to situations in which, after airlifting individuals in both emergency and non-emergency situations, the individuals are left with crippling and often life-altering "balance bills" that can be tens of thousands of dollars.

4.) The Federal Airline Deregulation Act (ADA) contains an express preemption clause which provides that "a State, political subdivision of a State, or political authority of at least 2 States may not enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart." 49 U.S.C. § 41713(b)(1).

5.) It is undisputed that air ambulances are "air carriers" as defined under the ADA.

6.) The McCarran-Ferguson Act, 15 U.S.C. § 1012(b), explicitly reserves the regulation of the business of insurance to the states and provides that any Federal law that infringes upon that regulation is preempted by state insurance laws, unless the Federal law specifically relates to the business of insurance.

7.) It is undisputed that the ADA does not specifically relate to the business of insurance.

8.) Various states have attempted to pass laws to protect consumers from high air ambulance bills, but several courts have ruled such laws were not enacted for the purpose of regulating the "business of insurance" and are therefore preempted by the ADA.

9.) Accordingly, until there is a Federal solution to these problems that would allow the states flexibility to protect consumers from excessive air ambulance "balance bills"

without the threat of Federal preemption, States should consider passing proactive yet narrow legislation under the states' McCarran-Ferguson authority to regulate "the "business of insurance."

10.) Proactive legislation or regulation may include "laws aimed at protecting or regulating the relationship between the insurer and the insured, whether directly or indirectly."[3] Such laws or regulations are considered to regulate the business of insurance.[4]

11.) The current situation is not working and left untouched, consumers will continue to be harmed by outrageous air ambulance "balance bills." Legislation specifically addressing the balance-billing issue to protect the policyholder could escape preemption.[5]

[3] Valley Med Flight, Inc. v. Dwelle, 171 F.Supp.3d 930 (2016)
[4] Id.
[5] Id.

State of _____ Legislative Resolution

Resolution Urging the United States Congress to Take Legislative Action and Exempt Matters Properly Governed by the McCarran-Ferguson Act from the Scope of the Airline Deregulation Act of 1978 to Authorize States to Regulate Air Ambulance Billing

Sponsored by

WHEREAS, air ambulance services are being used more frequently to transport patients to faraway hospitals; and

WHEREAS, many states are reporting that some air ambulance providers are not affiliated with a hospital and do not contract with an insurance carrier; and

WHEREAS, this creates numerous situations in which air ambulances are being called to airlift individuals in both emergency and non-emergency situations and are billing these individuals for out-of-network charges; and

WHEREAS, these charges can cost patients tens of thousands of dollars in out-of-pocket expenses when companies do not accept a patient's insurance; and

WHEREAS, emergency patients rarely are in a position, or have the capacity, to choose their own air ambulance carrier; and

WHEREAS, some air ambulance carriers refuse to reveal actual costs to insurers, and some insurers are unwilling to pay billed charges for the service; and

WHEREAS, Medicare reimbursements cover only a small portion of the actual cost of an air ambulance, forcing air ambulances to charge patients more; and

WHEREAS, the air ambulance industry has high fixed costs, including aircraft, pilots, and trained medical staff; and

WHEREAS, increased competition forces these costs to be recouped from a smaller number of flights per provider, leading to higher prices; and

WHEREAS, the Airline Deregulation Act of 1978 declared that "States may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier"; and

WHEREAS, various states have attempted to pass laws to protect consumers from out-of-network air ambulance bills, but courts have determined that these laws are preempted by the Airline Deregulation Act of 1978; and

NOW, THEREFORE, BE IT RESOLVED, that this legislative body urges the U.S. Congress to take legislative action by exempting matters properly governed by the McCarran-Ferguson Act, specifically matters central to the business of insurance that are related to health insurance network participation, reimbursement, balance billing, and/or transparency, from the scope of the Airline Deregulation Act of 1978, thereby permitting States to regulate air ambulance billing in an effort to protect consumers from crippling and often life-altering out-of-network air ambulance bills; and

AND, BE IT FINALLY RESOLVED, that a copy of this Resolution be sent to the U.S. Senate Majority Leader, the U.S. Senate Minority Leader, the Speaker of the House, the House Minority Leader, the members of the U.S. Senate Committee on Commerce, Science, and Transportation, Federal and State insurance legislators and regulators, and other interested parties.

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

National Conference of Insurance Legislators (NCOIL)

Model Consumer Protection Towing Act

To be Discussed by the NCOIL Property & Casualty Committee on July 14, 2017
****Sponsored by Rep. Matt Lehman (IN)***

DRAFT as of 9.21.16

Table of Contents

Section 1. Title

This Act shall be known and cited as the [State] Consumer Protection Towing Act.

Section 2. Purpose

The purpose of this Act is to establish minimum standards for towing vendor services and to promote fair and honest practices in the towing service business.

Section 3. Definitions

For purposes of this Act:

“Automobile club” - a legal entity which, in consideration of dues, assessments or periodic payments of money, promises its members or subscribers to assist them in matters relating to motor travel or the operation, use or maintenance of a motor vehicle, including auto dealers and insurance companies, by supplying services, which may include but are not limited to towing service, emergency road service and indemnification service.

“Crane service” - a form of towing service which involves moving vehicles by the use of a wheel-lift device, such as a lift, crane, hoist, winch, cradle, jack, automobile ambulance, tow dolly, or any other similar device.

“Flat bed (Roll-back) service” - a form of towing service which involves moving vehicles by loading them onto a flat-bed platform.

“Owner” - the person or entity to whom a vehicle is registered, or to whom it is leased, if the terms of the lease require the lessee to maintain and repair the vehicle. For the purposes of this Act, a rental vehicle company is the owner of a vehicle rented pursuant to a rental agreement.

“Rental vehicle company” – any person or organization, or any subsidiary or affiliate, including a franchisee, in the business of renting vehicles to the public.

“Towing company” - any service, company or business entity or operation that exists to tow or otherwise move motor vehicles by means of a tow truck, or the ownership or operation of a towing service storage lot. A towing business, service or company shall not include an automobile club, car dealership or insurance company.

“Towing service storage lot” - a property used to store vehicles that have been towed.

“Tow truck” - a motor vehicle equipped to provide any form of towing service.

“Tow truck operator” - a person who operates a motor vehicle that is equipped to provide any form of towing services.

“Emergency towing” – the towing of a vehicle due to a motor vehicle accident, mechanical breakdown on public roadway or other emergency related incident necessitating vehicle removal for public safety with or without the owner’s consent.

“Government agency towing” – the towing of government-owned or government controlled vehicles by the government agency that owns or controls them.

“Law enforcement towing” – the towing of a vehicle for law enforcement purposes other than “seizure towing,” including municipality approved preferred towing company vendors.

“Owner requested towing” – the request to tow a vehicle by the vehicle owner or operator.

“Private property towing” – the towing of a vehicle, without the owner’s consent, from private property where it was illegally parked, or for which some exigent circumstance necessitated its removal, to a nearby location.

“Seizure towing” – the taking of a vehicle for law enforcement purposes such as the maintenance of the chain of custody of evidence, or forfeiture of assets.

Section 4. General Provisions

The provisions of this chapter shall be applicable to any entity or person engaging in, or offering to engage in, the business of providing towing service in the State of XXXX. The provisions of this chapter shall not apply to vehicles towed into the State of XXXX or through the State of XXXX if the tow originates in another jurisdiction.

The provisions of this chapter are not applicable to the towing of motor vehicles by or on behalf of an “automobile club”, car dealership or insurance company.

The provisions of this chapter are not applicable to “government agency towing”, the towing of government-owned or government controlled vehicles by the government agency that owns or controls them.

The provisions of this chapter are not applicable to “seizure towing”, the towing of a vehicle for law enforcement purposes.

The provisions of this chapter confer exclusive regulatory jurisdiction to the [regulatory body] in the State of XXXX over the towing and storage services of towing companies and vehicle storage companies. The [regulatory body] shall establish a complaint mechanism for consumers and insurers.

Drafting Note: Legislators should consider establishing rules whereby a [regulatory body] govern licensing, registration, operation and permitting of towing companies and vehicle storage companies in accordance with this act.

In addition to any penalty imposed under Section 14 of this chapter, any for-hire motor carrier engaged in the towing of motor vehicles who violates Section 14 is subject to sanctions imposed by the [regulatory body] in the State of XXXX.

Section 5. Emergency Towing Requirements

A. It is a misdemeanor for a towing company to stop or cause a person to stop at the scene of an accident or near a disabled vehicle for the purpose of soliciting an engagement for “emergency towing” services, either directly or indirectly, to provide towing services, to move a vehicle from a highway, street, or when there is an injury as the result of an accident, or to accrue charges for services provided under those circumstances, unless requested to perform that service by a law enforcement officer or public agency pursuant to that agency’s procedures, or unless summoned to the scene or requested to stop by the owner or operator of a disabled vehicle.
B. The owner or operator of the vehicle being towed shall summon to the scene the tow truck operator of the owner's or operator's choice, either directly or through an insurer’s emergency service arrangement, in consultation with law enforcement or authorized municipal personnel and designate the location where the vehicle is to be towed
    a. The provisions of this section shall not apply when the owner or operator is incapacitated, otherwise unable to summon a tow truck operator or defers to law enforcement or authorized municipal personnel.
    b. b. The authority provided to the owner or operator in this section may be superseded by the law enforcement officer or authorized municipal personnel if the tow truck operator of choice cannot respond to the scene in a timely fashion and the vehicle is a hazard, impedes the flow of traffic or may not legally remain in its location in the opinion of law enforcement or authorized municipal personnel.
C. If a towing company is summoned for an “emergency tow” by the owner or operator of a disabled vehicle, the towing company shall record the first name, last name, and working telephone number of the person who summoned it to the scene; and the make, model, year, vehicle identification number (VIN) and license plate.
D. If a towing company is summoned for an “emergency tow” by a law enforcement officer or designee of a public safety agency with territorial jurisdiction, the towing company shall record the identity of the law enforcement officer or designee of a public safety agency with territorial jurisdiction, the log number, call number, incident number, or dispatch number assigned to the incident by law enforcement or the public agency.
E. Prior to towing a vehicle under this section, a towing company shall take photographs, video or other visual documentation to evidence the vehicle damages, debris, damaged cargo or property, complications to recovery process.
F. The towing company shall maintain record of C., D., and E. above, and provide the records to law enforcement, upon request, from the time it appears at the scene until the time the vehicle

is towed and released to a third party, and shall retain that information for three years. The towing company or owner or operator of a tow truck shall make records available for inspection and copying within 48 hours of a written request from law enforcement, [regulatory body], vehicle owner, or agent of vehicle owner..

G. The towing company must properly secure all towed vehicles and make all reasonable efforts to prevent further damage, weather damage or theft to all towed vehicles, including the vehicle's cargo and contents.

Section 6. Private Property Towing Requirements

A. The owner of private property may establish a private tow-away zone by posting a sign that is at least eighteen inches by twenty-four inches in size, includes a statement that the property is a tow-away zone, and a description of persons authorized to park on the property.
B. Prior to towing a vehicle under this section, a towing company shall take photographs, video or other visual documentation to evidence that the vehicle is clearly parked on private property in violation of a private tow-away zone. The towing company shall record the time and date of the photographs and retain the records for at least two years after the date on which the vehicle was towed.
C. A towing company must ensure that a vehicle towed under this section is taken to a location that is located within twenty-five miles (***Drafting note: depending on the population density of a state, legislators may consider increasing this distance**.)* of the location of the private tow-away zone.
D. If the owner or operator of a vehicle is parked in violation of a private tow-away zone, and arrives while their vehicle is being removed, the towing company shall give the vehicle owner or operator oral or written notification that the vehicle owner or operator may pay a fee (in cash, check, credit card, or debit card) of not more than one-half of the fee for the release of the vehicle. Upon payment of that fee, the towing company shall release the vehicle and give the vehicle owner or operator a receipt showing both the full amount normally assessed and the actual amount received.
H. The towing company shall provide notice of the tow to law enforcement within two hours of removing the vehicle from private property.
I. The towing company must properly secure all towed vehicles and make all reasonable efforts to prevent further damage, weather damage or theft to all towed vehicles, including the vehicle's cargo and contents.

Section 7. Estimate Requirements

A. Prior to attaching a vehicle to the tow truck, if the vehicle owner or operator is present at the time and location of the anticipated tow, the towing company shall furnish the vehicle's owner or operator with a written itemized estimate of all charges and services to be performed. The estimate shall include all of the following:
    a. The name, address, telephone number, and motor carrier permit number of the towing company.
    b. The license plate number of the tow truck performing the tow.
    c. An itemized description and cost for all services, including, but not limited to, charges for labor, special equipment, mileage from dispatch to return, and storage fees, expressed as a 24-hour rate.
B. The tow truck operator shall obtain the vehicle owner or operator's signature (written or electronic) on the itemized estimate and shall furnish a copy to the person who signed the estimate.
    a. The requirements in paragraph (A) of this section may be completed after the vehicle is attached and removed to the nearest safe shoulder or street if done at the request of law enforcement or a public agency, provided the estimate is furnished prior to the removal of the vehicle from the nearest safe shoulder or street.
C. The towing company shall maintain the records described in this subdivision for three years, and shall make the records available for inspection and copying within 48 hours of a written

request from law enforcement, attorney general, district attorney, city attorney's office, vehicle owner, or agent of vehicle owner.

Section 8. Itemized Invoice Requirements

A. Each itemized invoice for towing costs must be available to vehicle owner or his agent within 24 hours of completed tow and shall contain the following:
    a. The location from which the vehicle was towed;
    b. The storage location of the vehicle
    c. The name, address and phone number of the tow truck company;
    d. A description of the vehicle including but not limited to the make, model, year, vehicle identification number (VIN) and color of the towed vehicle;
    e. The license plate number and state of registration of the towed vehicle;
    f. The cost of the original tow;
    g. The daily storage charge and the number of days the vehicle was stored;
    h. Each additional service must be set forth individually as a single line item with an explanation and the exact charge for the service. Itemized separately for Truck and Cargo or Tractor, Trailer, and Cargo. A copy of each invoice and receipt submitted by a tow truck operator in accordance with the requirements of this section shall be retained by the towing business for two years from the date of issuance.
    i. Cost of doing business costs, such as fuel, administration fees, equipment maintenance, etc. may only be determined based on actual costs. Not flat fees or based on percentage of overall invoice total.

Section 9. Notice Requirements

A. Within 24 hours of commencement of towing, the towing company or storage facility must commence a search of the records of the bureau of motor vehicles to ascertain the identity of the owner and any lienholder of the motor vehicle. No storage charges beyond the initial 24-hour charge will accrue until the notice requirement has been met. Written notice shall be given directly to the owner by registered mail within five business days. Notice to the owner or insurer shall contain the following:
        a. The date and time the vehicle was towed;
        b. The location from which the vehicle was towed;
        c. The location and address where the vehicle will be located;
        d. The location, address and phone number where payment and business transactions take place if different from business address;
        e. The name, address and phone number of the tow truck company;
        f. The name of the tow truck operator;
        g. A description of the towed vehicle including but not limited to the make, model, year, vehicle identification number and color of the towed vehicle;
        h. The license plate number and state of registration of the towed vehicle.

Section 10. Fees

A. A towing company shall not charge a fee for towing, clean-up services and/or storage of a vehicle in excess of the greater of the following:
    a. The fee that would have been charged for that towing, clean-up services and/or storage made at the request of a law enforcement agency under an agreement between a towing company and the law enforcement agency that exercises primary jurisdiction in the city in which the vehicle was, or was attempted to be, removed, or if not located within a city, the law enforcement agency that exercises primary jurisdiction in the county in which the vehicle was, or was attempted to be, removed.
    b. The fee that would have been charged for that towing, clean-up services and/or storage under the rate approved for that towing company by [regulatory body] for the jurisdiction from which the vehicle was, or was attempted to be, removed.

B. No charge shall be made in excess of the estimated price without the prior consent of the vehicle owner or operator.
C. All services rendered by a tow company, including any warranty or zero cost services, shall be recorded on an invoice. The towing company or the owner or operator of a tow truck shall maintain the records for two years, and shall make the records available for inspection and copying within 48 hours of a written request from law enforcement, attorney general, district attorney, or city attorney's office.

Section 11. Release of Vehicle

A. All towing companies and towing service storage lots must release the vehicle to the owner or the insurance company representative upon receipt of payment.
B. All towing companies and towing service storage lots must release the vehicle to the insurance company representative when:
    a. the owner's insurance company representative presents proof that the vehicle is insured with the company; or,
    b. the vehicle owner approves release of the vehicle to the insurance company representative.
C. All towing businesses must be open between the hours of 7:00 AM and 6:00 PM Monday through Friday and hold reasonable hours on the weekend and holidays for purposes of payment and release of vehicles.
D. Acceptable methods of payment must include but are not limited to cash, insurance check, credit card, debit card, certified check or money order.
E. The owner or the owners' insurance company representative shall have the right to inspect the vehicle before accepting its return.

Section 12. License Requirements

A. The [regulatory body] shall approve an application for a towing company certificate or certificate renewal, and shall issue or renew a certificate, provided the applicant submits to the [regulatory body] a completed application on a form prescribed by the [regulatory body], and also pays the application fee set by the [regulatory body].
B. An application shall include:
    a. The applicant's workers' compensation coverage.
    b. The applicant's unemployment compensation coverage.
    c. The financial responsibility of an applicant relating to liability insurance or bond requirements according to state XXXX.
C. The applicant must not have been convicted of fraud or had a civil judgment rendered against it for fraud nor has any officer, director or partner of an applicant that is a corporation or partnership during officer's, director's or partner's tenure.

Section 13. Prohibited Acts

A. It shall be unlawful for any person or entity conducting a towing company or for any person acting on his/her behalf:
    a. to falsely represent, either expressly or by implication, that the towing business represents or is approved by any private organization which provides emergency road service for disabled motor vehicles.
    b. to require an owner/operator of a motor vehicle involved in an accident or breakdown, to preauthorize more than 24 hours of storage, tear down and/or repair work as a condition to providing towing service for the vehicle.
    c. to charge more than one (1) towing fee when the owner/operator of a disabled vehicle requests transport of the vehicle to a repair facility owned or operated by the person or entity conducting the tow.

B. Tow truck operators shall not tow vehicles to a repair facility unless the owner or the owner's designated representative gives written consent before removal of the vehicle from the scene of the accident.
C. No towing service storage lot may refuse to release a vehicle to the owner or the owners' insurer upon-tender of full payment along with an itemized receipt for all lawful charges made in connection with the towing and storage of a vehicle.
D. Prior to payment of fees and release of a vehicle, no towing service provider may refuse the right of physical inspection of the towed vehicle by the owner, or the owners' insurer.
E. No towing service storage lot may charge storage for any day where release of the stored vehicle or access to the stored vehicle for inspection by the owner or auto insurer is not permitted by the provider.
F. It shall be a violation of this act for any towing company or towing service storage lot to submit false or fraudulent information to obtain a towing license.

Section 14. Penalties and Enforcement

A. Drafting Note: Legislators should consider drafting rules that establish rules that allow for the [regulatory body] to be responsible for the administration and enforcement of all towing businesses and towing service storage lots in the state of XXXX.
B. The [regulatory body] shall have authority for the inspection of all towing businesses.
C. All suspected violations will be filed with the [regulatory body] who shall investigate such complaint and take all proper and necessary remedial action.
D. A person who willfully violates the provisions set forth by this act is guilty of a misdemeanor, punishable by a fine of not more than two thousand five hundred dollars ($2,500), or by imprisonment in a county jail for not more than three months, or by both that fine and imprisonment.
E. Any towing company or towing service storage lot that submits false of fraudulent information to obtain a towing license will have their license automatically revoked.

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

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

Resolution in Support of an Exemption for Community Banks from Onerous and Unnecessary Regulations

To be considered by the NCOIL Financial Services Committee on July 15, 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.

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

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

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

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].")[6]

[6] 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

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

September 19, 2016

Commissioner Adam Hamm, Chair
NAIC Cybersecurity Task Force (EX)

Director Raymond G. Farmer, Vice Chair
NAIC Cybersecurity Task Force (EX)

National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

Via e-mail: Srobben@naic.org

Re: August 17, 2016 Revised Draft of Insurance Data Security Model Law

Dear Commissioner Hamm and Director Farmer:

On behalf of the National Conference of Insurance Legislators (NCOIL), I thank you for the opportunity to submit comments in response to the National Association of Insurance Commissioners' (NAIC) Cybersecurity Task Force's Revised Draft of the Insurance Data Security Model Law (Revised Draft). Additionally, we all appreciate the time NAIC staff spent with our members and staff last week to walk through the revised draft model.

Please note that NCOIL is in the process of forming a Cybersecurity Task Force in an effort to consider and analyze the emerging issues concerning cybersecurity. Once formed, the Task Force plans to review the Revised Draft in more detail and submit comments. Accordingly, NCOIL reserves the right to submit additional formal comments on the Revised Draft after the Task Force holds an interim meeting next month.

However, as a threshold issue, it should be recognized that over 70 of the 99 State legislative bodies across the country combine insurance with other financial industries such as banking, commerce, and financial services. Accordingly, NCOIL believes that limiting a Data Security Model Law to the insurance industry only, when the other financial services industries also deal with very sensitive personal information that invites hacking and merits special protection, will ultimately invite a conflict of laws within the

states themselves. Indeed, we believe such an approach could have the effect of inviting federal legislative intervention.

NCOIL appreciates the time and effort that the NAIC Cybersecurity Task Force has given to these issues and we look forward to working with you in the future. Please do not hesitate to contact me if you have any questions.

With appreciation for your consideration and kind regards, I am,

Very truly yours,

Thomas B. Considine
NCOIL CEO

CC: Hon. Travis Holdman
Hon. Steve Riggs
Hon. Jason Rapert
Hon. Bill Botzow
Hon. Neil Breslin

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

May 24, 2017

The Honorable Al Redmer
Chairman
NAIC Travel Insurance (C) Working Group
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

Submitted via e-mail: DMatthews@naic.org

Re: May 9, 2017 Working Group Discussion on Key Issues List – Travel Insurance Policy Issues for Preliminary Discussion Document

Dear Chairman Redmer & NAIC Travel Insurance Working Group Members:

On behalf of the National Conference of Insurance Legislators (NCOIL), I thank you for the opportunity to submit comments in response to the National Association of Insurance Commissioners (NAIC) Travel Insurance Workings Group's (Working Group) discussions regarding what it believes to be the significant issues that need resolution before drafting a Travel Insurance Model Law.

NCOIL applauded the initial news that the Working Group would be using the recently adopted NCOIL Travel Insurance Model Law (NCOIL Model) as a template for its own Travel Insurance Model efforts. It was our understanding that any work product from the Working Group, whether statutory or regulatory in form, would serve to fill in any gaps that the NCOIL Model does not address. However, the litany of concerns that the Working Group has voiced regarding the NCOIL Model indicates otherwise. For example, the issues labeled by the Working Group as "primary" and "secondary", are, in effect, distinctions without differences, and when viewed together, represent a nearly section-by-section dismantling of the NCOIL Model.

The legislative members of NCOIL feel strongly that the State Legislatures they represent would be far more open to amending a Model Law that has passed in over 40 legislatures, rather than sponsoring a wholly different Model Law from a different organization.

The NCOIL Model was intentionally drafted as a general framework for the travel insurance industry and includes "Section 14. Regulations" because NCOIL envisioned the promulgation of accompanying regulatory material that would carry out the purpose of the NCOIL Model. I know, and we acknowledge that a number of NAIC members have trepidation adopting Model Regulations because they lack the independent statutory authority to promulgate regulations in their states. We are confident that said section provides the specific statutory authority for the promulgation of such regulations in each State in which the NCOIL Model is adopted.

Indeed, as subsection "A." from "Section 2. Scope and Purposes" states:

> 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. (emphasis added)

Accordingly, NCOIL believes that it is appropriate for the Working Group to draft and adopt a Travel Insurance Model Regulation that uses the NCOIL Model as its legislative authorization and guiding template. Doing so would preserve the intention of the NCOIL Model, avoid duplication of legislative efforts, and be appropriately within the province of the NAIC as the States' national insurance regulatory organization.

NCOIL appreciates the time and effort that the Working Group has given to these issues and we look forward to working with you in the future. Please do not hesitate to contact me if you have any questions or wish to discuss this matter further.

With appreciation for your consideration and kind regards, I am,

Very truly yours,

Thomas B. Considine
NCOIL CEO

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

May 5, 2017

Richard Revesz
Director
American Law Institute
4025 Chestnut St.
Philadelphia, PA 19104

Stephanie Middleton
Deputy Director
American Law Institute
4025 Chestnut St.
Philadelphia, PA 19104

Re: Concerns with ALI's proposed Restatement of the Law of Liability Insurance

Dear Director Revesz and Deputy Director Middleton:

On behalf of the National Conference of Insurance Legislators (NCOIL), I write to you expressing NCOIL's concern regarding the American Law Institute's (ALI) proposed Restatement of the Law of Liability Insurance (the proposed Restatement). While NCOIL just recently learned of this issue and our review of the proposed Restatement is, accordingly, ongoing, several of its provisions that go beyond established law are of immediate concern because they appear to address matters which are properly within the legislative prerogative.

NCOIL is a national legislative organization created by and comprised of State legislators, principally 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 primacy of legislators in making State policy when it comes to insurance and educate State legislators on current and perennial insurance issues.

We understand that the proposed Restatement will be presented to the ALI membership for approval at the ALI's annual meeting, scheduled to commence on May 22, 2017. NCOIL respectfully requests that the ALI defer that vote pending further review by NCOIL and its members. Our request is driven in no small part by the weight the ALI's Restatements have historically been accorded by the bench and bar. Restatements – according to the ALI's Revised "Style Manual" - are supposed to be "clear formulations of common law and its statutory elements or variations and reflect the law as it presently stands or might appropriately be stated by a court." Against that

standard, however, the proposed Restatement appears to be a Restatement in name only as it contains several departures from established law. For example:

- *Insurance contracts do not need to be enforced as written*: The bedrock principle of insurance contract construction in most states is the "plain meaning rule" – pursuant to which courts give words their plain, ordinary and popular meaning. But Section 3(2) of the proposed Restatement states that "[a]n insurance policy term is interpreted according to its plain meaning, if any, unless extrinsic evidence shows that a reasonable person in the policyholder's position would give the term a different meaning."

- *Insurers in breach of a defense obligation may be forced to pay uncovered claims*: As per Section 19, an insurer found to have unreasonably failed to defend the policyholder loses all coverage defenses - a "bad faith" penalty without any need to demonstrate that an insurer acted in bad faith.

- *Insurers that reasonably refuse a settlement demand are liable for damages in excess of limits and punitive damages, irrespective of law or public policy to the contrary*: Section 24 purports to announce a public policy elevating over other settlement considerations the importance of an outcome that will "protect the insured from a judgment in excess of the applicable policy limits." As per Section 27, an insurer's reasonable rejection of a settlement demand will create an excess of limits exposure and liability for "any other foreseeable harm," including punitive damages, even where such damages are uninsurable as a matter of law and/or public policy.

- *Policyholders – but not insurers – can shift attorneys' fees:* Under the American Rule, a party to an action pays her/his own attorneys' fees, absent a statutory or contractual provision to the contrary. But Section 48(4), Section 49 (3) and Section 51(1) allow policyholders (and only policyholders) to seek recovery of their attorneys' fees, even though the overwhelming majority of states either do not permit attorney fee shifting or do so as a matter of specific statutory law.

Our concerns with the proposed Restatement are not confined to the provisions cited above, but these provisions represent clear examples where the draft proposes significant changes to current law. Such matters are the primary prerogative of the legislative branch of government, which consists of publicly elected and accountable individuals who must consider all relevant policy considerations such as the impact of proposed law changes on the availability and affordability of insurance. Indeed, the ALI itself recognizes that an "unelected body like The American Law Institute has limited competence and no special authority to make major innovations in matters of public policy."

NCOIL submits that the ALI should not endorse and publish this work as a Restatement, as opposed to a Principles project or some other designation. To the extent it intends to do so, however, NCOIL asks that the ALI defer any vote on the proposed Restatement

pending further review. The interests of all stakeholders – policyholders, insurers, legislators, regulators, the courts, and the ALI – are best served by continued discussion of what positions the Restatement should take, as well as when it should defer action to legislative bodies better suited to make public policy determinations.

NCOIL is unaware of any urgency requiring that the proposed Restatement be approved or published in 2017. It is far more important to ensure that all interested voices are truly heard, considered and reflected in a work that is a Restatement in substance as well as title. We welcome representatives of the ALI to come to a meeting of the NCOIL Property & Casualty Committee later this year to have a dialogue around the Restatement issues.

I note that should the ALI refuse our invitation for a dialogue and proceed towards seeking approval of the proposed Restatement from ALI membership at its annual meeting, NCOIL will be forced to consider passing a Resolution that opposes the proposed Restatement as a misrepresentation of the law of liability insurance, and as a usurpation of lawmaking authority from State insurance legislators. NCOIL will circulate the Resolution to all State legislative bodies and State regulators across the country to alert them of the problems associated with the proposed Restatement and to urge them to join in opposition.

We appreciate the ALI's consideration and look forward to hearing from you.

Very truly yours,

Thomas B. Considine
Chief Executive Officer
National Conference of Insurance Legislators

cc:

Tom Baker
Reporter
ALI Liability Insurance Restatement
University of Pennsylvania Law School
3501 Sansom St.
Philadelphia, PA 19104

Kyle D. Logue
Associate Reporter
ALI Liability Insurance Restatement
University of Michigan Law School
408 Hutchins Hall
Ann Arbor, Michigan 48109-1215

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
AIR AMBULANCE TASK FORCE
INTERIM CONFERENCE CALL
JUNE 8, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Air Ambulance Task Force held an interim meeting via conference call on Thursday, June 8, 2017 at 10:00 A.M. (EDT).

Representative Jeff Greer (KY), Chair of the Task Force, presided.

Other members of the Task Force present were:

Rep. Greg Cromer, LA
Rep. George Keiser, ND
Asm. Will Barclay, NY
Asm. Kevin Cahill, NY
Rep. Bill Botzow, VT

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 OF TASK FORCE'S COURSE OF ACTION TO HELP SOLVE AIR AMBULANCE BALANCE BILLING PROBLEM

Rep. Greer stated that, above all, he hopes to have an open discussion on the issues regarding air ambulances and balance billing so that the Task Force could gain a better understanding of the underlying reasons for which there are disputes and then draft an acceptable dispute resolution process that meets the needs of all stakeholders. Rep. Greer further stated that he hopes a good rapport can be developed among both sides of the issues with the end result being that health insurers cover emergency air ambulance services.

Rep. Greer stated that he does not support the previously discussed Task Force Resolution that supported S. 471, "The Isla Rose Life Flight Act" ("Tester Bill") because: a.) he wants the Task Force to further discuss and analyze the issues surrounding air ambulances before the Task Force takes a position; and b.) he believes the Tester Bill will never receive proper consideration since it is sponsored by the Minority party. Rep. Greer stated that at the NCOIL Summer Meeting in Chicago, he would like the Task Force to hold an open and robust discussion and afterwards, the Task Force can again meet with the ultimate goal being a Model Act that the Health Committee could consider at the NCOIL Annual Meeting in November. Rep. Greer stated that he believes a State solution to these issues must be found before it is passed over to the U.S. Congress.

Asm. Cahill stated that the Task Force was formed with the purpose of providing advice to the Health Committee, which would consider whether or not to then send said advice to the Executive Committee for consideration. Asm. Cahill stated that he agreed that the Tester Bill probably does not have a good chance of becoming law, which is why the Task Force Resolution was amended to remove references to the Tester Bill and

therefore reshape the Resolution as a “call on Congress” to help solve these problems by exempting matters properly governed by the McCarran-Ferguson Act from the scope of the Airline Deregulation Act of 1978 (ADA). Asm. Cahill stated that getting that concept on the radar screen of State legislators across the country will help, especially since the Task Force, and NCOIL, is bi-partisan.

Asm. Cahill further stated it would be a disservice to everyone involved with these issues to draft and propose a Model Law that would have a high probability of getting struck down as preempted by the ADA. Therefore, the “guidelines” that were drafted and distributed to the Task Force demonstrate a product that could be adopted by the Task Force and sent to States, in essence saying “because of the large preemptive scope of the ADA, NCOIL does not feel currently equipped to draft Model legislation in this area. However, these are guidelines of what we believe States can currently do to help solve problems associated with air ambulances, and we will return to the issue when it is clearer as to what can and can’t be done on the State level.” Asm. Cahill then made a Motion for the Task Force to: a.) adopt the Resolution; b.) adopt the guidelines; and c.) leave it up to the discretion of Chairman Greer as to whether the guidelines would be sent out to the States, or forwarded to the Health Committee for consideration. Asm. Cahill stated that this would show that NCOIL is serious about these issues and is working hard to do what it can given the pervasiveness of Federal preemption. Rep. Keiser seconded the Motion.

Rep. Greer stated that he does not want to vote now on a Resolution and guidelines since the Task Force has not had a chance to sit down together in-person. There has not been an adequate amount of time to fully analyze these issues. Rep. Cromer agreed with Rep. Greer. Asm. Cahill stated that he sees some value in the Task Force meeting and discussing the issues further but one of the main reasons the Task Force was formed was to allow work product to form faster than it would have if treated like an agenda topic during the Health Committee. Rep. Greer stated that he thought the revised Resolution and guidelines were distributed without enough time to fully analyze them, and that he would like to hear from more insurance companies on these issues, not just American’s Health Insurance Plans (AHIP). Asm. Cahill then withdrew his earlier Motion and requested that the Task Force review the Resolution and guidelines prior to meeting in Chicago. Rep. Keiser then withdrew his second.

Rep. Cromer stated that he would like the Task Force to have another conference call before meeting in Chicago. Rep. Greer stated that a call could be arranged for Task Force members. Commissioner Tom Considine, NCOIL CEO, stated that scheduling a call is not a problem but the call would need to be open to the public and not held only for Task Force members.

Angela Perry from Consumers Union stated that Consumers Union is very involved with these issues and has a report and several articles that detail the problems associated with air ambulances. Ms. Perry offered to distribute those materials to the Task Force. Ms. Perry also inquired as to how the Resolution was drafted. Rep. Greer referred Ms. Perry to NCOIL Support Services staff for questions about the Resolution.

Ron Jackson from the American Insurance Association (AIA) stated that the issues surrounding air ambulances can arise not just in health insurance, but in other lines of insurance such as workers’ compensation. Mr. Jackson urged representatives in other

lines of insurance to get involved in the Task Force and noted the case of *PHI Air Medical, LLC v. Texas Mutual Insurance Company, et al.*, held that certain Texas Workers' Compensation Act (TWCA) provisions were not preempted by the ADA – that case is currently on appeal.

Rep. Greer stated that when discussing these issues it would be unfair to put the blame on either side and that the goal of the Task Force should be to eventually draft and pass a Model Act.

Both Christopher Eastlee from The Association of Air Medical Services (AAMS) and Dianne Bricker of AHIP offered their respective organizations as resources for the Task Force to use as they further consider these issues.

Sean Dugan from the National Association of Insurance Commissioner (NAIC) stated that NAIC has been working with Congressman Tester's office and helped write S. 471. Mr. Dugan stated that NAIC believes there is an appetite for S. 471 in the current Congress; that it is not a partisan issue. Mr. Dugan stated that the Aircraft Owners and Pilots Association (AOPA) is a powerful trade group and that they have made it clear that the biggest holdup in supporting S. 471 is their concern that it could affect other areas of the aviation industry outside of air ambulances. Mr. Dugan stated that having members of the Task Force reach out to AOPA to discuss the issue and explain the nature of the state-based system of insurance regulation would go a long way in seeing S. 471 progress. Rep. Greer stated that he respected Mr. Dugan's opinion but is very doubtful of seeing S. 471 progress.

ADJOURNMENT

There being no further business, the Committee adjourned at 10:50 A.M.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
INTERIM COMMITTEE CALL
JUNE 5, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee held an interim meeting via conference call on Monday, June 5 2017, at 12:15 P.M. (EDT).

Assemblyman Ken Cooley, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Peggy Mayfield, IN
Rep. Joseph Fischer, KY
Sen. Dorsey Ridley, KY
Rep. Steve Riggs, KY
Rep. Bart Rowland, KY
Rep. Greg Cromer, LA
Sen. Jerry Klein, ND
Asm. Will Barclay, NY
Sen. Bob Hackett, OH
Rep. Matt Lehman, OH
Rep. Marguerite Quinn, PA
Rep. Bill Botzow, VT
Del. Steve Westfall, WV

Other legislators present were:

Rep. Sam Kito, AK
Rep. Richard Smith, GA

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 AND CONSIDERATION OF NCOIL ASBESTOS BANKRUPTCY TRUST CLAIMS TRANSPARENCY MODEL LAW

Asm. Cooley (CA) provided the Committee with some brief background on the issues surrounding asbestos litigation and stated that when considering Model legislation on such an issue, it is important to strive to ensure that everyone effected by it is treated fairly.

Sen. Klein (ND) stated that he has spent a lot of time on this issue in North Dakota and legislation similar to the proposed NCOIL Model was passed earlier this year.

Sen. Hackett (OH) stated that he sponsored similar legislation in Ohio which passed in 2013, and despite initial fear that the law would delay resolution of asbestos cases, the transparency requirements contained within the law, and the NCOIL Model, have resulted in quicker, more efficient litigation.

Former U.S. Congressman Barry Goldwater, Jr. stated that the proposed NCOIL Model strikes a fair balance between plaintiff and defendant interests in asbestos litigation. Congressman Goldwater stated that this issue is a perfect example of how it is sometimes necessary to take a step back, analyze a situation, and adjust in order to make sure there is a level playing field for everyone involved.

Mark Behrens, Esq., Shook, Hardy & Bacon, LLP, provided some background on asbestos litigation in an effort to illustrate the problems surrounding it. Asbestos litigation is nearly 40 years old, and the culpable asbestos companies that were major asbestos producers have gone bankrupt. As a result of those bankruptcies, privately managed trusts were created which today collectively hold approximately $37 billion dollars available to those exposed and harmed from asbestos.

What has transpired over the years is that plaintiffs have been suing companies that are extremely remote in terms of asbestos exposure such as small hardware and plumbing stores. Therefore, plaintiffs today have two different sources of recovery: the trust system, and the tort system. However, by delaying the filing of trust claims until after a personal injury case is resolved, the jury in the personal injury case is misinformed about all of the plaintiff's exposures. This enables plaintiffs to "double dip", i.e. receive a settlement or judgment in an asbestos-related personal injury lawsuit and then receive additional payments from multiple trusts for the same injury.

Mr. Behrens stated that the bankruptcy case *In re Garlock Sealing Technologies, LLC*, 504 B.R. 71 (W.D.N.C. Bankr. 2014), perfectly illustrates these problems. In that case, the Federal bankruptcy judge found that Garlock Sealing Technologies, LLC was a very remote company in terms of asbestos exposure, but they became a target defendant after the major asbestos companies went bankrupt. The judge in *Garlock* conducted a study of asbestos cases, the findings of which showed that every single plaintiff that had certified during the tort case that they could not recall/had never been exposed to any other asbestos besides the company they were suing, then proceeded to file multiple trust claims against other companies, thereby resulting in "double dipping."

Mr. Behrens stated that, to help solve this problem, 12 States have passed legislation simply stating that in asbestos litigation, trust claims must be filed concurrently with personal injury lawsuits. Such legislation in no way presents a roadblock to plaintiff recovery – it simply ensures that the juries in the tort cases have all the information they need to make a proper determination as to who is at fault. Wrongdoers will continue to be held accountable under such legislation. Mr. Behrens further stated that the proposed NCOIL Model is very similar to the legislation passed in West Virginia last year, which is important because that legislation represents a product of significant negotiations involving one of the largest plaintiff law firms in the country. The West Virginia legislation passed nearly unanimously, with bi-partisan support.

Rep. Riggs (KY) asked whether the proposed NCOIL Model restricts or delays plaintiff access to court in any way. Mr. Behrens replied no – the Model just says that 120 days prior to trial in the tort case, the plaintiff must 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. Mr. Behrens further stated that in Ohio, similar legislation was adopted in 2013, and it is therefore a good place to look as a predictor of future behavior. The results in Ohio show that the legislation has helped asbestos victims because it has enabled them to acquire money from the trusts more quickly.

Additionally, the legislation has resulted in less discovery disputes between attorneys in tort litigation, leading to more efficient litigation.

Asm. Cooley then opened up the discussion to interested parties. Hearing no comments, a Motion was then made and seconded to waive the quorum requirement.

Upon a Motion made and seconded, the Committee then voted to adopt the NCOIL Asbestos Bankruptcy Trust Claims Transparency Model Law without dissent.

ADJOURNMENT

There being no further business, the Committee adjourned at 12:45 P.M.

[DISCUSSION DRAFT]

115TH CONGRESS

1ST SESSION **H. R. _____**

To preserve the State-based system of insurance regulation and provide greater oversight of and transparency on international insurance standards setting processes, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. DUFFY (for himself and Mr. HECK) introduced the following bill; which was referred to the Committee on_____

A BILL

To preserve the State-based system of insurance regulation and provide greater oversight of and transparency on international insurance standards setting processes, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ‘‘International Insurance Standards Act of 2017’’.

SEC. 2. CONGRESSIONAL FINDINGS.

The Congress finds the following:

(1) The State-based system for insurance regulation in the United States has served American consumers well for more than 150 years and has fostered

an open and competitive marketplace with a diversity of insurance products to the benefit of policyholders and consumers.

(2) Protecting policyholders by regulating to ensure an insurer's ability to pay claims has been the hallmark of the successful United States system and should be the paramount objective of domestic prudential regulation and emerging international standards.

(3) The Dodd-Frank Wall Street Reform and Consumer Protection Act (Public Law 111–203) re-affirmed the State-based insurance regulatory system.

SEC. 3. REQUIREMENT THAT INSURANCE STANDARDS REFLECT UNITED STATES POLICY.

Parties representing the Federal Government in any international regulatory, standard-setting, or supervisory forum or in any negotiations of any international agreements relating to the prudential aspects of insurance shall not agree to, accede to, accept, or establish, and shall use their voice and vote to oppose, any international insurance standard proposal, including proposals developed by the International Association of Insurance Supervisors, that—

(1) is inconsistent with and does not reflect existing Federal and State laws, regulations, and policies on regulation of insurance, including the primacy of policyholder protection in solvency regulation; and

(2) would not recognize existing Federal and State laws, regulations, and policies on the regulation of insurance as satisfying such proposals.

SEC. 4. STATE INSURANCE REGULATOR INVOLVEMENT IN INTERNATIONAL STANDARD SETTING.

In developing international insurance standards pursuant to section 3, and throughout the negotiations of such standards, parties representing the Federal Government shall, on matters related to insurance, closely consult, coordinate with and include in such meetings, State insurance commissioners or, at the option of the State insurance commissioners, designees of the insurance commissioners acting at their direction.

SEC. 5. CONSULTATION WITH CONGRESS.

(a) CONSULTATION.— Before initiating negotiations to enter into an agreement under section 3, during such negotiations, and before entering into any such agreement, parties representing the Federal Government shall provide written notice to and consult with the Committee on Financial Services of the House of Representatives and the Committee on Banking, Housing, and Urban Affairs of the Senate regarding—

(1) the intention of the United States to participate or enter into such negotiations;

(2) the nature and objectives of the negotiations; and

(3) the implementation of the agreement, including how it is consistent with and does not materially differ from or otherwise affect State laws or regulations.

(b) SUBMISSION AND LAYOVER PROVISIONS.—Parties representing the Federal Government may not sign the final text or otherwise agree to, accept, or establish an agreement under section 3 before—

(1) such parties submit to the committees specified in subsection (a), on a day in which both Houses of Congress are in session, a copy of the final legal text of the agreement; and

(2) a period of 90 calendar days beginning on the date on which the copy of the final legal text of the agreement is submitted to the congressional committees under paragraph (1) has expired.

SEC. 6. CONGRESSIONAL REVIEW.

(a) IN GENERAL.—The final legal text of any agreement reached by parties representing the Federal Government under section 3 shall, except as provided in sub5 section (b) of this section, be treated as a rule for the purposes chapter 8 of title 5, United States Code, and shall have no force and effect if disapproved under such 8 chapter.

(b) INAPPLICABILITY.—Paragraph (2) of section 801(b) of title 5, United States Code, shall not apply to any agreement described in subsection (a) of this section that is disapproved pursuant to such subsection and chapter 8 of title 5, United States Code.

(c) SUBMISSION OR PUBLICATION DATE.—With respect to Congressional consideration of an agreement described in subsection (a) of this section, pursuant to subsection (a) of this section and chapter 8 of title 5, United States Code, the term ‘‘submission or publication date’’ means the day on which the final legal text of the agreement is signed or the agreement is entered into by parties representing the Federal Government.

SEC. 7. COVERED AGREEMENTS.

(a) PREEMPTION OF STATE INSURANCE MEASURES.—Subsection (f) of section 313 of title 31, United States Code, is amended by striking ‘‘Director’’ each place such term appears and inserting ‘‘Secretary.”

(b) DEFINITION.—Paragraph (2) of section 313(r) of title 31, United States Code, is amended—

(1) in subparagraph (A), by striking ‘‘and’’ at the end;

(2) in subparagraph (B), by striking the period at the end and inserting ‘‘; and’’; and

(3) by adding at the end the following new subparagraph:

‘‘(C) does not include new prudential requirements for United States insurers.’’.

(c) CONSULTATION; SUBMISSION AND LAYOVER; CONGRESSIONAL REVIEW.—Section 314 of title 31, United States Code is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) by striking ‘‘and’’ after ‘‘House of Representatives’’ and inserting a comma; and

(ii) by inserting after ‘‘Committee on Finance of the Senate’’ the following: ‘‘, and the International Trade Advisory Committee on Services and Finance Indus-tries established pursuant to section 135(c)(1) of the Trade Act of 1974 (19 U.S.C. 2155(c)(1))’’; and

(B) in paragraph (2)(C), by striking ‘‘laws’’ and inserting the following: ‘‘and Federal law, and the nature of any changes in the laws of the United States or the administration of such laws that would be required to carry out a covered agreement’’;

(2) in subsection (c)—

(A) in the matter preceding paragraph (1), by striking ‘‘only if—’’ and inserting the fol10 lowing: ‘‘only if, before signing the final legal text or otherwise entering into the agreement—’’;

(B) in paragraph (1)—

(i) by striking ‘‘congressional committees specified in subsection (b)(1)’’ and inserting ‘‘congressional committees and International Trade Advisory Committee specified in subsection (b)(1) and to staff with proper security clearances’’; and

(ii) by striking ‘‘; and’’ and inserting ‘‘and a report detailing any anticipated changes to United States law and the rationale for such changes, including why such changes are in the best interest of the United States;’’; and

(C) in paragraph (2), by inserting ‘‘, International Trade Advisory Committee, and staff’’ after ‘‘congressional committees’’;

(3) by adding at the end the following new subsections:

‘‘(d) CONGRESSIONAL REVIEW.—

‘‘(1) IN GENERAL.—The final legal text of a covered agreement shall be treated as a rule for the purposes of chapter 8 of title 5, United States Code, and shall have no force and effect if disapproved under such title.

‘‘(2) INAPPLICABILITY.—Paragraph (2) of section 801(b) of title 5, United States Code, shall not apply to any covered agreement that is disapproved pursuant to paragraph (1) of this subsection and 16 chapter 8 of title 5, United States Code.

‘‘(3) SUBMISSION OR PUBLICATION DATE.— With respect to Congressional consideration of a covered agreement, pursuant

to paragraph (1) of this subsection and chapter 8 of title 5, United States Code, the term ‘submission or publication date’ means the day on which the final legal text of the covered agreement is signed or the agreement is entered into by parties representing the Federal Government

‘‘(e) PARTICIPATION OF STATE INSURANCE COMMISSIONERS.—Throughout the negotiations of a covered agreement, parties representing the Federal Government shall closely consult and coordinate with, and include in such meetings, State insurance commissioners or, at the option of the State insurance commissioners, designees of the insurance commissioners acting at their direction.’’