TENTATIVE GENERAL SCHEDULE
NCOIL SPRING MEETING
MARCH 2-4, 2018

As of February 16, 2018, and Subject to Change

The Whitley Hotel
Atlanta, Georgia

NCOIL SPRING MEETING
Atlanta, Georgia
March 2-4, 2018
TENTATIVE SCHEDULE

FRIDAY, MARCH 2nd

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.	-	9:45 a.m.
Networking Break	9:45 a.m.	-	10:00 a.m.
General Session – Health Insurance Exchanges in The Trump Administration: Are Waivers the Solution?	10:00 a.m.	-	11:45 a.m.
Joint State-Federal Relations and International Insurance Issues Committee	11:45 a.m.	-	12:45 p.m.
The Institutes Griffith Foundation Legislator Luncheon	12:45 p.m.	-	1:45 p.m.
Property & Casualty Insurance Committee	1:45 p.m.	-	3:00 p.m.
Networking Break	3:00 p.m.	-	3:15 p.m.
Workers' Compensation Insurance Committee	3:15 p.m.	-	4:15 p.m.
NCOIL – NAIC Dialogue	4:15 p.m.	-	5:30 p.m.
Adjournment			5:30 p.m.
IEC Board Meeting	5:30 p.m.	-	6:00 p.m.
CIP Member Reception	6:00 p.m.	-	6:45 p.m.
Welcome Reception	6:30 p.m.	-	7:30 p.m.

SATURDAY, MARCH 3RD

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	7:00 a.m.	-	5:00 p.m.
Life Insurance & Financial Planning Committee	8:45 a.m.	-	10:00 a.m.
General Session – Principles Based Regulation: Who Needs Legislation Anyway?	10:00 a.m.	-	11:00 a.m.
Legislative Micro Meetings	11:15 a.m.	-	11:45 a.m.
Luncheon with Keynote Address	11:45 a.m.	-	1:15 p.m.
Financial Services Committee	1:15 p.m.	-	2:15 p.m.
Adjournment			2:15 p.m.

SUNDAY, MARCH 4TH

Registration *Exhibits Open: 8:00 a.m. – 10:00 a.m.*	8:00 a.m.	-	9:00 a.m.
Health, Long Term Care and Health Retirement Issues Committee	8:45 a.m.	-	10:45 a.m.
Business Planning Committee and Executive Committee	10:45 a.m.	-	12:00 p.m.
Adjournment			12:00 p.m.

FRIDAY, MARCH 2, 2018

Welcome Breakfast
March 2, 2018
8:30 a.m. – 9:45 a.m.

1. Welcome to Atlanta
2. President Welcome
3. New member welcome and introduction
4. Comments from NCOIL CEO Commissioner Tom Considine
5. Keynote Address from the 82nd and Current Governor of Georgia The Honorable Nathan Deal
6. Adjournment

Networking Break
March 2, 2018
9:45 a.m. – 10:00 a.m.

General Session
Health Insurance Exchanges in the Trump Administration – Are Waivers the Solution?
March 2, 2018
10:00 a.m. – 11:45 a.m.

Joint State-Federal Relations and International Insurance Issues Committee
March 2, 2018
11:45 a.m. – 12:45 p.m.

State-Federal Relations Committee – Chair: Sen. Dan "Blade" Morrish (LA)
Vice Chair: Rep. Glen Mulready (OK)
International Insurance Issues Committee – Chair: Sen. Jerry Klein (ND)
Vice Chair: Sen. Roger Picard (RI)

1. Call to order/roll call/approval of November 17, 2017 committee meeting minutes
2. Discussion on the Impact of Federal Tax Reform on the Insurance Industry
3. Discussion on the Status of NFIP and State Flood Insurance Markets

4. Any other business
5. Adjournment

The Institutes Griffith Foundation Legislator Luncheon
March 2, 2018
12:45 p.m. – 1:45 p.m.

Property & Casualty Insurance Committee
March 2, 2018
1:45 p.m. – 3:00 p.m.

Chair: Rep. Richard Smith (GA)
Vice Chair: Rep. David Santiago (FL)

1. Call to order/roll call/approval of November 16, 2017 and January 29, 2018 committee meeting minutes
2. Consideration of Consumer Protection Towing Model Act
3. Consideration of Amendments to NCOIL Model State Uniform Building Code
4. Update on ALI Proposed Restatement of the Law of Liability Insurance
5. Introduction of The Role of Insurance in Public-Private Partnership (p3s) Projects
6. Any other business
7. Adjournment

Networking Break
March 2, 2018
3:00 p.m. – 3:15 p.m.

Workers' Compensation Insurance Committee
March 2, 2018
3:15 p.m. – 4:15 p.m.

Chair: Rep. Marguerite Quinn (PA)
Vice Chair: Asw. Maggie Carlton (NV)

1. Call to order/roll call/approval of November 17, 2017 committee meeting minutes
2. Continued discussion on physician dispensing and drug compounding
3. Discussion on Presumptive PTSD Legislation
4. Any other business
5. Adjournment

NCOIL – NAIC Dialogue
March 2, 2018
4:15 p.m. – 5:30 p.m.

Chair: Rep. Bill Botzow (VT)
Vice Chair: Sen. Jim Seward (NY)

1. Call to order/roll call/approval of November 17, 2017 committee meeting minutes
2. Update on NAIC Travel Insurance Working Group
3. Discussion on Long Term Care Developments
    a.) Amendments to NAIC Life and Health Guaranty Association Model Act
    b.) Run-off facilities
    c.) Other
4. Review of NAIC Public Hearing on Covered Agreement
5. Discussion on AHP and STLD Federal Regulations
6. Any other business
7. Adjournment

IEC Board Meeting
March 2, 2018
5:30 p.m. – 6:00 p.m.

CIP Member Reception
March 2, 2018
6:00 p.m. – 6:45 p.m.

Welcome Reception
March 2, 2018
6:30 p.m. – 7:30 p.m.

SATURDAY, MARCH 3, 2018

Life Insurance & Financial Planning Committee
March 3, 2018
8:45 a.m. – 10:00 a.m.

Chair: Rep. Deborah Ferguson (AR)
Vice Chair: Rep. Joe Hoppe (MN)

1. Call to order/roll call/approval of November 16, 2017 committee meeting minutes
2. Discussion on requiring notification before adverse changes in life insurance premiums and annuity policies
3. The DOL Fiduciary Rule – Not All Quiet on the State Front
4. Any other business
5. Adjournment

General Session
Principles Based Regulation – Who Needs Legislation Anyway?
March 3, 2018
10:00 a.m. – 11:00 a.m.

Legislative Micro Meetings
March 3, 2018
11:00 a.m. – 11:45 a.m.

Luncheon with Keynote Address
March 3, 2018
11:45 a.m. – 1:15 p.m.

Financial Services Committee
March 3, 2018
1:15 p.m. – 2:15 p.m.

Chair: Sen. Bob Hackett (OH)
Vice Chair: Rep. Sam Kito (AK)

1. Call to order/roll call/approval of November 16, 2017 committee meeting minutes
2. Presentation on Promoting Financial Education for Insurance Consumers
3. Discussion on the Elimination of the Producer Appointment Process
4. Discussion on Preventing Financial Exploitation of the Elderly in the Banking and Financial Services Industries
5. Any other business
6. Adjournment

SUNDAY, MARCH 4, 2018

Health, Long Term Care, and Health Retirement Issues Committee
March 4, 2018
8:45 a.m. –10:45 a.m.

Chair: Asm. Kevin Cahill (NY)
Vice Chair: Rep. Tom Oliverson, M.D. (TX)

1. Call to order/roll call/approval of November 18, 2017 committee meeting minutes
2. Discussion on the Regulation of Pharmacy Benefit Managers (PBMs)
3. Discussion on State Options for Responding to Changes in Federal Health Policy
4. Presentation on:
    a.) Mental Health Support Efforts
    b.) Initiatives to Promote Solutions Across the Autism Spectrum

5. Discussion of Resolution in Support of Short Term Medical Plans
6. Discussion of Reporting and Notification Requirements for Prescription Drug Manufacturers Related to Drug Pricing (*see California SB 17 (2017) and Vermont S.216 (2016))*
7. Any other business
8. Adjournment

Business Planning Committee and Executive Committee
March 4, 2018
10:45 a.m. – 12:00 p.m.

1. Call to order/roll call/approval of November 19, 2017 and January 5, 2018 committee meeting minutes
2. Future meeting locations
3. Recruitment of new member states
4. Administration
    a. Meeting Report
    b. Receipt of Financials and Audit
5. Consent Calendar
    -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
    c. Griffith Foundation Legislator Luncheon
    d. Featured Speakers
8. Any other business
9. Adjournment

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

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

To be considered by the NCOIL Executive Committee on March 4, 2018

****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 ensure that NAIC and NCOIL are properly supported to ensure that insurance public policymakers are kept informed concerning issues which are dependent upon legislative authority for their positive resolution and which are being debated by state regulators. This Act will further amend a State's insurance code provision establishing the powers and duties of the office of Insurance Commissioner to require that State Insurance Commissioner shall make a presentation, or coordinate with the NAIC for such a presentation to be made, which can inform Members of key policy and fiscal oversight committees, at least every other year, on the status and activities of the National Association of Insurance Commissioners and the role therein of legislative delegation and incorporation by reference of existing or future NAIC policy adoptions. Finally, to support the informed exercise of legislative delegation in the field of insurance regulation, this measure will require the insurance commissioner to support more informed participation by key policy and budget legislators in the NCOIL and NAIC process.

Section 2. Insurance Department and Legislative Participation in NAIC & NCOIL

(a) The State Insurance Commissioner, (during even numbered years or the first year of each legislative biennium) shall appear before each insurance committee of this state, and as optionally determined by the Committee on Rules of each House, each budget committee, to provide a presentation on the National Association of Insurance Commissioners accreditation process. The presentation shall provide an overview of the role of the delegation of legislative authority for policy development which enables the NAIC accreditation process to function.

(b) This presentation shall provide an explanation, including citations to the relevant sections of state law which reflect NAIC accreditation standards or incorporation of existing NAIC rules, standards and processes by reference.

(c). Provisions which can operate to authorize future NAIC changes to be operative in this state without additional authorization by the Legislature shall be identified in a standalone format which highlights the future delegation authority in existing law or regulation of this state.

(d) The presentation shall further provide an overview of the minimum NAIC accreditation standards pertaining to 1), Laws & Regulations, (2), Regulatory Practices & Procedures, and 3), Organizational & Personnel Practices. The Commissioner shall provide an overview of the specific laws and regulations which the accreditation standard specifies, the intended purpose of each, when they were adopted by the NAIC and in this state, and any changes to any of these standards since the last briefing provided to the Legislature pursuant to this provision.

(e) This presentation may be done at a hearing that is held jointly with the relevant House and Senate standing committees and budget committees.

(f) In lieu of the presentation specified in Subdivisions (a), (b), (c), (d) and (e) above, the Insurance Department may coordinate with the National Association of Insurance Commissioners to conduct a similar training session, specific to the laws of this State, during any NAIC National Meeting in which case the Department of Insurance shall provide from its general operating funds necessary expenses for registration and reimbursement for reasonable food, travel and lodging during the National meeting two policy committee members from each house and one budget committee member.

(g) The Department of Insurance shall annually from its general operating funds provide funding for the state's membership in, and reasonable food, travel and lodging sufficient to provide for the chairmen and ranking members of the House and Senate insurance committees of jurisdiction, and the budget committees, to fully participate in the National Conference of Insurance Legislators.

Section 3. Effective Date

This Act shall take effect _____

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Workers' Compensation Pharmaceutical Reimbursement Rates Model Act

Drafting Note: This model language is intended for inclusion in state insurance codes or regulations related to workers' compensation medical fee schedules. This model succeeds and augments the previous model Act on Workers' Compensation Repackaged Pharmaceutical Reimbursement Rates adopted by NCOIL on July 12, 2013.

Proposed Amendments Sponsored by Rep. Marguerite Quinn (PA)

Discussion Draft

Table of Contents

Section 1. Short Title

This Act shall be known as the "*Workers' Compensation Pharmaceutical Reimbursement Rates Model Act*."

Section 2. Purpose

The purpose of this Act is to establish clear guidelines for reimbursement of pharmaceutical products in order to help reduce workers' compensation insurance costs.

Section 3. Definitions

Drafting Note: Definitions for language in this Act would track definitions in [insert relevant workers' compensation statute].

For the purpose of this Act, these defined words have the following meaning:

"Repackaged Pharmaceutical Product" -- A finished drug product removed from the container in which it was distributed by the original manufacturer and placed into a different container without further manipulation of the drug. The term also includes the act of placing the contents of multiple containers of the same finished drug product into one container, as long as the container does not include other ingredients. The term does not include a drug that is manipulated in any other way, including if the drug is reconstituted, diluted, mixed, or combined with another ingredient.

"Average Wholesale Price" The wholesale price charged on a specific commodity that is assigned by the drug manufacturer and is listed in a nationally recognized drug pricing file.

"Emergency Room" The facility within a licensed hospital that provides urgent medical treatment for acute illnesses and injuries.

"Compounded Pharmaceutical Products" a pharmaceutical product created by a licensed pharmacist by virtue of mixing or altering drugs and/or components to meet the unique needs of an individual patient when a commercially available drug does not meet those needs and when the finished product does not recreate a commercially available product.

Section 4. Reimbursement for Repackaged Pharmaceutical Product*

A. All pharmaceutical bills submitted for a Repackaged Pharmaceutical Product must include either:

(1) The National Drug Code (NDC) Number of the original manufacturer registered with the U.S. Food & Drug Administration (FDA). Under no circumstance shall an NDC Number other than the original manufacturers NDC number be used. A repackaged NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number.

(2) An authorized distributor's stock package used in the repackaging process.

B. The reimbursement rate for Repackaged Pharmaceutical Product bills shall be as follows:

(1) If submitted in accordance with Section (4)(A)(1), reimbursement shall be based on the current published manufacturer's Average Wholesale Price (AWP) of the product, plus a dispending fee, calculated on a per unit basis, as of the date of dispensing.

(2) If submitted in accordance with Section (4)(A)(2), where the original manufacturer's NDC Number is not provided on the bill, then the reimbursement shall be based on the AWP of the lowest priced therapeutically equivalent drug, calculated on a per unit basis.

Drafting Note: A state where a workers' compensation pharmacy fee schedule is already in place should use the following subsection B, in place of subsection B above:

B. The maximum reimbursement allowed shall be based on the current pharmacy fee schedule reimbursement methodology, utilizing the original manufacturer's NDC and corresponding Average Wholesale Price (AWP) of the drug product, calculated on a per unit basis, as of the date of dispensing.

C. When medications are dispensed by a physician, and they have been repackaged, the maximum reimbursement shall be the lesser of:

1. The fee schedule amount of the underlying or original manufacturer's NDC, assigned by the FDA; or

2. The contract rate as agreed upon between the payer and the provider

D. If the provider fails to furnish the underlying or original manufacturer's NDC, the payer has discretion to determine the appropriate NDC to use or deny coverage until the appropriate NDC is furnished.

E. The dispense fees otherwise provided in *[insert relevant workers' compensation statute]* shall be payable when applicable.

Drafting Note: Calculation of the AWP should be based on one or both of the universally accepted reporting databases, Medispan or Redbook, as selected by the payer or mandated by (State).

Section 5. Reimbursement for Physician Distributed Pharmaceutical Products

A. An employer, their workers' compensation insurance carrier or their designated third-party administrator, may restrict reimbursement for pharmaceutical products to a directed network of preferred pharmaceutical providers as follows:

(1) At any time, when a prescription is obtained other than when from a provider described in Subsections 5(A)(2) and 5(A)(3).

(2) After a maximum allowable supply of seven (7) days' medication, when a prescription is obtained by the patient for an acute illness or injury from a provider in an emergency room.

(3) After a maximum allowable supply of thirty (30) days' medication, when a prescription is distributed by the hospital provider to the patient upon discharge from in-patient care.

(4) Nothing in this section shall apply to pharmaceutical products dispensed for in-patient hospital care.

B. Physician distributed pharmaceutical products shall be limited to the initial treatment provider only and reimbursable for no more than a first fill within 7 days from the date of injury.

(1) Notwithstanding this restriction, reasonable exceptions to this policy would be appropriate in the following situations:

a. The injured worker does not have access to a retail pharmacy within 20 miles of the patients' home or work address.

b. Emergency treatment where the injured worker would be placed at higher risk if medications did not begin immediately upon departure from physician's office.

C. Medications dispensed either after the initial visit or greater than 7 days' post-accident must meet all the following conditions:

(1) A licensed pharmacist must dispense the medications.

(2) It must be in a pharmacy setting which is accessible to the general public.

D. Medications dispensed shall conform to dosages which are widely available to the general public.

Section 6. Reimbursement for Compounded Pharmaceutical Products

A. An employer, their workers compensation insurance carrier, or their designated third-party administrator may require a critical evaluation, physician documented medical necessity, or utilization review, of compounded pharmaceutical products prescribed for patients.

B. An employer, their workers compensation insurance carrier, or their designated third-party administrator may restrict reimbursement for compounded pharmaceutical products to a directed network of preferred pharmaceutical providers.

C. Nothing in this section shall prevent an employer, their workers compensation insurance carrier, or their designated third-party administrator from excluding coverage for compounded pharmaceutical products through the policy.

D. Nothing in Subsections 6(A) or 6(B) shall apply to in-patient hospital care. A maximum supply of 30 days medication may be distributed by the hospital provider upon discharge from in-patient care.

Section 7. Enforcement

The *[insert applicable state agency]* shall have enforcement authority as provided under *[insert workers' compensation statute]*.

Section 8. Effective Date

This Act shall take effect *[insert months]* after enactment.

*Drafting Note: * Based on provisions in TN Dept. of Labor & Workforce Development, Division of Workers' Compensation Rule 0800-02-18-.12*

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NATIONAL COUNCIL 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)***

****Re-adoption is pending discussion and review of proposed Amendments to the Model that are sponsored by Rep. Lewis Moore (OK) and are to be discussed during the NCOIL Property & Casualty Committee on March 2, 2018****

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.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Proposed Amendments to NCOIL Model State Uniform Building Code

Proposed Amendments are sponsored by Rep. Lewis Moore (OK) and are to be discussed during the NCOIL Property & Casualty Committee on March 2, 2018

SECTION 1.

A. Beginning January 1, 20XX, property insurance companies shall provide a premium discount or insurance rate reduction to any owner who builds or locates a new insurable property in the State of XXXXXXXXX if the insurable property is certified as being constructed in accordance with the standards set forth in subsection B of this section. Insurance companies shall be required to offer such a premium discount or rate reduction only when the insurer determines they are actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in subsection B of this section. In addition, insurance companies may also offer additional adjustments in deductible, other risk differentials, or a combination thereof, collectively referred to as other adjustments.

B. To obtain the premium discount, rate reduction, or other adjustment provided in this section, an insurable property in this state shall be certified as constructed in accordance with the FORTIFIED Home High Wind and Hail Standards as may from time to time be adopted by the Institute for Business and Home Safety or a successor entity. An insurable property shall be certified as conforming to the FORTIFIED Home High Wind and Hail Standards only after evaluation and certification by an evaluator certified pursuant to the FORTIFIED Home High Wind and Hail Standards.

C. An owner of insurable property claiming a premium discount, rate reduction, or other adjustment pursuant to this section shall maintain sufficient certification records and construction records including, but not limited to, a certification of compliance with the FORTIFIED Home High Wind and Hail Standards provided in subsection B of this section, receipts from contractors and receipts for materials. The records shall be subject to audit by the Insurance Commissioner, or his or her representatives, and copies of any such records shall be presented to the insurer or potential insurer of a property owner before the premium discount, rate reduction, or other adjustment becomes effective for the insurable property.

D. Insurers that write policies that are subject to the premium discount or rate reduction required by this section shall submit a rating plan certified by their actuary as actuarially justified

providing for the premium discount or rate reduction described in this section. A premium discount, rate reduction, or other adjustment shall only apply to policies that provide wind or hail coverage and to that portion of the premium for wind or hail coverage. A premium discount, rate reduction, or other adjustment shall apply exclusively to the wind and hail premium applicable to improved insurable property. If an insurer already offers an actuarially justified hail resistance discount, that discount shall be deemed as having met the requirements of this act as it pertains to hail-related discounts or rate reductions and no additional hail-related discount or rate reduction shall be required. If an insurer already offers an actuarially justified discount for IBHS FORTIFIED Home standards, that discount shall be deemed as having met the requirements of this act as it pertains to wind-related discounts or rate reductions and no additional wind-related discount or rate reduction shall be required. Insurers shall apply any applicable premium discount, rate reduction or other adjustment to the wind and hail premium at the policy renewal that follows the submission of the certification to the insurer. At the time of a policy renewal for which a premium discount, rate reduction, or other adjustment has previously been made, the insurer may request documentation or recertification that the fortified standards as described in subsection C of this section continue to be met. In addition to the requirements of this section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

SECTION 2.

A. Beginning January 1, 20XX, property insurance companies shall provide a premium discount or insurance rate reduction to any owner who retrofits an insurable property in the State of XXXXXXXXX if the insurable property is certified as being retrofitted in accordance with the standards set forth in subsection B of this section. Insurance companies shall be required to offer a premium discount or rate reduction only when the insurer has deemed the adjustments to be actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in subsection B of this section. In addition, insurance companies may also offer additional adjustments in deductible, other risk differentials, or a combination thereof, collectively referred to as other adjustments.

B. To obtain the premium discount, rate reduction, or other adjustment provided in this section, an insurable property shall be retrofitted to the FORTIFIED Home High Wind and Hail Standards, as may from time to time be adopted by the Institute for Business and Home Safety (IBHS) or a successor entity. Wind-Zone-3-HUD-Code manufactured homes installed on a permanent foundation and retrofitted as defined in the FORTIFIED Home High Wind and Hail Standards, as may from time to time be adopted by the Institute for Business and Home Safety or a successor entity, shall be eligible for the premium discount or rate reduction provided in this section. An insurable property shall be certified as conforming to FORTIFIED Home High Wind and Hail Standards only after evaluation and certification by an evaluator certified pursuant to the FORTIFIED Home High Wind and Hail Standards.

C. An owner of insurable property claiming a premium discount, rate reduction, or other adjustment pursuant to this section shall maintain sufficient certification records and construction records including, but not limited to, a certification of compliance with the FORTIFIED Home High Wind and Hail Standards as provided in subsection B of this section, receipts from

contractors, and receipts for materials. The records shall be subject to audit by the Insurance Commissioner, or his or her representatives, and copies of any such records shall be presented to the insurer or potential insurer of a property owner before the premium discount, rate reduction, or other adjustment becomes effective for the insurable property.

D. Insurers that write policies that are subject to the premium discount or rate reduction required by this section shall submit rating plans certified by their actuary as actuarially justified providing for the premium discounts or rate reductions described in this section. A premium discount, rate reduction, or other adjustment shall only apply to policies that provide wind or hail coverage and to that portion of the premium for wind or hail coverage. A premium discount, rate reduction, or other adjustment shall apply exclusively to the wind and hail premium applicable to improved insurable property. If an insurer already offers an actuarially justified hail resistance discount, that discount shall be deemed as having met the requirements of this act as it pertains to hail-related discounts or rate reductions and no additional hail-related discount or rate reduction shall be required. If an insurer already offers an actuarially justified discount for IBHS FORTIFIED Home standards, that discount shall be deemed as having met the requirements of this act as it pertains to wind-related discounts or rate reductions and no additional wind-related discount or rate reduction shall be required. Insurers shall apply the premium discount, rate reduction, or other adjustment to the wind premium at the policy renewal that follows the submission of the certification to the insurer. At the time of a policy renewal for which a premium discount, rate reduction, or other adjustment has previously been made, the insurer may request documentation or recertification that the fortified standards as described in subsection C of this section continue to be met. In addition to the requirements of this section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

SECTION 3.

For the purposes of this act, the term "insurable property" includes single-family residential property. Insurable property also includes modular homes satisfying the codes, standards or techniques as provided in Section 1 or 2 of this act. Manufactured homes or mobile homes are excluded, except as expressly provided in subsection B of Section 2 of this act.

SECTION 4.

This act shall only apply to new insurance policies written, or existing policies renewed, on or after January 1, 20XX.

SECTION 5.

The Insurance Commissioner shall promulgate such rules as are necessary to implement and administer this act.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Consumer Protection Towing Model Act

To be Considered by The NCOIL Property & Casualty Committee on March 2, 2018
Sponsored by Rep. Matt Lehman (IN)

****All parties are hereby on notice that the sponsor, Rep. Matt Lehman (IN), reserves the right to make amendments to this Model to conform it to certain provisions in Indiana HB1352. A copy of Indiana HB 1352 follows this Model. Interested parties are encouraged to submit any comments on this Model or Indiana HB 1352 to NCOIL Legislative Director Will Melofchik at wmelofchik@ncoil.org****

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 <violation to be established by the adopting state> 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, , 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 or unless the owner of the disabled vehicle previously provided consent to the towing company.

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 or automobile club'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 or in the event of a declared emergency

    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 the disabled vehicle is causing a potential safety hazard to any of the parties at the scene, the vehicle can be moved to a safe place once released by law enforcement for the procurement of sections D.,E., and F. below.

D. 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 telephone number of the person who summoned it to the scene; and the make, model, year, vehicle identification number (VIN) and license plate.

E. 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.

F. 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.

G. The towing company shall maintain record of D. E. and F. 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 two 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.

H. 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. If one is established, you must post a sign that is clearly visible to the public. The sign must include 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.

E. The towing company shall provide notice of the tow to law enforcement within two hours of removing the vehicle from private property.

F. 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 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, 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 based on a 24 hour rate;
    h. Other fees including but not limited to: Documentation fees and motor vehicle registration search fees.
    i. 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.

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.

B. If the search under A above result is a corporately owned vehicle then the above notice shall be sent to the state corporate address listed on the registration. The vehicle must be held for up to 60 days in order for the vehicle owner to retrieve the towed vehicle. The rate charged must be comparative the standard daily rate. If at any time more than one vehicle owned by the same corporation is under your control each vehicle shall be processed under a separate transaction.

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 upon written request from law enforcement.

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 accessible during normal business hours. Outside of normal business hours, the towing company must provide a 24-hour phone number and calls to the towing company must be returned within 18 hours.

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. Certification 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. If applicable by state law, 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, in the past 5 years, 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.

HB1352.1

January 26, 2018

HOUSE BILL No. 1352

DIGEST OF HB 1352 (Updated January 24, 2018 12:41 pm - DI 123)

Citations Affected: IC 9-13; IC 9-18.1; IC 9-22; IC 9-33; IC 24-5; IC 24-14.

Synopsis: Towing services. Amends the statute concerning the release of an abandoned motor vehicle that has been towed to a storage yard or towing facility as follows: (1) Provides that upon payment of all costs incurred against a vehicle, the vehicle must be released to a representative of the insurance company that insures the vehicle if certain conditions are met. (2) Provides inspection rights for owners, lienholders, and insurance company representatives. (3) Requires a towing service or storage yard to: (A) provide an itemized receipt upon payment; and (B) meet certain requirements as to: (i) hours of operation; and (ii) receiving and returning telephone calls. Includes lienholders in the statutory definition of "owner". Makes the following changes to the statute concerning a public agency's or towing service's duty to notify the owner that an abandoned vehicle has been removed to a storage yard or towing service: (1) Provides that the required notice shall also be provided to the insurer of the vehicle, if: (A) the insurer is known; and (B) the vehicle is covered by an active insurance policy.

(2) Specifies additional information that must be included in the notice.

(3) Specifies a public agency's or towing service's duties with respect to vehicles owned by a corporation or another business entity. Creates a new article in the Indiana Code to establish certain requirements for towing companies that engage in, or offer to engage in, the business of providing towing service in Indiana, including provisions concerning the following: (1) Emergency towing. (2) Private property towing. (3)

(Continued next page)

Effective: July 1, 2018.

Mahan, Lehman

January 16, 2018, read first time and referred to Committee on Roads and Transportation.
January 25, 2018, amended, reported — Do Pass.

Estimates and invoices for towing services. (4) Releasing towed motor vehicles. (4) Prohibited acts by towing companies and storage facilities. Provides that a person who violates these new provisions commits a deceptive act that is: (1) actionable under; and (2) subject to the penalties and remedies set forth in; the statute governing deceptive consumer sales. Provides that the attorney general: (1) shall receive, and may investigate, complaints alleging violations of the new provisions; and (2) after finding that a violation has occurred, may take appropriate action under the statute governing deceptive consumer sales. Authorizes the attorney general to adopt rules to implement the new provisions.

January 26, 2018

Second Regular Session of the 120th General Assembly (2018)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~. Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.
Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2017 Regular Session of the General Assembly.

HOUSE BILL No. 1352

A BILL FOR AN ACT to amend the Indiana Code concerning motor vehicles.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 9-13-2-149.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: **Sec. 149.6. "Record of sale" has the meaning set forth in IC 9-22-1-4(a).**

SECTION 2. IC 9-18.1-3-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: **Sec. 4.5. (a) The bureau may not register a vehicle to a person who has not fully paid all costs and fines imposed under IC 9-22-1-4.**

(b) If a person described in subsection (a) fully pays all costs and fines imposed under IC 9-22-1-4, the bureau shall proceed with the registration of the vehicle as prescribed by this chapter.

(c) It is the responsibility of the person described in subsection (a) to demonstrate compliance with subsection (b).

SECTION 3. IC 9-18.1-3-7.5 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: **Sec. 7.5. (a) The bureau may withhold the annual registration of any vehicle registered to a person who has not fully paid all costs and fines imposed under IC 9-22-1-4.**

(b) If a person described in subsection (a) fully pays all costs and fines imposed under IC 9-22-1-4, the bureau shall proceed with the registration of the vehicle as prescribed by this chapter.

(c) It is the responsibility of the person described in subsection (a) to demonstrate compliance with subsection (b).

SECTION 4. IC 9-22-1-4, AS AMENDED BY P.L.157-2017, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 4. (a) **As used in this section, "record of sale" means either of the following:**

(1) A legible photocopy of a reassigned vehicle title.

(2) A form document that includes the:

(A) name, address, and signature of the person to whom a vehicle is sold or transferred; and

(B) date of sale or transfer of the vehicle.

(b) Except as provided in subsection ~~(c),~~ **(d),** the owner of an abandoned vehicle or parts is:

(1) responsible for the abandonment; and

(2) liable for all of the costs incidental to the removal, storage, and disposal;

of the vehicle or the parts under this chapter.

~~(b)~~ **(c)** The costs for storage of an abandoned vehicle may not exceed two thousand dollars ($2,000).

(d) The owner of a motor vehicle who:

(1) delivers:

(A) possession of the vehicle; and

(B) the applicable certificate of title;

to a subsequent purchaser or transferee; and

(2) possesses a record of sale for the vehicle that is delivered to the subsequent purchaser or transferee;

is not liable for any costs or fines that result from the ownership or use of the vehicle by the subsequent purchaser or transferee, including any costs or fines that result from the abandonment of the vehicle by the subsequent purchaser or transferee.

~~(c)~~ **(e)** If an abandoned vehicle is sold by a person who removed, towed, or stored the vehicle, the person who previously owned the vehicle is not responsible for storage fees.

~~(d)~~ **(f)** If an abandoned vehicle is sold by a person who removed, towed, or stored the vehicle, and proceeds from the sale of the vehicle

covered the removal, towing, sale disposal, and storage expenses, any remaining proceeds from the sale of the vehicle shall be returned as described in this chapter or IC 9-22-6, whichever is applicable.

SECTION 5. IC 9-22-1-8, AS AMENDED BY P.L.125-2012, SECTION 117, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 8. **(a) Subject to subsection (c),** if:

(1) the properly identified person who owns or holds a lien on a vehicle; **or**

(2) subject to subsection (b), a representative of the insurance company that insures the vehicle;

appears at the site of storage before disposal of the vehicle or parts and pays all costs incurred against the vehicle or parts at that time, the vehicle or parts shall be released.

(b) Upon payment of all costs incurred against a vehicle or parts, as described in subsection (a), a towing service or storage yard shall release the vehicle to a representative of the insurance company that insures the vehicle if:

(1) the insurance company representative presents proof that the vehicle is insured with the insurance company; or

(2) the owner of the vehicle approves release of the vehicle to the insurance company representative.

(c) An owner, a lienholder, or an insurance company representative has the right to inspect a vehicle before accepting return of the vehicle under this section.

(d) A towing service or storage yard must accept payment made by any of the following means from a person seeking to release a vehicle under this section:

(1) Cash.

(2) An insurance check.

(3) Certified check.

(e) Upon receiving payment of all costs incurred against a vehicle or parts, a towing service or storage yard shall provide to the person making payment an itemized receipt that includes the information set forth in IC 24-14-5-2(a), to the extent the information is known or available.

(f) A towing service or storage yard must be open for business and accessible by telephone during normal business hours. A towing service or storage yard must provide a telephone number that is available on a twenty-four (24) hour basis to receive calls and messages from callers, including calls made outside of normal business hours. All calls made to a towing service or storage yard must be returned within twenty-four (24) hours from the time

received. However, if adverse weather, an act of God, an emergency situation, or another act over which the towing service or storage yard has no control prevents the towing service or storage yard from returning calls within twenty-four (24) hours, the towing service or storage yard shall return all calls received as quickly as possible.

(g) A towing service **or storage yard** shall notify the appropriate public agency of all releases under this section. The notification must include:

(1) the name, ~~signature,~~ and address of:

(A) the person that owns or holds a lien on the vehicle; **and**

(B) the insurance company that insures the vehicle, if the vehicle was released to a representative of the insurance company in accordance with subsection (b);

(2) the signature of the individual to whom the vehicle was released;

(3) a description of the vehicle or parts;

(4) costs **paid;** and

(5) the date of release.

SECTION 6. IC 9-22-1-19, AS AMENDED BY P.L.157-2017, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 19. (a) Within seventy-two (72) hours after removal of a vehicle to a storage yard or towing service under section 13, 14, 16, or 31 of this chapter or IC 9-22-6, the public agency or towing service shall conduct a search of national data bases, including a data base of vehicle identification numbers, to attempt to obtain the last state of record of the vehicle in order to attempt to ascertain the name and address of the person who owns or holds a lien on the vehicle.

(b) **Subject to subsection (d),** a public agency or towing service that obtains the name and address of the owner of or lienholder on a vehicle shall, not later than seventy-two (72) hours after obtaining the name and address, ~~notify~~ **provide, using any method described in subsection (c), a notice that complies with subsection (c) to:**

(1) the person who owns or holds a lien on the vehicle; ~~of the following~~: **and**

(2) if known to the public agency or towing service, the insurer of the vehicle, if the vehicle is covered by an active policy of insurance.

(c) The notice required under subsection (b) must include the following:

(1) The name, address, and telephone number of the public

agency or towing service.

(2) The date and time the vehicle was towed.

(3) The location from which the vehicle was towed.

(4) A description of the towed vehicle, including the:

(A) make;

(B) model;

(C) year;

(D) vehicle identification number; and

(E) color;

of the motor vehicle.

(5) The license plate number and state of registration for the towed vehicle.

(6) The name, address, and telephone number of the storage yard or towing service where the vehicle is being stored.

(7) The address and telephone number for the location where payments are accepted, if different from the storage yard or towing service identified under subdivision (6).

~~(2)~~ **(8)** That storage charges are being accrued and the vehicle is subject to sale if the vehicle is not claimed and the charges are not paid.

~~(3)~~ **(9)** The earliest possible date and location of the public sale or auction.

The notice must be made by certified mail or a certificate of mailing or by means of an electronic service approved by the bureau.

Notwithstanding section 4 of this chapter, a public agency or towing service that fails to notify the owner of or lienholder on the vehicle as set forth in this subsection may not collect additional storage costs incurred after the date of receipt of the name and address obtained.

SECTION 7. IC 9-33-1-1, AS AMENDED BY P.L.198-2016, SECTION 630, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. This article applies to the following:

(1) Actions taken under a court order.

(2) Actions required under IC 9-24-2-1, IC 9-24-2-2, or IC 9-24-2-4.

(3) Actions required under IC 9-24-6 (before its repeal on July 1, 2016).

(4) Actions required under IC 9-24-6.5-6(c) (before its repeal on July 1, 2016).

(5) Actions taken under IC 9-24-6.1.

(6) Actions required under IC 9-25.

(7) Actions taken under IC 9-28.

(8) Actions required under IC 9-30.

(9) Refunds claimed after June 30, 2016, of fees imposed by the bureau.

(10) Actions taken under IC 9-22-1-4.

SECTION 8. IC 24-5-0.5-3, AS AMENDED BY P.L.170-2017, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 3. (a) A supplier may not commit an unfair, abusive, or deceptive act, omission, or practice in connection with a consumer transaction. Such an act, omission, or practice by a supplier is a violation of this chapter whether it occurs before, during, or after the transaction. An act, omission, or practice prohibited by this section includes both implicit and explicit misrepresentations.

(b) Without limiting the scope of subsection (a), the following acts, and the following representations as to the subject matter of a consumer transaction, made orally, in writing, or by electronic communication, by a supplier, are deceptive acts:

(1) That such subject of a consumer transaction has sponsorship, approval, performance, characteristics, accessories, uses, or benefits it does not have which the supplier knows or should reasonably know it does not have.

(2) That such subject of a consumer transaction is of a particular standard, quality, grade, style, or model, if it is not and if the supplier knows or should reasonably know that it is not.

(3) That such subject of a consumer transaction is new or unused, if it is not and if the supplier knows or should reasonably know that it is not.

(4) That such subject of a consumer transaction will be supplied to the public in greater quantity than the supplier intends or reasonably expects.

(5) That replacement or repair constituting the subject of a consumer transaction is needed, if it is not and if the supplier knows or should reasonably know that it is not.

(6) That a specific price advantage exists as to such subject of a consumer transaction, if it does not and if the supplier knows or should reasonably know that it does not.

(7) That the supplier has a sponsorship, approval, or affiliation in such consumer transaction the supplier does not have, and which the supplier knows or should reasonably know that the supplier does not have.

(8) That such consumer transaction involves or does not involve a warranty, a disclaimer of warranties, or other rights, remedies, or obligations, if the representation is false and if the supplier

knows or should reasonably know that the representation is false.
(9) That the consumer will receive a rebate, discount, or other benefit as an inducement for entering into a sale or lease in return for giving the supplier the names of prospective consumers or otherwise helping the supplier to enter into other consumer transactions, if earning the benefit, rebate, or discount is contingent upon the occurrence of an event subsequent to the time the consumer agrees to the purchase or lease.
(10) That the supplier is able to deliver or complete the subject of the consumer transaction within a stated period of time, when the supplier knows or should reasonably know the supplier could not. If no time period has been stated by the supplier, there is a presumption that the supplier has represented that the supplier will deliver or complete the subject of the consumer transaction within a reasonable time, according to the course of dealing or the usage of the trade.
(11) That the consumer will be able to purchase the subject of the consumer transaction as advertised by the supplier, if the supplier does not intend to sell it.
(12) That the replacement or repair constituting the subject of a consumer transaction can be made by the supplier for the estimate the supplier gives a customer for the replacement or repair, if the specified work is completed and:
(A) the cost exceeds the estimate by an amount equal to or greater than ten percent (10%) of the estimate;
(B) the supplier did not obtain written permission from the customer to authorize the supplier to complete the work even if the cost would exceed the amounts specified in clause (A);
(C) the total cost for services and parts for a single transaction is more than seven hundred fifty dollars ($750); and
(D) the supplier knew or reasonably should have known that the cost would exceed the estimate in the amounts specified in clause (A).
(13) That the replacement or repair constituting the subject of a consumer transaction is needed, and that the supplier disposes of the part repaired or replaced earlier than seventy-two (72) hours after both:
(A) the customer has been notified that the work has been completed; and
(B) the part repaired or replaced has been made available for examination upon the request of the customer.
(14) Engaging in the replacement or repair of the subject of a

consumer transaction if the consumer has not authorized the replacement or repair, and if the supplier knows or should reasonably know that it is not authorized.

(15) The act of misrepresenting the geographic location of the supplier by listing an alternate business name or an assumed business name (as described in IC 23-0.5-3-4) in a local telephone directory if:

(A) the name misrepresents the supplier's geographic location;

(B) the listing fails to identify the locality and state of the supplier's business;

(C) calls to the local telephone number are routinely forwarded or otherwise transferred to a supplier's business location that is outside the calling area covered by the local telephone directory; and

(D) the supplier's business location is located in a county that is not contiguous to a county in the calling area covered by the local telephone directory.

(16) The act of listing an alternate business name or assumed business name (as described in IC 23-0.5-3-4) in a directory assistance data base if:

(A) the name misrepresents the supplier's geographic location;

(B) calls to the local telephone number are routinely forwarded or otherwise transferred to a supplier's business location that is outside the local calling area; and

(C) the supplier's business location is located in a county that is not contiguous to a county in the local calling area.

(17) The violation by a supplier of IC 24-3-4 concerning cigarettes for import or export.

(18) The act of a supplier in knowingly selling or reselling a product to a consumer if the product has been recalled, whether by the order of a court or a regulatory body, or voluntarily by the manufacturer, distributor, or retailer, unless the product has been repaired or modified to correct the defect that was the subject of the recall.

(19) The violation by a supplier of 47 U.S.C. 227, including any rules or regulations issued under 47 U.S.C. 227.

(20) The violation by a supplier of the federal Fair Debt Collection Practices Act (15 U.S.C. 1692 et seq.), including any rules or regulations issued under the federal Fair Debt Collection Practices Act (15 U.S.C. 1692 et seq.).

(21) A violation of IC 24-5-7 (concerning health spa services), as set forth in IC 24-5-7-17.

(22) A violation of IC 24-5-8 (concerning business opportunity transactions), as set forth in IC 24-5-8-20.
(23) A violation of IC 24-5-10 (concerning home consumer transactions), as set forth in IC 24-5-10-18.
(24) A violation of IC 24-5-11 (concerning real property improvement contracts), as set forth in IC 24-5-11-14.
(25) A violation of IC 24-5-12 (concerning telephone solicitations), as set forth in IC 24-5-12-23.
(26) A violation of IC 24-5-13.5 (concerning buyback motor vehicles), as set forth in IC 24-5-13.5-14.
(27) A violation of IC 24-5-14 (concerning automatic dialing-announcing devices), as set forth in IC 24-5-14-13.
(28) A violation of IC 24-5-15 (concerning credit services organizations), as set forth in IC 24-5-15-11.
(29) A violation of IC 24-5-16 (concerning unlawful motor vehicle subleasing), as set forth in IC 24-5-16-18.
(30) A violation of IC 24-5-17 (concerning environmental marketing claims), as set forth in IC 24-5-17-14.
(31) A violation of IC 24-5-19 (concerning deceptive commercial solicitation), as set forth in IC 24-5-19-11.
(32) A violation of IC 24-5-21 (concerning prescription drug discount cards), as set forth in IC 24-5-21-7.
(33) A violation of IC 24-5-23.5-7 (concerning real estate appraisals), as set forth in IC 24-5-23.5-9.
(34) A violation of IC 24-5-26 (concerning identity theft), as set forth in IC 24-5-26-3.
(35) A violation of IC 24-5.5 (concerning mortgage rescue fraud), as set forth in IC 24-5.5-6-1.
(36) A violation of IC 24-8 (concerning promotional gifts and contests), as set forth in IC 24-8-6-3.
(37) A violation of IC 21-18.5-6 (concerning representations made by a postsecondary credit bearing proprietary educational institution), as set forth in IC 21-18.5-6-22.5.
(38) A violation of IC 24-14 (concerning towing services), as set forth in IC 24-14-8-1.

(c) Any representations on or within a product or its packaging or in advertising or promotional materials which would constitute a deceptive act shall be the deceptive act both of the supplier who places such representation thereon or therein, or who authored such materials, and such other suppliers who shall state orally or in writing that such representation is true if such other supplier shall know or have reason to know that such representation was false.

(d) If a supplier shows by a preponderance of the evidence that an act resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adopted to avoid the error, such act shall not be deceptive within the meaning of this chapter.

(e) It shall be a defense to any action brought under this chapter that the representation constituting an alleged deceptive act was one made in good faith by the supplier without knowledge of its falsity and in reliance upon the oral or written representations of the manufacturer, the person from whom the supplier acquired the product, any testing organization, or any other person provided that the source thereof is disclosed to the consumer.

(f) For purposes of subsection (b)(12), a supplier that provides estimates before performing repair or replacement work for a customer shall give the customer a written estimate itemizing as closely as possible the price for labor and parts necessary for the specific job before commencing the work.

(g) For purposes of subsection (b)(15) and (b)(16), a telephone company or other provider of a telephone directory or directory assistance service or its officer or agent is immune from liability for publishing the listing of an alternate business name or assumed business name of a supplier in its directory or directory assistance data base unless the telephone company or other provider of a telephone directory or directory assistance service is the same person as the supplier who has committed the deceptive act.

(h) For purposes of subsection (b)(18), it is an affirmative defense to any action brought under this chapter that the product has been altered by a person other than the defendant to render the product completely incapable of serving its original purpose.

SECTION 9. IC 24-14 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]:

ARTICLE 14. TOWING SERVICES

Chapter 1. Application

Sec. 1. (a) This article applies to any person engaging in, or offering to engage in, the business of providing towing service in Indiana.

(b) This article does not apply to the towing of motor vehicles:

(1) into Indiana; or

(2) through Indiana;

if the towing originates in another state.

Sec. 2. This article does not apply to seizure towing.

Sec. 3. This article does not supersede or nullify a towing

company's or any other person's rights, duties, or obligations under the following:

(1) IC 24-4-6-2.

(2) IC 9-22-1.

(3) IC 9-22-6.

Chapter 2. Definitions

Sec. 1. The definitions in this chapter apply throughout this article.

Sec. 2. "Affiliate" has the meaning set forth in IC 23-1-43-1.

Sec. 3. (a) "Automobile club" means a person that, for consideration, promises to assist its members or subscribers in matters relating to:

(1) motor travel; or

(2) the operation, use, or maintenance of a motor vehicle;

by supplying services, which may include towing service, emergency road service, or indemnification service.

(b) The term includes:

(1) a motor vehicle dealer; or

(2) an insurance company;

operating as an automobile club to provide any of the services described in subsection (a).

Sec. 4. "Crane service" means a type of towing service that 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.

Sec. 5. "Emergency towing" means the towing of a motor vehicle, with or without the owner's consent, because of:

(1) a motor vehicle accident on a public street, road, or highway; or

(2) an incident:

(A) related to an emergency; and

(B) necessitating the removal of the motor vehicle from a location for public safety reasons.

Sec. 6. "Flat bed service" means a type of towing service that involves moving vehicles by loading them onto a flat bed platform.

Sec. 7. (a) "Law enforcement towing" means the towing of a motor vehicle for law enforcement purposes.

(b) The term includes towing for law enforcement purposes that is performed by a towing company:

(1) under a contract with the state, a local unit, or a law enforcement agency of the state or local unit; or

(2) on behalf of the state, a local unit, or a law enforcement

agency of the state or local unit.

(c) The term does not include seizure towing.

Sec. 8. "Motor vehicle" means any vehicle that:

(1) is manufactured primarily for use on public streets, roads, and highways (not including a vehicle operated exclusively on a rail or rails); and

(2) has at least four (4) wheels.

Sec. 9. "Owner", with respect to a motor vehicle, means any of the following:

(1) The person to whom a motor vehicle is registered.

(2) A person that holds a lien on the motor vehicle.

(3) The person to whom a motor vehicle is leased, if the terms of the lease require the lessee to maintain and repair the motor vehicle.

(4) In the case of a motor vehicle rented under a rental agreement (as defined in IC 24-4-9-5), the rental company (as defined in IC 24-4-9-7).

Sec. 10. "Private property towing" means the towing of a motor vehicle, without the owner's consent:

(1) from private property on which the motor vehicle was illegally parked; or

(2) from private property because of an exigent circumstance necessitating its removal;

to another location.

Sec. 11. "Seizure towing" means the towing of a motor vehicle for law enforcement purposes involving:

(1) the maintenance of the chain of custody of evidence; or

(2) the forfeiture of assets.

Sec. 12. (a) "Storage facility" means any:

(1) lot;

(2) facility; or

(3) other property;

used to store motor vehicles that have been removed from another location by a tow truck.

(b) The term includes a storage yard (as defined in IC 9-22-1-3.5).

Sec. 13. "Tow truck" means a motor vehicle equipped to provide any form of towing service, including crane service or flat bed service.

Sec. 14. "Tow truck operator" means an individual who operates a tow truck as an employee or agent of a towing company.

Sec. 15. (a) "Towing company" means a service or business

that:

(1) tows or otherwise moves motor vehicles by means of a tow truck; or

(2) owns or operates a storage lot.

(b) The term includes a tow truck operator acting on behalf of a towing company when appropriate in the context.

Chapter 3. Emergency Towing

Sec. 1. This chapter applies to a towing company that engages in, or offers to engage in, emergency towing.

Sec. 2. (a) Except as provided in subsection (b), a towing company shall not stop, or cause a person to stop, at the scene of an accident or near a disabled motor vehicle:

(1) if there is an injury as the result of an accident; or

(2) for the purpose of:

(A) soliciting an engagement for emergency towing services;

(B) moving a motor vehicle from a public street, road, or highway; or

(C) accruing charges in connection with an activity described in clause (A) or (B).

(b) A towing company may stop, or cause a person to stop, at the scene of an accident or near a disabled motor vehicle under the circumstances, or for any of the purposes, described in subsection (a) if:

(1) the towing company is requested to stop or to perform a towing service by a law enforcement officer or by authorized state, county, or municipal personnel;

(2) the towing company is summoned to the scene or requested to stop by the owner or operator of a disabled vehicle; or

(3) the owner of a disabled motor vehicle has previously provided consent to the towing company to stop or perform a towing service.

Sec. 3. (a) Except as provided in subsections (b) and (c), the owner or operator of a disabled motor vehicle may, in consultation with law enforcement or with authorized state, county, or municipal personnel (if appropriate):

(1) summon to the disabled motor vehicle's location the towing company of the owner's or operator's choice, either directly or through an insurance company's or an automobile club's emergency service arrangement; and

(2) designate the location to which the disabled motor vehicle

is to be towed. However, if the location designated by the owner or operator is not a storage facility owned or operated by the towing company, the owner or operator must make arrangements for payment to the towing company at the time the towing company is summoned.

(b) Subsection (a) does not apply:

(1) in any case in which the owner or operator of a disabled motor vehicle:

(A) is incapacitated or otherwise unable to summon a towing company; or

(B) defers to law enforcement or to authorized state, county, or municipal personnel as to:

(i) the towing company to be summoned; or

(ii) the location to which the disabled motor vehicle is to be towed; or

(2) in the event of a declared emergency.

(c) The authority of an owner or operator of a disabled vehicle to summon the towing company of the owner's or operator's choice under subsection (a) shall be superseded by a law enforcement officer or by authorized state, county, or municipal personnel if the towing company of choice of the owner or operator:

(1) is unable to respond to the location of the disabled motor vehicle in a timely fashion; and

(2) the disabled motor vehicle:

(A) is a hazard;

(B) impedes the flow of traffic; or

(C) may not legally remain in its location;

in the opinion of the law enforcement officer or authorized state, county, or municipal personnel.

Sec. 4. If a disabled motor vehicle:

(1) is causing; or

(2) poses;

a safety hazard to any of the parties at the scene of the disabled motor vehicle, the disabled motor vehicle may be moved by a towing company to a safe location after being released by a law enforcement officer or by authorized state, county, or municipal personnel for that purpose.

Sec. 5. (a) If a towing company is summoned for emergency towing by the owner or operator of a disabled motor vehicle, the towing company shall make a record of the following, to the extent available:

(1) The:

(A) first and last name; and
(B) telephone number;
of the person who summoned the towing company to the scene.
(2) The make, model, year, vehicle identification number, and license plate number of the disabled motor vehicle.
(b) If a towing company is summoned for emergency towing by a law enforcement officer or by authorized state, county, or municipal personnel, the towing company shall make a record of the following, to the extent available:
(1) The identity of:
(A) the law enforcement agency; or
(B) authorized state, county, or municipal agency;
requesting the emergency towing.
(2) The make, model, year, vehicle identification number, and license plate number of the disabled motor vehicle.
(c) A towing company:
(1) shall:
(A) maintain a record created under subsection (a) or (b); and
(B) provide a record created under subsection (a) or (b) to a law enforcement agency upon request;
from the time the towing company appears at the scene of the disabled motor vehicle until the time the motor vehicle is towed and released to an authorized third party; and
(2) shall:
(A) retain a record created under subsection (a) or (b) for a period of two (2) years from the date the disabled vehicle was towed from the scene; and
(B) throughout the two (2) year period described in clause (A), make the record available for inspection and copying, not later than forty-eight (48) hours after receiving a written request for inspection from:
(i) a law enforcement agency;
(ii) the attorney general;
(iii) the disabled motor vehicle's owner; or
(iv) an authorized agent of the disabled motor vehicle's owner.
Sec. 6. A towing company that performs emergency towing under this chapter shall:
(1) properly secure all towed motor vehicles; and
(2) take all reasonable efforts to prevent:

(A) further damage (including weather damage) to; or
(B) the theft of;
all towed motor vehicles, including a motor vehicle's cargo and contents.

Chapter 4. Private Property Towing

Sec. 1. (a) This chapter applies to a towing company that engages in, or offers to engage in, private property towing.

(b) This chapter does not apply to the towing of a motor vehicle from a tow-away zone that is not located on private property.

Sec. 2. The owner of private property may establish a tow-away zone on the owner's property.

Sec. 3. A property owner that establishes a tow-away zone under this chapter shall post at the location of the tow-away zone a sign that:

(1) is clearly visible to the public; and

(2) includes:

(A) a statement that the area is a tow-away zone; and

(B) a description of any persons authorized to park in the area.

Sec. 4. A towing company that tows a motor vehicle under this chapter shall ensure that the motor vehicle is towed to:

(1) a storage facility that is located within twenty-five (25) miles of the location of the tow-away zone from which the motor vehicle was removed; or

(2) if there is no storage facility located within twenty-five (25) miles of the location of the tow-away zone, to the storage facility nearest to the tow-away zone.

Sec. 5. If the owner or operator of a motor vehicle that is parked in violation of a tow-away zone arrives at the location of the tow-away zone while the motor vehicle is in the process of being towed, the towing company shall give the owner or operator either oral or written notification that the owner or operator may pay a fee in an amount that is not greater than half of the amount of the fee the towing company normally charges for the release of a motor vehicle. Upon the owner's or operator's payment of the amount specified, the towing company shall:

(1) release the motor vehicle to the owner or operator; and

(2) give the owner or operator a receipt showing:

(A) the full amount of the fee the towing company normally charges for the release of a motor vehicle; and

(B) the amount of the fee paid by the owner or operator.

Sec. 6. Not later than two (2) hours after completing a tow of a

motor vehicle from private property, a towing company shall provide notice of the towing to the law enforcement agency having jurisdiction in the location of the private property.

Sec. 7. A towing company that performs private property towing under this chapter shall:

(1) properly secure all towed motor vehicles; and

(2) take all reasonable efforts to prevent:

(A) further damage (including weather damage) to; or

(B) the theft of;

all towed motor vehicles, including a motor vehicle's cargo and contents.

Sec. 8. This chapter does not affect a private property owner's rights under IC 9-22-1 with respect to abandoned vehicles on the property owner's property.

Chapter 5. Invoices for Towing Services

Sec. 1. (a) An itemized invoice of actual towing charges assessed by a towing company for a completed tow shall be made available to the owner of the motor vehicle or the owner's authorized agent not later than one (1) business day after:

(1) the tow is completed; or

(2) the towing company has obtained all necessary information to be included on the invoice, including any charges submitted by subcontractors used by the towing company to complete the tow;

whichever occurs later.

(b) The itemized invoice required by this section must contain the following information:

(1) The location from which the motor vehicle was towed.

(2) The location to which the motor vehicle was towed.

(3) The name, address, and telephone number of the towing company.

(4) A description of the towed motor vehicle, including the:

(A) make;

(B) model;

(C) year;

(D) vehicle identification number; and

(E) color;

of the motor vehicle.

(5) The license plate number and state of registration for the towed motor vehicle.

(6) The cost of the original towing service.

(7) The cost of any vehicle storage fees, expressed as a daily

rate.

(8) Other fees, including documentation fees and motor vehicle search fees.

(9) The costs for services that were performed under a warranty or that were otherwise performed at no cost to the owner of the motor vehicle.

(c) Any service or fee in addition to the services or fees described in subsection (b)(6), (b)(7), or (b)(8) must be set forth individually as a single line item on the invoice required by this section, with an explanation and the exact charge for the service or the exact amount of the fee.

Sec. 2. A copy of each invoice and receipt submitted by a tow truck operator in accordance with section 1 of this chapter shall:

(1) be retained by the towing company for a period of two (2) years from the date of issuance; and

(2) throughout the two (2) year period described in subdivision (1), be made available for inspection and copying not later than forty-eight (48) hours after receiving a written request for inspection from:

(A) a law enforcement agency;

(B) the attorney general;

(C) the prosecuting attorney or city attorney having jurisdiction in the location of any of the towing company's Indiana business locations;

(D) the disabled motor vehicle's owner; or

(E) the agent of the disabled motor vehicle's owner.

Chapter 6. Releasing Towed Motor Vehicles

Sec. 1. This chapter applies to the following:

(1) A towing company that tows and stores a motor vehicle under this article.

(2) A storage facility that stores a motor vehicle that is towed by a towing company under this article, regardless of whether the towing company and the storage facility are affiliates.

Sec. 2. Upon payment of all costs incurred against a motor vehicle that is towed and stored under this article, the towing company or storage facility shall release the motor vehicle to:

(1) a properly identified person who owns or holds a lien on the motor vehicle; or

(2) a representative of the insurance company that insures the motor vehicle, if the vehicle is covered by an active policy of insurance;

in accordance with the procedures, and subject to the same

requirements, set forth in IC 9-22-1-8 with respect to abandoned motor vehicles.

Chapter 7. Prohibited Acts

Sec. 1. A towing company shall not do any of the following:

(1) Falsely represent, either expressly or by implication, that the towing company represents or is approved by any organization that provides emergency road service for disabled motor vehicles.

(2) Require the owner or operator of a disabled motor vehicle to preauthorize:

(A) repair work; or

(B) more than twenty-four (24) hours of storage;

as a condition for providing towing service for the disabled motor vehicle.

(3) Charge more than one (1) towing fee when the owner or operator of a disabled motor vehicle requests that the disabled motor vehicle be towed to a repair facility owned or operated by the towing company.

(4) Tow a motor vehicle to a repair facility unless:

(A) either:

(i) the owner of the motor vehicle; or

(ii) the owner's designated representative;

gives consent for the motor vehicle to be towed to the repair facility; and

(B) the consent described in clause (A) is given before the motor vehicle is removed from the location from which it is to be towed.

However, the prohibition set forth in this subdivision does not apply in any case in which a towing company tows a motor vehicle to a storage facility that includes a repair facility on the same site.

Sec. 2. A towing company or a storage facility shall not do any of the following:

(1) Upon payment of all costs incurred against a motor vehicle that is towed and stored under this article, refuse to release the motor vehicle to:

(A) a properly identified person who owns or holds a lien on the motor vehicle; or

(B) a representative of the insurance company that insures the motor vehicle, if the vehicle is covered by an active policy of insurance;

in accordance with the procedures, and subject to the same

requirements, set forth in IC 9-22-1-8 with respect to abandoned motor vehicles. However, a towing company or storage facility shall not release a motor vehicle in any case in which a law enforcement agency has ordered the motor vehicle not to be released, or in any case in which the motor vehicle cannot be released because of pending litigation.

(2) Refuse to permit:

(A) a properly identified person who owns or holds a lien on a motor vehicle; or

(B) a representative of the insurance company that insures the motor vehicle, if the vehicle is covered by an active policy of insurance;

to inspect the motor vehicle before all costs incurred against the motor vehicle are paid or the motor vehicle is released.

(3) Charge any storage fee for a stored motor vehicle with respect to any day on which:

(A) release of the motor vehicle; or

(B) inspection of the motor vehicle by the owner, lienholder, or insurance company;

is not permitted during normal business hours by the towing company or storage facility.

Chapter 8. Violations

Sec. 1. A person who violates this article commits a deceptive act that is:

(1) actionable under IC 24-5-0.5; and

(2) subject to the remedies and penalties set forth in IC 24-5-0.5.

Sec. 2. (a) The attorney general:

(1) shall receive; and

(2) may investigate;

complaints alleging one (1) or more violations of this article.

(b) After finding, either upon a complaint made or upon the attorney general's own investigation, that a violation of this article has occurred, the attorney general may take appropriate action under IC 24-5-0.5-4(c).

Sec. 3. The attorney general may adopt rules under IC 4-22-2 to implement this article, including emergency rules in the manner provided by IC 4-22-2-37.1. Notwithstanding IC 4-22-2-37.1(g), an emergency rule adopted by the attorney general under this section and in the manner provided by IC 4-22-2-37.1 expires on the date on which a rule that supersedes the emergency rule is adopted by the attorney general under IC 4-22-2-24 through IC 4-22-2-3

NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES
11 NYCRR 48
(INSURANCE REGULATION 210)

LIFE INSURANCE AND ANNUITY NON-GUARANTEED ELEMENTS

I, Maria T. Vullo, Superintendent of Financial Services, pursuant to the authority granted by Sections 202 and 302 of the Financial Services Law, and Sections 301, 1106, 1113, 3201, 3203, 3209, 3219, 3220, 3223, 4216, 4221, 4223, 4224, 4231, 4232, 4238, 4239, 4240, 4511, 4513, 4518 and Article 24 of the Insurance Law, do hereby promulgate a new Part 48 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Insurance Regulation 210) to take effect on March 19, 2018, to read as follows:

(ALL MATERIAL IS NEW)

Section 48.0 Purpose, scope, and unfair trade practice.

(a) The purpose of this Part is to establish standards for the determination and any readjustment of nonguaranteed elements that may vary at the insurer's discretion for life insurance policies and annuity contracts delivered or issued for delivery in this State, to ensure that policy forms do not contain provisions that may mislead policy owners as to the crediting of non-guaranteed amounts or the deduction of non-guaranteed charges, and to ensure that the issuance of any policy forms would not be prejudicial to the interest of owners or members or contain provisions that are unjust, unfair or inequitable.

(b) (1) This Part shall apply to any determination or readjustment of non-guaranteed elements occurring on or after the effective date of this Part, including any readjustment of non-guaranteed elements occurring on or after the effective date of this Part for life insurance policies or annuity contracts issued prior to the March 19, 2018.

(2) This Part shall apply to all individual life insurance policies, individual annuity contracts, and applicable group certificates, except as otherwise provided in this Part.

(3) This Part shall not apply to any corporate or bank owned individual life insurance policy or group life insurance certificate authorized by Insurance Law section 3205(a)(1)(B) or (d) where all benefits under the policy are payable to the corporate or bank policy owner.

(c) A contravention of this Part shall be deemed to be an unfair method of competition or an unfair or deceptive act and practice in the conduct of the business of insurance in this State, and shall be deemed to be a trade practice constituting a determined violation, as defined in section 2402(c) of the Insurance Law, in violation of section 2403.

Section 48.1 Definitions.

For purposes of this Part:

(a) *Adverse change in the current scale of non-guaranteed elements* means any change in the current scale of non-guaranteed elements that increases or may increase a charge or reduces or may reduce a benefit to the policy owner, other than a change in a credited interest rate or an index account parameter based entirely on changes in the insurer's expected investment income or hedging costs.

(b) *Anticipated experience factor* means an assumption as to a future experience factor as determined by the insurer.

(c) *Applicable group certificate* means any group life insurance or group annuity certificate where:

(1) the group life insurance certificate:

(i) may develop nonforfeiture values that are affected by non-guaranteed elements; or

(ii) the certificate holder is required to contribute to the cost of the certificate, the certificate allows for changes in the rate of the certificate holder's contributions, and there is a guaranteed maximum contribution scale that exceeds five years; or

(2) the group annuity certificate is:

(i) funding individual retirement accounts or individual retirement annuities, as defined in the Internal Revenue Code at 26 U.S.C. section 408,

(ii) funding annuities in accordance with the Internal Revenue Code at 26 U.S.C. section 403(b), or

(iii) providing a plan of retirement annuities under which the payments are derived substantially from funds contributed by the person covered.

(d) *Board-approved criteria* means written criteria adopted by the board of directors of an insurer, or a committee of directors thereof, that are the basis for determining non-guaranteed charges or benefits.

(e) *Class of policies* means all policies with similar expectations as to anticipated experience factors that are grouped together for the purpose of determining non-guaranteed elements.

(f) *Current scale of non-guaranteed elements* means the non-guaranteed elements that apply to a policy in the current and future years unless changed by the insurer.

(g) *Exempt policy provision* means a dividend provision, a provision providing for readjustments described in Insurance Law section 4231(g)(1)(C), or any other policy provision that gives the insurer discretion and that in the superintendent's opinion is not designed to allocate to the policy a portion of the anticipated financial experience of an insurer on the policy, such as minimum transaction amounts, maximum number of transactions, or limits on premiums or deposits. Exempt policy provision also means any separate account expense charge providing solely for the actual expense incurred, without profit to the insurer.

(h) *Experience factor* means a value or set of values consisting of investment income, mortality, morbidity, persistency, or expense that represents the insurer's financial experience on a class of policies. Profit margin is not an experience factor.

(i*) Indeterminate premium policy* means a life insurance policy as described in Insurance Law section 4231(g)(1)(D).

(j) *Index account parameter* means a feature impacting the net credited rate for an index account such as participation rate, cap, or spread.

(k) *Insurer* means an authorized life insurance company or authorized fraternal benefit society.

(l) *Non-guaranteed element* means any element within a policy provision other than an exempt policy provision that may be changed at the insurer's discretion without the consent or request of the policy owner and that affects the policy charges or benefits. Non-guaranteed element includes indeterminate premium policy rates, expense and benefit charge rates, interest crediting rates, cost of insurance rates, and index account parameter, but shall not include elements that are not within the insurer's discretion, such as the pass-through of variable fund returns. Non-guaranteed element does not include current annuity purchase rates.

(m) *Policy* means any individual life insurance policy, individual annuity contract, or applicable group certificate.

(n) *Pricing cell* means a collection of policies for which the same anticipated experience factors are used to determine the same current scale of non-guaranteed elements.

(o) *Profit margin* means expected revenues less costs.

(p) *Qualified actuary* means an individual who:

(1) is a member in good standing of the American Academy of Actuaries;

(2) meets the American Academy of Actuaries qualification standards for statements of actuarial opinion required by this Part;

(3) is an associate or fellow by examination of either the Society of Actuaries or the Institute of Actuaries or is designated in writing by the superintendent as a qualified

actuary after written application to the superintendent providing evidence of the actuary's actuarial knowledge and experience of non-guaranteed elements, and stating that the actuary is familiar with the New York Insurance Law and regulations promulgated thereunder and the current standards of practice of the American Academy of Actuaries involving non-guaranteed charges or benefits;

(4) has not been found by a commissioner or superintendent of insurance of any state, following appropriate notice and hearing, within the past five years, to:

(i) have violated any provision of, or any obligation imposed by, any law in the course of his or her dealings as a qualified actuary; or

(ii) have demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(5) has not resigned or been removed as a qualified actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards; and

(6) has not been convicted of any crime involving fraudulent or dishonest practices within the past five years.

Section 48.2 Non-guaranteed elements.

(a) (1) An insurer shall establish board-approved criteria for determining non-guaranteed charges or benefits.

(2) An insurer, in the assignment of policies into classes of policies, for the purpose of determining nonguaranteed elements:

(i) shall not unfairly discriminate among policies with similar expectations as to anticipated experience factors;

(ii) shall assign policies into classes based on sound actuarial principles;

(iii) shall assign policies with material differences in expected costs into different classes;

(iv) shall have sufficient refinement of classes to place reasonable limits on anti-selection;

(v) shall distinguish between policies when the cost of guarantees are not similar. For example, policies with a low guaranteed interest rate shall not be combined with policies with a high guaranteed interest rate;

(vi) may distinguish based on the date of policy issue with different issue periods;

(vii) shall not result in a change to a less favorable underwriting risk class applied to existing coverage than the underwriting risk class assigned to existing coverage prior to the change; and

(viii) shall be consistent with the language of the policy and the solicitation, advertising or other material provided by the insurer to the policy owner.

(b) Readjustments to non-guaranteed elements on existing policies shall be subject to the following:

(1) At the time of revision of a scale for an indeterminate premium policy, the difference from the point of revision between the revised scale and the scale in effect at the later of the date of issue or the date of last revision, shall be reasonably based on the difference from the point in time of revision and application of the anticipated experience factors underlying the two scales with respect to expenses, mortality, policy claims, taxes, investment income and lapses.

(2) At the time of revision of a scale of non-guaranteed elements for a policy subject to Insurance Law section 4232(b), the difference from the point in time of revision and application of the revised scale and the scale in effect at the later of the date of issue or the date of last revision, shall be reasonably based on the difference from the point of revision of the anticipated experience factors underlying the two scales with respect to expenses, mortality, investment income and persistency.

(3) At the time of revision of a scale of non-guaranteed elements for a policy subject to Insurance Law section 4232(a), the difference from the point in time of revision and application of the revised scale and the scale in effect at the later of the date of issue or the date of last revision, shall be reasonably based on the difference from the point of revision of the anticipated experience factors underlying the two scales with respect to expenses, mortality and investment income.

(4) At the time of revision of a scale of non-guaranteed elements for a policy not subject to paragraphs (1), (2), or (3) of this subdivision, the difference from the point in time of revision and application of the revised scale and the scale in effect at the later of the date of issue or the date of last revision, shall be reasonably based on the difference from the point of revision of the anticipated experience factors underlying the two scales.

(5) At the time of revision of a scale of non-guaranteed elements for a policy, an insurer shall not increase the profit margins at any policy duration above the profit margin projected at that duration at the date of issue of the policy, unless approved by the superintendent upon a finding that the increase is necessary due to the financial condition of the insurer.

(6) A readjustment to non-guaranteed elements on existing policies shall be based on expectations as to future experience and shall not recoup past losses. Experience factors from the later of the date of issue or the date of last revision and up until the time of new revision shall be assumed to equal the anticipated experience factors as of the later of the date of issue or the date of last revision.

(c) Any readjustment in non-guaranteed charges and benefits on in-force policies resulting from a change in board-approved criteria shall meet the requirements of subdivision (b) of this section.

(d) An insurer shall not consider cost of reinsurance agreements or other third party agreements, when changing non-guaranteed elements, if it would cause an adverse impact on non-guaranteed elements of any existing policy, unless the costs are consistent with the insurer's own anticipated experience assumptions and the insurer would have made the changes to the non-guaranteed elements in the absence of the costs.

(e) An insurer's procedures for readjustment of non-guaranteed elements on an assumed or acquired class of business shall not be less favorable to policy owners than the procedures used by the original insurer when the policies in the class were issued, unless approved by the superintendent upon a finding that the increase is necessary due to the financial condition of the original insurer.

(f) The board-approved criteria shall:

(1) require that anticipated experience factors be consistent with experience that is credible and relevant, if any;

(2) require the examination, as needed, of anticipated experience factors at specified times and under specified conditions but no less frequently than required by law to determine if the factors are reasonable; and

(3) include a statement of the maximum period, not to exceed five years, between reviews of anticipated experience factors and non-guaranteed elements for reasonableness.

(g) In addition to the criteria required under subdivision (f) of this section, board-approved criteria also may include:

(1) an amount of in-force policies, either by number issued or premium volume, below which no changes in an anticipated experience factor will be made because of a lack of statistical credibility;

(2) a minimum change in anticipated experience factors that will result in readjustment to non-guaranteed elements, provided that the minimum change: shall be reasonable in relation to the value provided to the policy owner and the cost of implementing a change in non-guaranteed elements; and the minimum change in

anticipated experience factors that cause a readjustment in non-guaranteed elements favorable to policy owners shall be no greater than the minimum change in anticipated experience factors that causes a change in non-guaranteed elements adverse to policy owners; and

(3) averaging, smoothing, interpolating and rounding that are reasonable in relation to the values and benefits provided and that do not have a bias toward reducing policy benefits or values.

(h) Board-approved criteria shall place reasonable limits on the policy owner's exposure to higher unit expense costs from discontinued sales or a volume of sales significantly less than anticipated.

Section 48.3 Disclosure to policy owner.

(a) An insurer shall provide to a policy owner (other than an owner of a group annuity certificate used to fund an employee benefit plan within the meaning of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001 et seq.) the current scale of non-guaranteed elements no later than the date of issue, either in the policy, application, illustration of the policy as sold, or a special disclosure document, in a manner that will allow an easy comparison to the corresponding guarantees. For the purpose of Part 53 of this Title (Insurance Regulation 74), the special disclosure document by itself shall not constitute an illustration.

(b) An insurer shall provide a disclosure document to a policy owner (other than an owner of a group annuity certificate used to fund an employee benefit plan within the meaning of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001 et seq.) at least 60 days prior to any adverse change in the current scale of non-guaranteed elements. Using the same terminology that is used in the policy, the disclosure shall contain:

(1) the non-guaranteed elements that have changed;

(2) the new current scale of non-guaranteed elements;

(3) the prior current scale of non-guaranteed elements since the last disclosure;

(4) the guaranteed scale; and

(5) a prominent description of any adverse change in the current scale of non-guaranteed elements identifying the nature of the change and that the change is adverse or the conditions under which the change would be adverse.

Section 48.4 Filing and records requirements.

(a) An insurer shall obtain an actuarial memorandum signed and dated by a qualified actuary:

(1) prior to the issuance of any policy of a new policy form;

(2) prior to the issuance of any policy of a policy form for which the non-guaranteed elements have been changed for only new issues; and

(3) prior to any change to the non-guaranteed elements of an existing policy other than a change in a credited interest rate or an index account parameter based entirely on changes in the insurer's expected investment income or hedging costs.

(b) The actuarial memorandum shall contain the following as applicable:

(1) sufficient detail of the pricing assumptions by duration of the current scale of non-guaranteed elements and the anticipated experience factors on which they are based. The information shall include:

(i) premium;

(ii) gross investment returns;

(iii) investment expenses;

(iv) investment defaults;

(v) credited rates and index account parameters;

(vi) policyholder behavior assumptions including option elections and persistency;

(vii) benefits paid;

(viii) mortality rates;

(ix) morbidity rates;

(x) insurance expenses, including the allocation of tax, sale, maintenance, service and overhead expenses;

(xi) profit margins;

(xii) policy expense charges; and

(xiii) policy benefit charges;

(2) a description of the experience or other information used to determine the anticipated experience factors, including a description of the reasoning and analysis that led from the information to the anticipated experience factors;

(3) a description of the processes and methods used in the determination of non-guaranteed elements for a pricing cell from the anticipated experience factors;

(4) any formula used to determine index account parameters and a description of the index formula;

(5) the investment strategy, which shall include:

(i) a description of the method used for the allocation of investment income, specifying how trading gains and losses due to interest rate changes are allocated; and

(ii) a description of the methods used to assess deductions from gross earned rates for default, investment expenses and risk items; and

(6) a statement signed and dated by a qualified actuary that the anticipated experience factors in the actuarial memorandum are reasonable assumptions and are the basis for determining the scale of non-guaranteed elements, and that the actuary is familiar with the current requirements in this State for non-guaranteed elements.

(c) An insurer shall have procedures in place to require a qualified actuary acting on the insurer's behalf to notify the insurer of any action specified in sections 48.1(p)(4), (5), and (6) of this Part. The insurer shall notify the superintendent of the action taken against the actuary as soon as practicable.

(d) An insurer shall file any adverse change in the current scale of non-guaranteed elements applicable to existing life insurance policies or applicable group life insurance certificates with the superintendent at least 120 days prior to implementation. The filing shall include:

(1) the actuarial memorandum required by subdivision (a) of this section;

(2) a tabulation of all proposed changes in the current scale of non-guaranteed elements by pricing cell giving the current scale of non-guaranteed elements, the proposed current scale of non-guaranteed elements, and the changes in the non-guaranteed elements;

(3) a tabulation of all changes in the anticipated experience factors and profit margins by pricing cell giving the prior anticipated experience factors and profit margins, the current anticipated experience factors and profit margins, and the changes in the anticipated experience factors and profit margins;

(4) a narrative description of experience or other rationale that explain the changes in anticipated experience factors; and

(5) for pricing cells, a narrative description of any changes in the methods or procedures for determining non-guaranteed elements from the anticipated experience factors.

(e) By May 1 of each year, the insurer shall file with the superintendent a listing of any adverse change in the current scale of non-guaranteed elements of any existing policy that occurred in the prior calendar year. The filing shall include a statement signed and dated by a qualified actuary that all changes were in compliance with this Part.

(f) An insurer shall provide all records required by this Part to the Superintendent upon request.

(g) The insurer shall maintain in its records, for six years after the termination of the last policy subject to the board-approved criteria, the written documentation of the determination of non-guaranteed elements required by this Part. The insurer shall maintain the written documentation in accordance with section 243.3 of this Title (Insurance Regulation 152).

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National Council of Insurance Legislators (NCOIL)

Resolution In Support of Short Term Medical Plans

To be discussed by the NCOIL Health, Long Term Care and Health Retirement Issues Committee on March 4, 2018

****Sponsored by Rep. Justin Hill (MO)***

Whereas, the Affordable Care Act was designed to offer guaranteed issued coverage and stabilize risk pools through several different means of federal funding mechanisms; and,

Whereas, since the Affordable Care Act's inception, those mechanisms have not been fully funded causing destabilized risk pools; and,

Whereas, most insurance carriers have ceased participation in Federal and State exchanges; and, the individual market has seen premium increases in amounts greater than 100 percent; and,

Whereas, fewer people enrolled in coverage in 2018 and estimates project further decline and consumers are looking for more affordable coverage alternatives; and,

Whereas, many consumers are enrolling in short-term medical plans which are underwritten and more affordable; and,

Whereas, in an effort to discourage consumers from short-term medical plans, the Obama Administration limited short-term medical plans to a 90 day duration; and,

Whereas, consumers that elect short-term medical plans run the risk of having a major medical event without the ability to renew their coverage after 90 days;

Therefore, be it resolved, that the National Council of Insurance Legislators encourages the US Department of Health and Human Services, US Department of Labor, and US Treasury to rescind the rulemaking decision of 2017 that limited short-term medical policies to 90 days and restate the rule to allow 364 days of coverage.

California Senate Bill No. 17
CHAPTER 603

An act to amend Sections 1385.045 and 127280 of, to add Section 1367.243 to, to add Chapter 9 (commencing with Section 127675) to Part 2 of Division 107 of, and to repeal Section 127686 of, the Health and Safety Code, and to amend Section 10181.45 of, and to add Section 10123.205 to, the Insurance Code, relating to health care.

[Approved by Governor October 09, 2017. Filed with Secretary of State October 09, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

SB 17, Hernandez. Health care: prescription drug costs.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care (DMHC) and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance (DOI). Existing law requires health care service plans and health insurers to file specified rate information with DMHC or DOI, as applicable, for health care service plan contracts or health insurance policies in the individual or small group markets and for health care service plan contracts and health insurance policies in the large group market. Existing law requires health care service plans and health insurers to also disclose specified supporting information for the rate information described above. Existing law requires the DMHC and DOI, as applicable, to conduct an annual public meeting regarding large group rates within 3 months of posting that information.

This bill would require health care service plans or health insurers that file the above-described rate information to report to DMHC or DOI, on a date no later than the reporting of the rate information, specified cost information regarding covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs, dispensed as provided. DMHC and DOI would be required to compile the reported information into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums and publish the reports on their Internet Web sites by January 1 of each year. Except for the report, DMHC and DOI would be required to keep confidential all information provided pursuant to these provisions. The bill would also require health care service plans or health insurers that file the above-described rate information to disclose to DMHC and DOI with the rate information specified information regarding the relation of prescription drug costs to plan or insurer spending and premium charges. The bill would instead require DMHC and DOI to conduct an annual public meeting within 4 months of posting the rate information described above. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The bill would require a manufacturer of a prescription drug with a wholesale acquisition cost of more than $40 that is purchased or reimbursed by specified purchasers, including state agencies, health care service plans, health insurers, and pharmacy benefit managers, to notify the purchaser

of an increase in the wholesale acquisition cost of a prescription drug if the increase in the wholesale acquisition cost for a course of therapy, as defined, exceeds a specified threshold. The bill would require that notice to be given at least 60 days prior to the planned effective date of the increase. Commencing no earlier than January 1, 2019, the bill would require the manufacturer to notify the Office of Statewide Health Planning and Development (OSHPD) of specified information relating to that increase in wholesale acquisition cost on a quarterly basis at a time and in a format prescribed by the office. The bill would require the manufacturer to notify OSHPD of specified information relating to the wholesale acquisition cost, marketing, and usage of a new prescription drug if the cost exceeds a specified threshold, and would require OSHPD to publish that information on its Internet Web site, as specified. The bill would require OSHPD to enforce the provisions requiring manufacturer reporting to OSHPD and would subject a manufacturer to liability for a civil penalty if the information described above is not reported. The bill would authorize OSHPD to adopt regulations or issue guidance for the implementation of these provisions. The bill would require the California Research Bureau to report to the Legislature on the implementation of these provisions, and would subject these provisions to review by the appropriate policy committees of the Legislature, as specified.

Existing law establishes the California Health Data and Planning Fund within the office for the purpose of receiving and expending certain fee revenues. Existing law establishes the Managed Care Fund for the purpose of supporting the administration of DMHC. Existing law establishes the Insurance Fund for, among other things, the support of DOI as authorized in the annual Budget Act.

This bill would prohibit the use of any moneys in the fund from being used for the implementation of these provisions. The bill would provide that funding for the office to conduct the activities described above shall be provided, subject to appropriation by the Legislature, from transfers of moneys from the Managed Care Fund and the Insurance Fund, as specified.

This bill would provide that the above-described provisions are severable.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.
This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.243 is added to the Health and Safety Code, to read:

1367.243. (a) (1) A health care service plan that reports rate information pursuant to Section 1385.03 or 1385.045 shall report the information described in paragraph (2) to the department no later than October 1 of each year, beginning October 1, 2018.

(2) For all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be reported:

(A) The 25 most frequently prescribed drugs.

(B) The 25 most costly drugs by total annual plan spending.

(C) The 25 drugs with the highest year-over-year increase in total annual plan spending.

(b) The department shall compile the information reported pursuant to subdivision (a) into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. The data in the report shall be aggregated and shall not reveal information specific to individual health care service plans.

(c) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

(d) By January 1 of each year, beginning January 1, 2019, the department shall publish on its Internet Web site the report required pursuant to subdivision (b).

(e) After the report required in subdivision (b) is released, the department shall include the report as part of the public meeting required pursuant to subdivision (b) of Section 1385.045.

(f) Except for the report required pursuant to subdivision (b), the department shall keep confidential all of the information provided to the department pursuant to this section, and the information shall be protected from public disclosure.

SEC. 2. Section 1385.045 of the Health and Safety Code is amended to read:

1385.045. (a) For large group health care service plan contracts, each health plan shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of enrollees in each large group benefit design in the plan's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct an annual public meeting regarding large group rates within four months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health care service plan subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of enrollees.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.
(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Enrollees' share of premiums.

(H) Enrollees' cost sharing, including cost sharing for prescription drugs.

(I) Covered benefits in addition to basic health care services, as defined in Section 1345, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3) (A) The plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories, to the maximum extent possible, that are the same as, or similar to, those used by other plans.

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual plan contract trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(C) A comparison of the aggregate per enrollee per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in enrollee cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in enrollee cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of enrollees.

(E) Any changes in enrollee benefits over the prior year, including a description of benefits added or eliminated, as well as any aggregate changes, as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts since the plan's prior year's information pursuant to this section for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health plan.

(4) (A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member, per-month total health plan spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium.

(iv) The specialty tier formulary list.

(B) The plan shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.
(C) (i) The plan shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The plan shall also include the name or names of the pharmacy benefit manager, or managers if the plan uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2018, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 1385.07.

(e) For the purposes of this section, a “specialty drug” is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

SEC. 3. Section 127280 of the Health and Safety Code is amended to read:

127280. (a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall each year be charged a fee established by the office consistent with the requirements of this section.

(b) Commencing in calendar year 2004, every freestanding ambulatory surgery clinic as defined in Section 128700, shall each year be charged a fee established by the office consistent with the requirements of this section.

(c) The fee structure shall be established each year by the office to produce revenues equal to the appropriation made in the annual Budget Act or another statute to pay for the functions required to be performed by the office pursuant to this chapter, Article 2 (commencing with Section 127340) of Chapter 2, or Chapter 1 (commencing with Section 128675) of Part 5, and to pay for any other health-related programs administered by the office. The fee shall be due on July 1 and delinquent on July 31 of each year.

(d) The fee for a health facility that is not a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(e) The fee for a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(f) (1) The fee for a freestanding ambulatory surgery clinic shall be established at an amount equal to the number of ambulatory surgery data records submitted to the office pursuant to Section 128737 for encounters in the preceding calendar year multiplied by not more than fifty cents ($0.50).

(2) (A) For the calendar year 2004 only, a freestanding ambulatory surgery clinic shall estimate the number of records it will file pursuant to Section 128737 for the calendar year 2004 and shall report that number to the office by March 12, 2004. The estimate shall be as accurate as possible. The fee in the calendar year 2004 shall be established initially at an amount equal to the estimated number of records reported multiplied by fifty cents ($0.50) and shall be due on July 1 and delinquent on July 31, 2004.

(B) The office shall compare the actual number of records filed by each freestanding clinic for the calendar year 2004 pursuant to Section 128737 with the estimated number of records reported pursuant to subparagraph (A). If the actual number reported is less than the estimated number reported, the office shall reduce the fee of the clinic for calendar year 2005 by the

amount of the difference multiplied by fifty cents ($0.50). If the actual number reported exceeds the estimated number reported, the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents ($0.50) unless the actual number reported is greater than 120 percent of the estimated number reported, in which case the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference, up to and including 120 percent of the estimated number, multiplied by fifty cents ($0.50), and by the amount of the difference in excess of 120 percent of the estimated number multiplied by one dollar ($1).

(g) There is hereby established the California Health Data and Planning Fund within the office for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(h) Any amounts raised by the collection of the special fees provided for by subdivisions (d), (e), and (f) that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office in succeeding years when appropriated by the Legislature in the annual Budget Act or another statute, for expenditure under the provisions of this chapter, Article 2 (commencing with Section 127340) of Chapter 2, and Chapter 1 (commencing with Section 128675) of Part 5, or for any other health-related programs administered by the office, and shall reduce the amount of the special fees that the office is authorized to establish and charge. In no event, however, shall those amounts be used for programs administered by the office pursuant to Sections 127676, 127679, 127681, 127683, and 127685, that become effective on or after January 1, 2019.

(i) (1) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. A new, previously unlicensed, health facility shall be charged a pro rata fee to be established by the office during the first year of operation.
(2) The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (c).

(j) This section shall become operative on January 1, 2002.

SEC. 4. Chapter 9 (commencing with Section 127675) is added to Part 2 of Division 107 of the Health and Safety Code, to read:

CHAPTER 9. Prescription Drug Pricing for Purchasers

127675. (a) This chapter shall apply to a manufacturer of a prescription drug that is purchased or reimbursed by any of the following:

(1) A state purchaser in California, including, but not limited to, the Public Employees' Retirement System, the State Department of Health Care Services, the Department of General Services, and the Department of Corrections and Rehabilitation, or an entity acting on behalf of a state purchaser.

(2) A licensed health care service plan.

(3) A health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(4) A pharmacy benefit manager as defined in subdivision (j) of Section 4430 of the Business and Professions Code.

(b) For the purposes of this chapter, the term "office" shall mean the Office of Statewide Health Planning and Development.

127676. (a) The Legislature finds and declares that the State of California has a substantial public interest in the price and cost of prescription drugs. California is a major purchaser through the Public Employees' Retirement System, the State Department of Health Care Services, the Department of General Services, the Department of Corrections and Rehabilitation, and other entities acting on behalf of a state purchaser. California also provides major tax expenditures through the tax exclusion of employer sponsored coverage and tax deductibility of coverage purchased by individuals, as well as tax deductibility of excess health care costs for individuals and families.

(b) (1) It is the intent of the Legislature in enacting this chapter to provide notice and disclosure of information relating to the cost and pricing of prescription drugs in order to provide accountability to the state for prescription drug pricing.

(2) It is further the intent of the Legislature to permit a manufacturer of a prescription drug to voluntarily make pricing decisions regarding a prescription drug, including any price increases. It is further the intent of the Legislature to permit purchasers, both public and private, as well as pharmacy benefit managers, to negotiate discounts and rebates consistent with existing state and federal law.

127677. (a) A manufacturer of a prescription drug with a wholesale acquisition cost of more than forty dollars ($40) for a course of therapy shall notify each purchaser described in Section 127675 if the increase in the wholesale acquisition cost of a prescription drug is more than 16 percent, including the proposed increase and the cumulative increases that occurred within the previous two calendar years prior to the current year. For purposes of this section, a "course of therapy" is defined as either of the following:

(1) The recommended daily dosage units of a prescription drug pursuant to its prescribing label as approved by the federal Food and Drug Administration for 30 days.

(2) The recommended daily dosage units of a prescription drug pursuant to its prescribing label as approved by the federal Food and Drug Administration for a normal course of treatment that is less than 30 days.

(b) The notice required by subdivision (a) shall be provided in writing at least 60 days prior to the planned effective date of the increase.

(c) (1) The notice required by subdivision (a) shall include the date of the increase, the current wholesale acquisition cost of the prescription drug, and the dollar amount of the future increase in the wholesale acquisition cost of the prescription drug.

(2) The notice required by subdivision (a) shall include a statement regarding whether a change or improvement in the drug necessitates the price increase. If so, the manufacturer shall describe the change or improvement.

(d) The notice required by subdivision (a) shall be provided to each state purchaser and other purchasers described in paragraphs (2) to (4), inclusive, of subdivision (a) of Section 127675 if a purchaser registers with the office for the purpose of this notification. The office shall make available to manufacturers a list of registered purchasers for the purpose of this notification.

(e) If a pharmacy benefit manager receives a notice of an increase in wholesale acquisition cost consistent with subdivision (a), it shall notify its large contracting public and private purchasers of the increase. For the purposes of this section, a "large purchaser" means a purchaser that provides coverage to more than 500 covered lives.

127679. (a) On a quarterly basis at a time prescribed by the office and in a format prescribed by the office, commencing no earlier than January 1, 2019, a manufacturer shall report to the office all of the following information for each drug for which an increase in wholesale acquisition cost is described in Section 127677:

(1) A description of the specific financial and nonfinancial factors used to make the decision to increase the wholesale acquisition cost of the drug and the amount of the increase, including, but not limited to, an explanation of how these factors explain the increase in the wholesale acquisition cost of the drug.

(2) A schedule of wholesale acquisition cost increases for the drug for the previous five years if the drug was manufactured by the company.

(3) If the drug was acquired by the manufacturer within the previous five years, all of the following information:

(A) The wholesale acquisition cost of the drug at the time of acquisition and in the calendar year prior to acquisition.

(B) The name of the company from which the drug was acquired, the date acquired, and the purchase price.

(C) The year the drug was introduced to market and the wholesale acquisition cost of the drug at the time of introduction.

(4) The patent expiration date of the drug if it is under patent.

(5) If the drug is a multiple source drug, an innovator multiple source drug, a noninnovator multiple source drug, or a single source drug, as defined in subparagraph (A) of paragraph (7) of subdivision (k) of Section 1396r–8 of Title 42 of the United States Code.

(6) A description of the change or improvement in the drug, if any, that necessitates the price increase.

(7) Volume of sales of the manufacturer's drug in the United States for the previous year.

(b) The manufacturer may limit the information reported pursuant to subdivision (a) to that which is otherwise in the public domain or publicly available.

(c) The office shall publish the information provided to it pursuant to this section on its Internet Web site on no less than a quarterly basis. The information shall be published within 60 days of receipt from a manufacturer. The information shall be published in a manner that identifies the information that is disclosed on a per-drug basis and shall not be aggregated in a manner that would not allow identification of the drug.

(d) The office shall be responsible for the enforcement of this section.

(e) A manufacturer of a prescription drug subject to this chapter that does not report the information required pursuant to this section is liable for a civil penalty of one thousand dollars ($1,000) per day for every day after the reporting period described in this section that the required information is not reported.
(f) A civil penalty shall be assessed and recovered in a civil action brought by the office in the name of the people of the State of California. Assessment of a civil penalty may, at the request of any manufacturer of a prescription drug subject to this section, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(g) Any money received by the office pursuant to this section shall be paid into the Managed Care Fund.

127681. (a) A manufacturer of a prescription drug shall notify the office in writing if it is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)). The notice shall be provided in writing within three days after the release of the drug in the commercial market. A manufacturer may make this notification pending approval by the federal Food and Drug Administration, if commercial availability is expected within three days of approval.

(b) No later than 30 days after notification pursuant to this section, a manufacturer shall report all of the following information to the office in a format prescribed by the office:

(1) A description of the marketing and pricing plans used in the launch of the new drug in the United States and internationally.

(2) The estimated volume of patients that may be prescribed the drug.

(3) If the drug was granted breakthrough therapy designation or priority review by the federal Food and Drug Administration prior to final approval.

(4) The date and price of acquisition if the drug was not developed by the manufacturer.

(c) The manufacturer may limit the information reported pursuant to subdivision (b) to that which is otherwise in the public domain or publicly available.

(d) The office shall publish the information provided to it pursuant to this section on its Internet Web site on no less than a quarterly basis. The information shall be published in a manner that identifies the information that is disclosed on a per-drug basis and shall not be aggregated in a manner that would not allow identification of the drug.

(e) The office shall be responsible for the enforcement of this section.

(f) A manufacturer of a prescription drug subject to this chapter that does not report the information required pursuant to this section is liable for a civil penalty of one thousand dollars ($1,000) per day for every day after the notification period described in this section that the required information is not reported.

(g) A civil penalty shall be assessed and recovered in a civil action brought by the office in the name of the people of the State of California. Assessment of a civil penalty may, at the request of any manufacturer of a prescription drug subject to this section, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(h) Any money received by the office pursuant to this section shall be paid into the Managed Care Fund.

127683. (a) Funding for the actual and necessary expenses of the office to conduct the activities described in this section and in Sections 127676, 127679, 127681, and 127685, shall be provided, subject to appropriation by the Legislature, from transfers of moneys from the Managed Care Fund and the Insurance Fund.

(b) The share of funding from the Managed Care Fund shall be based on the number of covered lives in the state that are covered under plans regulated by the Department of Managed Health Care, including covered lives under Medi-Cal managed care, as determined by the Department of Managed Health Care, in proportion to the total number of all covered lives in the state.

(c) The share of funding to be provided from the Insurance Fund shall be based on the number of covered lives in the state that are covered under health insurance policies and benefit plans regulated by the Department of Insurance, including covered lives under Medicare supplement plans, as determined by the Department of Insurance, in proportion to the total number of all covered lives in the state.

127685. (a) The office may adopt regulations or issue guidance for the implementation of this chapter. All information that is required to be reported to the office pursuant to this chapter shall be reported in a form prescribed by the office, commencing in the first calendar quarter of 2019.

(b) The office may consult with the Department of Managed Health Care, the Department of Insurance, the California State Board of Pharmacy, and any state purchaser of prescription drugs, or an entity acting on behalf of a state purchaser, in issuing guidance or adopting necessary regulations pursuant to subdivision (a), in posting information on its Internet Web site pursuant to this chapter, and in taking any other action for the purpose of implementing this chapter.

127686. (a) By January 1, 2022, the California Research Bureau shall report to the Legislature on the implementation of this chapter, including, but not limited to, this chapter's effectiveness in addressing the following goals:

(1) Promoting transparency in pharmaceutical pricing for the state and other payers.

(2) Enhancing understanding about pharmaceutical spending trends.

(3) Assisting the state and other payers in management of pharmaceutical drug costs.
(b) A report submitted pursuant to subdivision (a) shall be submitted in compliance with Section 9795 of the Government Code.

(c) Notwithstanding any other law, implementation of this chapter shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed on January 1, 2023.

(d) This section shall remain in effect only until January 1, 2024, and as of that date is repealed.

SEC. 5. Section 10123.205 is added to the Insurance Code, to read:

10123.205. (a) (1) A health insurer that reports rate information pursuant to Section 10181.3 or 10181.45 shall report the information described in paragraph (2) to the department no later than October 1 of each year, beginning October 1, 2018.

(2) For all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be reported:

(A) The 25 most frequently prescribed drugs.

(B) The 25 most costly drugs by total annual plan spending.

(C) The 25 drugs with the highest year-over-year increase in total annual plan spending.

(b) The department shall compile the information reported pursuant to subdivision (a) into a report for the public and legislators that demonstrates the overall impact of drug costs on health

care premiums. The data in the report shall be aggregated and shall not reveal information specific to individual health insurers.

(c) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

(d) By January 1 of each year, beginning January 1, 2018, the department shall publish on its Internet Web site the report required pursuant to subdivision (b).

(e) After the report required in subdivision (b) is released, the department shall include the report as part of the public meeting required pursuant to subdivision (b) of Section 10181.45.

(f) Except for the report required pursuant to subdivision (b), the department shall keep confidential all of the information provided to the department pursuant to this section, and the information shall be protected from public disclosure.

SEC. 6. Section 10181.45 of the Insurance Code is amended to read:

10181.45. (a) For large group health insurance policies, each health insurer shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of insureds in each large group benefit design in the insurer's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A health insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct an annual public meeting regarding large group rates within four months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health insurer subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of insureds.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Insureds' share of premiums.

(H) Insureds' cost sharing, including cost sharing for prescription drugs.

(I) Covered benefits in addition to basic health care services, as defined in Section 1345 of the Health and Safety Code, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3) (A) The insurer's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year. A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the health insurer's insureds shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories, to the maximum extent possible, that are the same or similar to those used by other insurers.

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual policy trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the insureds shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other insurers.

(C) A comparison of the aggregate per insured per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in insured cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in insured cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of insureds.

(E) Any changes in insured benefits over the prior year, including a description of benefits added or eliminated as well as any aggregate changes as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts made since the insurer's prior year's information pursuant to this section for the same category of health insurer. To the extent possible, the insurer shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health insurer.

(4) (A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty

drugs dispensed at a pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member, per-month total health insurer spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium.

(iv) The specialty tier formulary list.
(B) The insurer shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The insurer shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The insurer shall also include the name or names of the pharmacy benefit manager, or managers if the insurer uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2016, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 10181.7.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

SEC. 7. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 8. The Legislature finds and declares that Sections 1 and 5 of this act, which add Section 1367.243 to the Health and Safety Code and Section 10123.205 to the Insurance Code, respectively, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:
In order to protect proprietary, confidential information regarding health care service plan and health insurer prescription drug utilization and spending information that is specific to the plan or

insurer and to protect the integrity of the competitive market, it is necessary that this act limit the public's right of access to that information.

SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

No. 165. An act relating to prescription drugs.

(S.216)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. FINDINGS

The General Assembly finds that:

(1) The costs of prescription drugs have been increasing dramatically without any apparent reason.

(2) Containing health care costs requires containing prescription drug costs.

(3) In order to contain prescription drug costs, it is essential to understand the drivers of those costs, as transparency is typically the first step toward cost containment.

Sec. 2. 18 V.S.A. § 4635 is added to read:

§ 4635. PHARMACEUTICAL COST TRANSPARENCY

(a) As used in this section:

(1) "Manufacturer" shall have the same meaning as "pharmaceutical manufacturer" in section 4631a of this title.

(2) "Prescription drug" means a drug as defined in 21 U.S.C. § 321.

(b)(1) The Green Mountain Care Board, in collaboration with the Department of Vermont Health Access, shall identify annually up to 15 prescription drugs on which the State spends significant health care dollars and for which the wholesale acquisition cost has increased by 50 percent or more over the past five years or by 15 percent or more over the past 12 months, creating a substantial public interest in understanding the development of the drugs' pricing. The drugs identified shall represent different drug classes.

(2) The Board shall provide to the Office of the Attorney General the list of prescription drugs developed pursuant to this subsection and the percentage of the wholesale acquisition cost increase for each drug and shall make the information available to the public on the Board's website.

(c)(1) For each prescription drug identified pursuant to subsection (b) of this section, the Office of the Attorney General shall require the drug's manufacturer to provide a justification for the

increase in the wholesale acquisition cost of the drug in a format that the Attorney General determines to be understandable and appropriate. The manufacturer shall submit to the Office of the Attorney General all relevant information and supporting
documentation necessary to justify the manufacturer's wholesale acquisition cost increase, which may include:

(A) all factors that have contributed to the wholesale acquisition cost increase;

(B) the percentage of the total wholesale acquisition cost increase attributable to each factor; and

(C) an explanation of the role of each factor in contributing to the wholesale acquisition cost increase.

(2) Nothing in this section shall be construed to restrict the legal ability of a prescription drug manufacturer to changes prices to the extent permitted under federal law.

(d) The Attorney General, in consultation with the Department of Vermont Health Access, shall provide a report to the General Assembly on or before December 1 of each year based on the information received from manufacturers pursuant to this section. The Attorney General shall also post the report on the Office of the Attorney General's website.

(e) Information provided to the Office of the Attorney General pursuant to this section is exempt from public inspection and copying under the Public Records Act and shall not be released in a manner that allows for the identification of an individual drug or manufacturer or that is likely to compromise the financial, competitive, or proprietary nature of the information.

(f) The Attorney General may bring an action in the Civil Division of the Superior Court, Washington County for injunctive relief, costs, and attorney's fees, and to impose on a manufacturer that fails to provide the information required by subsection (c) of this section a civil penalty of no more than $10,000.00 per violation. Each unlawful failure to provide information shall constitute a separate violation. In any action brought pursuant to this section, the Attorney General shall have the same authority to investigate and to obtain remedies as if the action were brought under the Consumer Protection Act, 9 V.S.A. chapter 63.

Sec. 3. PRESCRIPTION DRUG FORMULARIES; RULEMAKING

On or before January 1, 2017, the Commissioner of Financial Regulation shall adopt rules pursuant to 3 V.S.A. chapter 25 to require all health insurers that offer health benefit plans to Vermont residents through the Vermont Health Benefit Exchange to provide information to enrollees, potential enrollees, and health care providers about the Exchange plans' prescription drug formularies. The rules shall ensure that the formulary is posted online in a standard format established by the Department of Financial Regulation; that the formulary is updated frequently and is searchable by enrollees, potential enrollees, and health care providers; and that it includes information about the prescription drugs covered, applicable cost-sharing amounts, drug tiers, prior authorization, step therapy, and utilization management requirements.

Sec. 4. 340B DRUG DISPENSING FEES

(a) The Department of Vermont Health Access shall use the same dispensing fee in its reimbursement formula for 340B prescription drugs as the Department uses to pay for non-340B prescription drugs under the Medicaid program.

(b) Notwithstanding the provisions of subsection (a) of this section, the Department is authorized to modify the dispensing fee or reimbursement formula provided to federally qualified health centers and Title X family planning clinics for dispensing 340B prescription drugs to Medicaid beneficiaries.

Sec. 5. 340B DRUG REIMBURSEMENT; REPORT

(a) The Department of Vermont Health Access shall:

(1) determine the formula used by other states' Medicaid programs to reimburse covered entities that use 340B pricing for dispensing prescription drugs to Medicaid beneficiaries;

(2) evaluate the advantages and disadvantages of using the same dispensing fee in its reimbursement formula for 340B prescription drugs as the Department uses to pay for non-340B prescription drugs under the Medicaid program; and

(3) identify the benefits, if any, of 340B drug pricing to consumers, other payers, and the overall health care system.

(b) On or before March 15, 2017, the Department shall report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance regarding its findings and recommendations, including recommended modifications to Vermont's 340B reimbursement formula, if any, and the financial implications of implementing any recommended modifications.

Sec. 6. OUT-OF-POCKET PRESCRIPTION DRUG LIMITS; 2018 PILOT; REPORTS

(a) The Department of Vermont Health Access shall convene an advisory group to develop options for bronze-level qualified health benefit plans to be offered on the Vermont Health Benefit Exchange for the 2018 plan year, including:

(1) one or more plans with a higher out-of-pocket limit on prescription drug coverage than the limit established in 8 V.S.A. § 4089i; and
(2) two or more plans with an out-of-pocket limit at or below the limit established in 8 V.S.A. § 4089i.

(b) The advisory group shall include at least the following members:

(1) the Commissioner of Vermont Health Access or designee;

(2) a representative of each of the commercial health insurers offering plans on the Vermont Health Benefit Exchange;

(3) a representative of the Office of the Vermont Health Advocate;

(4) a member of the Medicaid and Exchange Advisory Board, appointed by the Commissioner;

(5) a representative of Vermont's AIDS services organizations;

(6) a consumer appointed by Vermont's AIDS services organizations;

(7) a representative of the American Cancer Society;

(8) a consumer appointed by the American Cancer Society; and

(9) a Vermont Health Connect navigator.

(c)(1) The advisory group shall meet at least six times prior to the Department submitting plan designs to the Green Mountain Care Board for approval.

(2) In developing the standard qualified health benefit plan designs for the 2018 plan year, the Department of Vermont Health Access shall present the recommendations of the advisory committee established pursuant to subsection

(a) of this section to the Green Mountain Care Board.

(d)(1) Prior to the date on which qualified health plan forms must be filed with the Department of Financial Regulation pursuant to 8 V.S.A. § 4062, a health insurer offering qualified health benefit plans on the Vermont Health Benefit Exchange shall seek approval from the Green Mountain Care Board to modify the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for one or more nonstandard bronze-level plans. In considering an insurer's request, the Green Mountain Care Board shall provide an opportunity for the advisory group established in subsection (a) of this section, and any other interested party, to comment on the recommended modifications.

(2)(A) Notwithstanding any provision of 8 V.S.A. § 4089i to the contrary, the Green Mountain Care Board may approve modifications to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for one or more bronze-level plans for the 2018 plan year only.

(B) For the 2018 plan year, the Department of Vermont Health Access shall certify at least two standard bronze-level plans that include the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i, as long as the plans comply with federal requirements. Notwithstanding any provision of 8 V.S.A. § 4089i to the contrary, the Department may certify one or more bronze-level qualified health benefit plans with modifications to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for the 2018 plan year only.

(e)(1) For each individual enrolled in a bronze-level qualified health benefit plan for plan years 2016 and 2017 who had out-of-pocket prescription drug expenditures during the 2016 plan year that met the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i, the health insurer shall, absent an alternative plan selection or plan cancellation by the individual, automatically reenroll the individual in a bronze-level qualified health benefit plan for plan year 2018 with an out-of-pocket prescription drug limit at or below the limit established in 8 V.S.A. § 4089i.

(2) Prior to reenrolling the individual in a plan pursuant to subdivision (1) of this subsection, the health insurer shall notify the individual of the insurer's intent to reenroll automatically the individual in a bronze-level plan for plan year 2018 with an out-of-pocket prescription drug limit at or below the limit established in 8 V.S.A. § 4089i and of the availability of bronze-level plans with higher out-of-pocket prescription drug limits.

(f)(1) The Director of Health Care Reform in the Agency of Administration, in consultation with the Department of Vermont Health Access and the Office of Legislative Council, shall determine whether the Secretary of the U.S. Department of Health and Human Services has the authority under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (ACA), to waive annual limitations on out-of-pocket expenses or actuarial value requirements for bronze-level plans, or both. On or before October 1, 2016, the Director shall present information to the Health Reform Oversight Committee regarding the authority of the Secretary of the U.S. Department of Health and Human Services to waive out-of-pocket limits and actuarial value requirements, the estimated costs of applying for a waiver, and alternatives to a waiver for preserving the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.

(2) If the Director of Health Care Reform determines that the Secretary has the necessary authority, then on or before March 1, 2017, the Commissioner of Vermont Health Access, with the Director's assistance, shall apply for a waiver of the cost-sharing or actuarial value limitations, or both, in order to preserve the availability of bronze-level qualified health benefit plans that meet Vermont's out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.

(g) On or before February 15, 2017, the Department of Vermont Health Access shall provide to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance:

(1) an overview of the cost-share increase trend for bronze-level qualified health benefit plans offered on the Vermont Health Benefit Exchange for the 2014 through 2017 plan years that were subject to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i;

(2) detailed information regarding lower cost-sharing amounts for selected services that will be available in bronze-level qualified health benefit plans in the 2018 plan year due to the flexibility to increase the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i pursuant to subdivision (d)(2) of this section;

(3) a comparison of the bronze-level qualified health benefit plans offered in the 2018 plan year in which there will be flexibility in the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i with the plans in which there will not be flexibility;

(4) information about the process engaged in by the advisory group established in subsection (a) of this section and the information considered to determine modifications to the cost-sharing amounts in all bronze-level qualified health benefit plans for the 2018 plan year, including prior year utilization trends, feedback from consumers and health insurers, Health Benefit Exchange outreach and education efforts, and relevant national studies;

(5) cost-sharing information for standard bronze-level qualified health benefit plans from states with federally facilitated exchanges compared to those on the Vermont Health Benefit Exchange; and

(6) an overview of the outreach and education plan for enrollees in bronze-level qualified health benefit plans offered on the Vermont Health Benefit Exchange.

(h) On or before February 1, 2018, the Department of Vermont Health Access shall report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance:

(1) enrollment trends in bronze-level qualified health benefit plans offered on the Vermont Health Benefit Exchange; and

(2) recommendations from the advisory group established pursuant to subsection (a) of this section regarding continuation of the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.

Sec. 7. EFFECTIVE DATE

This bill shall take effect on passage. Date Governor signed bill: June 2, 2016

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE AND HEALTH RETIREMENT ISSUES COMMITTEE
PHOENIX, ARIZONA
NOVEMBER 18, 2017
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health, Long Term Care and Health Retirement Issues Committee met at the Sheraton Grand Phoenix Hotel on Saturday, November 18, 2017 at 9:00 a.m.

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

Other members of the Committee present were:

Sen. Jason Rapert, AR
Rep. Martin Carbaugh, IN
Rep. Peggie Mayfield, IN
Rep. Joseph Fischer, KY
Rep. Jeff Greer, KY
Sen. Dan "Blade" Morrish, LA
Rep. John Wiemann, MO
Rep. Lois Delmore, ND
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Asw. Maggie Carlton, NV
Asm. Will Barclay, NY
Asm. Andrew Garbarino, NY
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Marguerite Quinn, PA
Rep. Bill Botzow, VT

Other legislators present were:

Rep. David Livingston, AZ
Rep. Richard Smith, GA
Rep. Doug Gutwein, IN
Rep. Matt Lehman, IN
Sen. Rick Billinger, KS
Sen. Neil Breslin, NY
Rep. Phil Jensen, SD
Rep. Tom Oliverson, TX
Rep. Jim Dunnigan, UT

Also in attendance were:

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

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 14, 2017 meeting in Chicago, Illinois, and its October 13, 2017 interim conference call committee minutes.

DISCUSSION/CONSIDERATION OF NCOIL OUT-OF-NETWORK BALANCE BILLING TRANSPARENCY MODEL ACT

Sen. James Seward (NY), sponsor of the Out-of-Network Balance Billing Transparency Model Act (Model), stated that the Committee has been discussing the Model for several meetings. The Model's purpose 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. Sen. Seward thanked interested parties for their comments on the Model and noted that the Committee held an interim meeting via conference call to discuss and review said comments.

Sen. Seward noted that since that interim meeting, he has made some changes to the Model:

a.) for purpose of uniformity, the word "physician" has been replaced with "provider" throughout the Model;

b.) the definition of "usual and customary cost" has been changed to "usual, customary, and reasonable rate[1]" (UCR rate) – and that definition has been moved from Section 6 to Section 4, the Definitions section;

c.) in Section 5 – Determination of Network Adequacy – language was added to require that 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 at each in-network health care facility sufficient to render the services covered by the health benefit plan. That added language is meant to address the problem of ensuring network adequacy for facility and hospital-based physicians at in-network hospitals;

d.) in Section 9 – Provider Notice to Enrollees – language was added to clarify that the notice requirements shall not apply to emergent or unforeseen conditions or circumstances discovered during a procedure. That added language is meant to recognize the fact that in emergent or unforeseen circumstances, it is not feasible to provide patients with certain information;

e.) in Section 13 – Balance Billing – language was added to allow for the enrollee, in addition to the insurer and provider, to initiate an independent dispute resolution (IDR) proceeding; and,

f.) in Section 16 – Provider Directories – a change was made from "periodically" to "annually" to standardize a time within which carriers much audit at least a reasonable sample size of its provider directories.

Sen. Seward also noted that he, along with NCOIL at an organizational level, believes that a good piece of Model legislation should be a generalized legislative framework. As States adopt the Model they can then modify it as they wish, as well as further develop it through the promulgation of more specific implementing regulations.

Sen. Seward stated that he views this proposed Model as an effort to expand and improve upon NCOIL's "Healthcare Balance Billing Disclosure Model Act," originally adopted in 2011. By way of example, a drafting note in the 2011 Model states that "States may wish to consider using an existing mediation process or establishing a mediation process to manage disputes that may arise regarding balance bills." Accordingly, the proposed Model proposes the inclusion of a process to resolve disputed out-of-network charges, including balance bills, similar to what some States have implemented, including New York. Such an approach, if set up and executed properly, can be more streamlined and help consumers more than other offered approaches because if each party knows there is a distinct possibility that they can lose outright, a strong incentive is created for the parties to negotiate and settle.

[1] The Model's definition of UCR rate is: 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 financially affiliated with an insurance carrier.

Further, Sen. Seward stated that he believes a strong Model has been drafted, and that his reaction to the comments – generally speaking – falls in favor of the drafted Model with the amendments announced today. That is not to say the Model is perfect; legislation never is. There may be instances where some clarification is warranted, perhaps through the issuance of more specific regulations. But, Sen. Seward strongly believes that this Model provides States with a solid starting point for debate on these issues. And with legislative sessions fast approaching in some States, Sen. Seward urged this Committee to pass this Model so that States can have it to debate in their respective legislatures.

Betsy Imholz from Consumers Union stated that Consumers Union supports the provisions of the Model that protect consumers from balance billing in emergency situations but that the other situation that warrants protection is when the consumer is at an in-network facility but receives a "surprise" bill because someone at the facility, perhaps an anesthesiologist, is out-of-network. Consumers Union appreciates the notice provisions in the Model and the provision that allows for enrollees to initiate an IDR process, but Ms. Imholz noted that in states that allow enrollees to initiate such a process they don't take advantage of it because it is hard for them to summon the time, money, and confidence to do so. Ms. Imholz stated that premiums are increasing at an alarming rate and the issue of reimbursement is primarily an issue between providers and plans, but consumers have an interest in keeping costs reasonable and urge caution on basing the reimbursement rate on billed charges because there is no ceiling or criteria on which to cap that. Ms. Imholz also urged the Committee to include more consumer stakeholders in future discussions on this Model and others the Committee may consider going forward.

Michele Kimball from Physicians for Fair Coverage (PFC) stated that PFC applauds Sen. Seward for his work on the Model and that she is here today not only on behalf of PFC but on behalf of other multi-specialty physician groups including orthopedics, oral and maxillofacial surgeons, the American college of emergency physicians, the American college of radiology, the society of plastic surgeons, the college of American pathology and the American Medical Association. Ms. Kimball stated that there are three key areas that are essential to ending surprise billing – all of which Sen. Seward's Model addresses: a.) taking the patient out of the middle – the most important area. Ms. Kimball requested that the expansion of the Model's provisions in that area apply to non-emergency situations; b.) transparency – Ms. Kimball requested that the audit of a carrier's provider directory should be biannual, not annual; c.) Ms. Kimball applauded the Model's definition of the UCR rate. Benchmarking reimbursements to a non-profit, non-conflicted, independent database of billed charges makes sense and doing so ensures that the database is not controlled or influenced by insurers or physicians. Most importantly, it allows for proper reimbursement, especially in rural areas. Ms. Kimball closed by stating that while the Model is not perfect, the Committee should adopt it as it is an excellent framework for States to consider.

Sherif Zaafran, Chair of the Ad Hoc Committee on Out of Network Payment, and on behalf of the American Society of Anesthesiologists and PFC, stated that in the two states that benchmark reimbursements to a non-profit, non-conflicted, independent database of billed charges, New York and Connecticut, it has worked very well. Since implementation in those States, the charges have remained fairly constant, and the idea that physicians would collude to cause an increase in charges has not come to fruition, particularly since it would be in violation of anti-trust rules. In response to Ms. Imholz' request for the Model to provide protections for consumers against "surprise" billing, Mr. Zaafran noted that Sections 9 D. and E., provide for disclosure when a provider refers a patient to an in-network facility that may potentially contain out-of-network providers. Mr. Zaafran did note, however, that the group of providers listed in

those sections of the Model is too narrow since it doesn't capture surgical assistants or neuromonitoring services. Accordingly, Mr. Zaafran recommended including the language "any anticipated service or provider." Mr. Zaafran also voiced support for the Model's IDR provisions and stated that such systems have worked well in the States that have implemented them.

David Boone, CEO of Alacura, stated that Alacura works directly with several insurance companies in trying to build networks and the costs differences between in and out of network are staggering. Mr. Boone stated that the definition of "emergency services" in legislation like the Model is critical in terms of whether the perspective set forth in the definition is of a prudent layperson's or a physician since that is a determining factor as to whom the Model's balance billing protections apply. Mr. Boone also commented on the Model's definition of UCR rate and stated that using such a benchmark could artificially raise charges and be detrimental to the system, particularly in areas where there is a lot of consolidation. Using a different benchmark such as an amount of Medicare is probably a better indicator of what a true and reasonable cost is.

Asw. Maggie Carlton (NV) stated that Nevada has been working on these issues for over a decade and thanked Sen. Seward for considering some of her suggestions. Asw. Carlton stated that she was concerned with the Model's definition of UCR rate. The biggest discussion point in Nevada when working on legislation that dealt with these issues was that of dis-incentivizing contracting. Nevada legislators were told that using a FAIR health database as an option for benchmarking would in fact dis-incentivize contracting – why would someone sign a contract at possibly 35% or 40% when they know that if they go out-of-network they are guaranteed 80%? Asw. Carlton stated that there are several provisions in the Model that she supports and would consider introducing in Nevada but because of the Model's definition of UCR rate she would not be able to support the Model.

Rep. Tom Oliverson (TX) stated that he appreciates the Model and that he thinks it is a better work product than what is currently in place in Texas. In response to Asw. Carlton's statement about dis-incentivizing contracting, Rep. Oliverson stated that physicians don't contract with networks based solely on reimbursement – the whole concept of contracting is that you accept a discount in exchange for a guarantee of volume. Rep. Oliverson noted that it is his understanding that the States that have used a benchmarking system similar to what the Model provides have not experienced an increase in physician charges, which seems to indicate that it is a stable model that is fairly reflective of actual market conditions, more so than Medicare.

Rep. Jim Dunnigan (UT) stated that he sponsored balance billing legislation in Utah that passed the House but was never voted on in the Senate. The Utah Medical and Hospital Associations wanted 85% of billed charges as the standard for reimbursement, which Rep. Dunnigan did not support. Rep. Dunnigan supported the Model's definition of UCR rate and agreed with Sen. Seward's earlier statement that States could adjust certain provisions of the Model, such as the percentile in the definition of UCR rate. Rep. Dunnigan stated that he is concerned that Section 7 of the Model - the health benefit plan ensuring that the enrollee incurs no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network provider, does not restrain out-of-network facilities at all and that it could drive healthcare costs up – both sides should have "skin in the game." Rep. Dunnigan also stated that he appreciates the Model's provisions regarding "surprise" billing but questioned the practicality of Section 9E - requiring the provider or provider's representative, when scheduling an enrollee to receive services at a health care facility, to give to the enrollee information about any anesthesiologist, laboratory, pathologist, radiologist and/or assistant surgeon who will also be providing services

to the enrollee consisting of: (1) name, practice name, mailing address, telephone number and (2) how to determine in which health benefit plan networks each participates.

Sen. Seward responded that, regarding Section 7, the Model's IDR provisions allow the parties to negotiate on what a proper reimbursement should be, and that even though Section 7 says "the health benefit shall ensure that the enrollee incur no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network provider," the intent of the Model is not for the health benefit plan to simply pay such a lump sum to the provider – the plan can initiate an IDR proceeding to negotiate proper payment. And regarding Section 9 and the issue of "surprise" billing, Sen. Seward stated that, in Section 5 – Determination of Network Adequacy – language was added to require that 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 at each in-network health care facility sufficient to render the services covered by the health benefit plan.

Rep. Richard Smith (GA) stated that he appreciates Sen. Seward's Model and that the environment in Georgia has been very contentious when discussing these issues. Rep. Smith stated that he introduced legislation in Georgia last year that stated if a provider had exclusive privileges at a hospital then the provider should be in the same network as that hospital. Such legislation was viewed as a "vicious" attack on providers. Rep. Smith stressed that getting the patient out of the middle is the most important thing in balance billing situations. Transparency must also be improved to ensure that the patient knows which providers are in and out of network.

Rep. Oliverson, a practicing anesthesiologist, stated that it is important to understand how contracting for hospital based providers works. Such providers are fairly unique in that the patient doesn't come to see them and are then taken to the facility, rather, the providers are already at the facility waiting for patients to come to them. Such providers first contract with a hospital to provide services, and then, secondly, they must independently contract with health plans. At the same time, the hospital independently contracts with health plans which is important because you don't want doctors owned or directly employed by the hospitals because financial incentives can become misaligned and the provider may not necessarily always do what is best for the patient and instead do what's best for the hospital. Essentially, Rep. Oliverson wanted to drive home the point that for hospital based providers who are out-of-network at an in-network facility, it's not always their choice – it is the result of a free-market negotiation process that has broken down or has not been resolved. Such providers would prefer to be in-network at in-network facilities so they are not blamed for being the one who has the out-of-network bill, but it is a negotiating tool often used against such providers in order for them to accept lower reimbursement rates.

Sen. Bob Hackett (OH) stated that in Ohio, hospitals used to be responsible for directing a patient to an out-of-network provider, but the law was changed. Also, in his experience, specialists do not like the networks and they will always seek to control the market when they can. Sen. Hackett also stated that the market is constantly changing with regard to hospitals employing providers.

Asm. Cahill noted that the issues being discussed today are very complex and that the Model is not the perfect solution, but, the Model encourages network participation, seeks to protect consumers and is a very strong framework for States to consider. Asm. Cahill then entertained a Motion to adopt the Model with the amendments announced earlier by Sen. Seward.

Assemblyman Andrew Garbarino (NY) made said Motion; Representative Bill Botzow (VT) seconded the Motion.

Asw. Carlton noted that what NCOIL does carries a lot of weight and a lot of States look to NCOIL's model legislation for guidance. Asw. Carlton stated that by passing this Model, the Committee will put her in a position of opposing an NCOIL Model in Nevada due to the Model's definition of the UCR rate. Asw. Carlton stated that her opponents in Nevada will use that against her, and it will make it more difficult for her to get balance billing legislation passed in Nevada. Sen. Seward stated that he understands and respects Asw. Carlton's concerns and he fully expects States to make modifications to the Model if they decide to introduce it in their legislatures. State legislators in one State may have an entirely different perspective on these issues than those in another State, but the Model is set forth as a framework and is based on provisions that have worked well in other States. Asw. Carlton stated that she again wanted to make clear that the Model will be another barrier that she will have to go over to get to where she needs to be.

Upon a request for a roll-call vote made by five members of the Committee (pursuant to NCOIL bylaws), the Committee voted to adopt the Model by a vote of 15-3.

EXAMINING PRESIDENT TRUMP'S EXECUTIVE ORDER ON HEALTHCARE: WHAT IS CHANGING AND WHAT IS THE IMPACT

Ms. Imholz stated that while Congress and the Administration have not yet repealed the ACA, the Administration has taken other steps that will weaken the ACA's underpinnings in the individual and small group markets. The concern is that the Executive Order (Order) issued on October 12, 2017, is another step in that direction. The American Academy of Actuaries has commented on the Order stating that creating exemptions for the ACA's insurance market rules can have far-reaching and unintended consequences such as tilting the market in favor of entities with weaker benefits or solvency standards and weakening the protections for consumers with pre-existing health conditions. The Order does not change the ACA or its regulations but rather sets in motion a regulatory process within the confines of existing law. The three main parts of the Order deal with association health plans (AHPs), short-term limited duration plans (STLDPs), and health reimbursement arrangements (HRAs). The proposed regulations on AHPs and STLDPs are at OMB but have not been seen publicly yet.

With regard to AHPs, the Order directs the DOL to consider, within 60 days, new rules or guidance to allow more employers to form AHPs under ERISA. Under current law, fully insured AHPs follow rules pertaining to the segment they enroll in, i.e. small group or individual. Those rules contain several consumer protections such as protection against denials for pre-existing conditions and requiring 10 EHBs. Large groups on the other hand are not required to adhere to such rules, and large group premiums can vary based on the expected health costs of the group and with greater allowance for variation of age. Prior to the ACA, AHPs were allowed to underwrite and set premiums based on the healthcare condition of its members. If the Order, as it seems to contemplate, allows AHPs to qualify as large groups, they can then return to their prior practices and eliminate many of the most important ACAs consumer protections. AHPs could then be free of State regulation, sell across State lines, and provide plans with skimpier benefits, making it easier to cherry-pick healthier enrollees and avoid unhealthy enrollees. At the same time, the premiums in the ACA compliant plans would increase because that risk-pool would deteriorate since it would contain less-healthy members. History is shown that the landscape is littered with AHPs that have failed – some were scams that defrauded their members and left millions of dollars in unpaid claims leaving both providers and consumers in

the lurch. MEWAs, which provide coverage for employees of two or more unrelated employers or self-employed individuals, have been quoted as "the vehicle of choice for promoters of phony insurance." In 1982, Congress amended ERISA to give States regulatory authority over MEWAs and States did a better job than the Federal government in administering them, but the fraud did continue. Between 2000 and 2002, insurance scams through AHPs left more than 200,000 policyholders with unpaid medical bills totaling $252 million. MEWAs have also been especially prone to insolvency, and just last week the DOL issued a cease and desist order against a MEWA. Ms. Imholz noted that the NAIC's position on AHPs is simply "AHPs are bad for consumers."

With regard to STLDs, the Order directs the Secretary of Labor, Treasury, and HHS within 60 days to consider revising regulations or guidance to expand the availability of STLDs, including increasing the plans time period and allowing them to be renewed by consumers. STLDs have long existed to allow coverage between jobs or for those who missed an open-enrollment period. The ACA excluded STLDs from its protections, so such plans can reject consumer due to pre-existing conditions. STLDs are meant as a stop-gap measure and because they are not ACA-complaint, they do not meet the ACA's individual mandate requirement. State insurance regulators have reported that they have seen fraudulent marketing of STLDs even in advance of the anticipated regulations or guidance. Consumers Union believes that expansion of STLDs will lead to adverse selection, consumer confusion, and de-stabilizing the individual market. Together, Consumers Union believes that the expansion of AHPs and STLDs will lead to more "junk" insurance – something that was prevalent before the ACA.

The Order also directs Treasury, Labor and HHS, to reduce restrictions on HRAs through guidance or regulations within the next 120 days. The primary goal seems to be to try to allow the use of HRAs to pay premiums in the individual market. Current law, however, allows them only in group plans paired with ACA compliant policies and requires them to fund only medical expenses for employees on a pre-tax basis. They must be funded solely from employer contributions. In 2016, the CURES Act created a very narrow exemption for small employers to use HRAs for premium payments. The concern is that employers might try to use HRAs as a way to stop covering higher risk employees and just provide such employees with money that they could use for a premium to shop elsewhere.

Ms. Imholz urged the Committee to stay vigilant as to what the specific proposed regulations say as they are not public yet. For AHPs, State legislators can assess their regulatory framework for in-state and out-of-state MEWAs and if Federal action in this area does not preempt State law, then State legislators can require compliance with small group/individual market rules; if preempted, State legislators can at least require financial solvency standards for those in-state MEWAs. For STLDPs, State legislators can assess their regulatory framework and try to prohibit their sale; ban their renewals; require compliance with some or all ACA market reforms, e.g. EHBs; no medical underwriting; place an assessment on STLDPs and invest that money in re-insurance; require STLDPs to meet minimum medical-loss-ratio standards; and at the very least try to require increased disclosure/notice requirements of STLDPs.

Rep. George Keiser (ND) stated that regarding MEWAs, it is North Dakota's interpretation that they are within the Federal government's jurisdiction, like ERISA plans, and will not qualify for the State guaranty funds. Ms. Imholz stated that may be correct and there are several factors that would go into answering ERISA-MEWA jurisdictional questions. Also, Ms. Imholz noted that most of her suggestions for State legislator action dealt with STLDPs, and not AHPs/MEWAs, which is an area that States have more jurisdictional flexibility with.

Asm. Cahill asked Ms. Imholz if there was a specific timeframe within which to expect the regulations so that States could plan appropriately. Ms. Imholz said she was not sure but noted that two of the three sets of regulations are at OMB – it is uncertain as to how quickly OMB will review them but Ms. Imholz expects the regulations to be ready as soon as January, 2018, but whether they can take effect immediately is another topic for discussion. Ms. Imohlz noted that in the face of such uncertainty, some States such as Pennsylvania are starting to ramp-up consumer warnings about what is true and what is not relating to the Order and how it relates to current ACA protections.

DISCUSSION OF MODEL ACT REGARDING AIR AMBULANCE INSURANCE CLAIMS

Rep. Jeff Greer (KY) stated that the Air Ambulance Task Force has worked very hard to make a recommendation to the Committee in the form of the Model Act Regarding Air Ambulance Insurance Claims, sponsored by Asm. Will Barclay (NY). Rep. Greer stated that he believes the Model will protect consumers from exorbitant balance bills after having received service from an air ambulance provider.

Asm. Cahill then provided a brief timeline of the Task Force's work: the Task Force was created in March 2017 and began to gather relevant information; after having several conference call meetings, the Task Force met in July 2017 and heard testimony from several interested parties; in October 2017 the Task Force voted to recommend Asm. Barclay's Model Act to the Committee by way of a voice vote on a joint interim conference call meeting of the Task Fore and Committee; on the same joint interim conference call meeting, the Committee voted by way of a voice vote to recommend the Asm. Barclay's to the Executive Committee for adoption; at the request of NCOIL President and Executive Committee Chairman Rep. Steve Riggs (KY), Asm. Barclay's Model was returned to the Health Committee for consideration of two technical amendments.

Asm. Barclay provided a brief summary of the Model and stated that the highlight of the Model is that it calls for a State Department of Insurance (DOI) to set up and Independent Dispute Resolution (IDR) program that takes the patient out of the middle and directs the provider and insurer to negotiate reimbursement. Asm. Barclay noted that it is important to recognize that such a process is possible because by registering and participating in the IDR program, the air ambulance provider waives the provider's ability to challenge the IDR program based on the Federal Airline Deregulation Act (ADA) preempting it. Asm. Barclay further noted that another highlight of the Model is that by registering in the IDR program, air ambulance providers agree to (a) publish air ambulance transport rates charged by it in that State and (b) provide de-identified, itemized billings for each of its transports in that State. Asm. Barclay then offered two technical amendments to the Model. First, in Section 2(C), clarification is needed to state that a "health plan" does not include: (a) Medicaid managed car programs operated [insert applicable State statute]; (b) Medicaid programs operated under [insert applicable state statute]; (c) the state child heath plan operated under [insert applicable state statute]; (d) Medicare; or (e) "excepted benefit: products as defined under 42 U.S.C. 300gg-91(c). Additionally, in Section 4(D)(1), language is needed to state that "<u>subject to the provisions of the covered person's health plan contract</u>, a health plan is responsible for payment directly to the air ambulance service provider or denial of a claim for air ambulance services within 30 days after receipt of a proof of loss." There could be constitutional issues if that language was not included when dealing with two independently contracting parties. Asm. Barclay then made a Motion for the Committee to adopt those two technical amendments; Sen. Dan "Blade" Morrish (LA) seconded

the Motion. The Committee then voted without objection by way of a voice vote to refer the Model back to the Executive Committee, as amended.

Asw. Carlton asked if the prior Motion was to vote on only the amendments or on the Model, as amended. Asm. Cahill stated that the Model was already adopted by the Health Committee on the Oct. 13 interim conference call meeting. Asw. Carlton stated that it was her understanding that there were not many Committee members on that conference call and that the Committee would be voting on the Model at this meeting. Asm. Cahill stated that the Oct. 13 minutes reflect that it was adopted by the Health Committee during that call and referred to the Executive Committee for adoption and that at the beginning of that call a Motion was made and adopted to waive the quorum requirement. Asw. Carlton stated that it was her mistake then that she had left that call early but that she has concerns with that process. Rep. Keiser stated that in North Dakota, if a bill is brought back to the relevant Committee for amendments, that Committee then has jurisdiction over the bill. Asm. Cahill then entertained another Motion to move the Model, as amended, back to the Executive Committee. Asm. Barclay made the Motion; Sen. Jason Rapert (AR) seconded the Motion. The Committee then voted by way of a voice vote to refer the Model back to the Executive Committee, as amended.

The Committee then recognized the retirement of Dianne Bricker from America's Health Insurance Plans (AHIP). Asm. Cahill stated that Ms. Bricker has been a friend of NCOIL for several years and thanked her for all of her hard work.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES COMMITTEE
PHOENIX, ARIZONA
NOVEMBER 16, 2017
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services Committee met at the Sheraton Grand Phoenix Hotel on Thursday, November 16, 2017 at 4:15 p.m.

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

Other members of the Committee present were:

Sen. Jason Rapert, AR
Rep. David Livingston, AZ
Rep. Martin Carbaugh, IN
Rep. Joseph Fischer, KY
Rep. Jim Gooch, KY
Rep. Steve Riggs, KY
Rep. Lois Delmore, ND
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Sen. James Seward, NY
Rep. Bill Botzow, VT

Other legislators present were:

Rep. Bryon Short, DE
Rep. Park Cannon, GA
Rep. Tom Oliverson, TX
Rep. Matt Lehman, IN
Rep. Jim Dunnigan, UT

Also in attendance were:

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

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 15, 2017 meeting in Chicago, Illinois.

DISCUSSION AND CONSIDERATION OF MODEL ACT TO SUPPORT STATE REGULATION OF INSURANCE BY REQUIRING COMPETITION AMONG INSURANCE RATING AGENCIES

NCOIL President Representative Steve Riggs (KY) stated that the Model seeks to embrace and expand competition in the insurance rating agency marketplace. Public entities over the years have been designating a single exclusive insurer rating requirement in statues, regulations, and bulletins. Rep. Riggs stated the solution to that problem could be this Model law because it promotes competition among insurer rating agencies since it lists multiple, competent insurer rating agencies. From competition among rating agencies, insurance companies and the insurance marketplace will prosper.

Mike Stinziano from Demotech began by thanking the Committee for unanimously supporting a Resolution in 2015 which supported the states' authority as the primary regulator of insurance companies and encouraged state officials to promote competition among the agencies that rate

insurers. Currently, the interactive, responsive State regulatory framework in place is consistent with the intent of the U.S. Senator Joseph O'Mahoney, a principal architect of the McCarran-Ferguson Act. His vision of insurance regulation was "public regulation by public authority." Senator O'Mahoney rejected private sector regulation as "harmful to the public interest." Contrast his vision of "public regulation by public authority" with the November 12, 2015 testimony of Britt Newhouse heard by this Committee. Mr. Newhouse, Chairman of Guy Carpenter and Company, LLC, a member of the public traded Marsh family of companies and a thirty-eight year veteran of the insurance industry noted: "the rating opinion published a single, privately held rating service carries significant disproportionate weight. Urging each State to foster competition in insurer ratings to benefit consumers, duly licensed insurance companies, producers, and other third-party stakeholders by promulgating and embracing insurer rating requirements in laws and regulations that incorporate the enumeration of multiple, competent insurer ratings organizations is an important step forward."

Mr. Stinziano discussed the results of a recent survey of insurance professionals related to the important topic of state regulation of insurance and a requirement for competition among insurer rating agencies. More than 100 insurance professionals responded to the survey, providing testimonials that confirm that a single, exclusive insurer rating requirement adversely impacts consumers in addition to disadvantaging the duly licensed carriers that States regulate. Survey responses came from insurance carriers operating in every state and the District of Columbia – from insurers large and small and of every form of insurer – privately held, publicly traded, mutual, risk retention group, mutual protective association, reciprocal, and captive insurers, and from independent agents and brokers who market on their behalf. Mr. Stinziano stated that consumers and duly licensed insurance carriers would benefit from a response to the threat to public regulation of insurance. The breadth and scope of unintended consequences caused by naming a single insurer rating option in legislation, regulations, and bulletins can no longer be dismissed. Some have interpreted such legislative and administrative rule making activity as a transfer of regulatory authority from the states to the single, privately held rating agency name in the statute, regulation, or bulletin. The clout of a single, privately-held insurer rating organization – ironically viewed by some as a regulator – harms consumers, duly licensed insurers and other parties by minimizing the value of the critical, statutory role of state regulation, impeding competition that benefits consumers while adversely impacting duly licensed insurers in good standing.

Mr. Stinziano closed by stating that the observations of those responding to the survey are clear – an unintended consequence of designating a single, exclusive insurer rating requirement in laws, statutes, bulletins or other public material has been the erosion of state regulatory authority and the misperception that one private sector insurance rating agency supersedes the state regulatory process that oversees duly licensed insurers. To remedy this situation, competition among competent insurer rating alternatives will benefit consumers, the third parties relying on the protection provided by insurance as well as the duly licensed insurers that states regulate. Most important, the utilization of multiple, competent insurer rating alternatives reinforces "pubic regulation by public authority."

Tina Bukow from Kroll Bond Rating Agency stated that Kroll believes ratings come along with tremendous social responsibility and embraces competition from other regulated rating agencies. Kroll believes that by encouraging competition, NCOIL will ensure higher working standards which will provide more accurate rating outcomes for all users of ratings, particularly policyholders.

Jay Neal, President of the Florida Association for Insurance Reform (FAIR), stated that competition among insurer rating agencies is a critical component of establishing and sustaining a healthy private insurance market. Without such competition, and without the primacy of state-based insurance regulation, a single, for-profit rating agency could remain the de-facto regulator and authoritative opinion to consumers within the insurance marketplace. Florida has benefited from such competition, and as a result, Mr. Neal stated that he believes Florida has the most robust and competitive property insurance market in the country. Mr. Neal stated that he believes that proposed Model Act is a big step towards the revitalization of the primacy of state-based insurance regulation and that it benefits consumers.

Matthew Mosher, Executive Vice President and Chief Operating Officer of A.M. Best, stated that A.M. Best supports and agrees with the "findings" of the Model Act. A.M. Best has never advocated for its ratings to be the sole rating to be used or even for its ratings to be listed in legislation. A.M. Best believes that its ratings being listed in statutes and regulations is a reflection of A.M. Best's 118-year history and for many of those years being the only rating agency that rated insurance companies. Ratings add value because they take a complex financial analysis and break it down to a scale that people can understand. However, because of that complex financial analysis, the evaluation needs to be something that is regulated and examined from a government entity in some way to ensure there is consistency and no conflict of interest. One such conflict could be a rating agency that provides consulting advice. For that reason, A.M. best has concerns with the proposed Model in terms of the Model's definition of "competent rating agency." A.M. Best believes that the Model should establish specific approval or certification standards when defining a "competent rating agency." The Dodd-Frank Act and the Credit Rating Agency Reform Act establish clear standards that most rating agencies are held to. Mr. Mosher stated that the rating agencies listed in the definition of "competent rating agency" are not held to the same standards so it could be misleading to consumers.

Rep. George Keiser (ND) stated that it is unusual to provide advertisements in statutes and asked why are the rating agencies specifically named instead of saying "a competent rating agency is a rating agency certified or approved by a national entity that engages in such a process?" Mr. Mosher agreed that the names of the rating agencies should not be listed and again stated that the most important thing is to set a standard for what a "competent" rating agency is. Mr. Stinziano stated that as the language for the Model Act was being developed, the idea of whether to specify Nationally Recognized Statistical Rating Organizations (NRSRO's) was ultimately rejected because the SEC - the entity that issues an NRSRO designation – is a federal entity and states should not defer any authority to the federal government in the area of insurance regulation pursuant to the McCarran-Ferguson Act. At the same time, there was concern when drafting the Model of simply leaving it to the States to decide what a "competent rating agency" is. Accordingly, the language "…a national entity that engages in such a process" anticipates that perhaps an organization like the NAIC, perhaps working with the SVO office, might decide it is an appropriate responsibility for them to undertake a national evaluation of insurance rating agency organizations that aren't NRSRO's.

Mr. Neal stated that after Hurricane Andrew in Florida, the problem was that state regulators stated that insurance companies had to have a rating from a company recognized by Fannie Mae and Freddie Mac – there are only 3 that meet that standard (A.M. Best, S&P, Demotech). The problem with requiring a rating agency to be an NRSRO is that it erodes the primacy of states in insurance regulation.

Rep. Joseph Fischer (KY) stated that it is hard to argue against promoting competition among insurance rating agencies but that the language "…or another rating agency certified or

approved by a national entity that engages in such a process" is vague. Rep. Fischer also noted a spelling error in Section 2.7 ("unintended") and that in Section 4, the word "agency" was missing.

Rep. Riggs stated that he did not want to refer to the NRSRO designation in the Model because doing so would be detrimental to the state-based system of insurance regulation and that the NRSRO designation is bank-centric. However, in response to Mr. Mosher's statements about setting standards for what a "competent" rating agency is, and in response to Rep. Fischer's concerns about vagueness, Rep. Riggs proposed including the requirements that the Dodd-Frank Act lists for rating agencies to be recognized as an NRSRO in the Model's definition of "competent rating agency." Rep. Fischer agreed that listing standards in the Model would be an improvement. Sen. James Seward (NY) also agreed and asked Rep. Riggs if he would consider removing the names of the rating agencies from the Model's definition of "competent rating agency." In response to Sen. Seward's question, Mr. Stinziano stated that NCOIL debated that issue when it considered the Model Act to Regulate Insurance Requirements for Transportation Network Companies and Transportation Network Drivers in 2015 – that Model does specifically list rating agencies, namely A.M. Best and Demotech.

Mr. Mosher stated that A.M. Best would support not naming any specific rating agencies in any legislation or regulation – the standards that the rating agencies must meet are what matter most. Additionally, as a minor note, Mr. Mosher stated that A.M. Best Rating Services, Inc. is the legal entity that issues ratings, not A.M. Best Company which is listed in the Model. Rep. Riggs and Sen. Hackett stated that they appreciate the desire to not list the names of rating agencies in the Model but that to best promote competition, the better method is to list the rating agencies and then include the language "….or another rating agency certified or approved by a national entity that engages in such a process." Mr. Mosher also noted that he was not sure how states would determine if the rating agencies met the standards that Rep. Riggs proposed adding, and stated that the issue of state-regulation of insurance in this arena is a red-herring because the NRSRO designation is simply a way that states can know a rating agency meets a certain standard. Joe Petrelli from Demotech stated that the NRSRO designation came into existence around 1975 and was not developed or initiated to review insurance company claims paying ability or insurer financial strength.

Sen. Hackett then asked Rep. Riggs how he would like to proceed regarding the proposed adoption of the Model. Rep. Riggs stated that he would like to proceed with adoption, knowing that between now and the Executive Committee meeting on Sunday, NCOIL staff would amend the Model to include the specific requirements that the Dodd-Frank Act lists for rating agencies to be recognized as an NRSRO in the Model's definition of "competent rating agency." Rep. Riggs made a Motion to proceed in that manner; Rep. Bill Botzow (VT) seconded the Motion. Rep. Keiser opposed the Motion and stated that the names of the rating agencies should not be listed in the Model.

Sen. Hackett then announced a Motion was needed to waive the quorum requirement in order to proceed with a vote on the Model. Rep. Keiser made said Motion; Rep. Riggs seconded the Motion. Sen. Seward then asked Rep. Riggs to clarify whether the specific requirements would be included in the Model's definition of "competent rating agency." Rep. Riggs replied "yes." Sen. Seward then asked if all the rating agencies listed in the Model meet those requirements. Mr. Mosher replied "no." Mr. Petrelli replied "yes." Mr. Mosher stated that one of the Model's listed rating agencies has consultancy offerings on its website which could be a problem when meeting one of the proposed standards - no conflict of interest. Mr. Petrelli acknowledged that Demotech is the rating agency with consultancy offerings on its website and stated that he is a

credentialed actuary bound by the American Academy of Actuaries' Board for Counseling and Discipline. Accordingly, Demotech will either rate or consult and was told by the Academy's Board to disclose that on their website and to their clients. Mr. Mosher stated that if A.M. Best had consultancy offerings on its website there would be a problem with the SEC and its NRSRO designation. Rep. Riggs stated that when listing the requirements in the Model, the language "but not necessarily limited to" will be included so that States could modify the certification process as they see fit. Mr. Petrelli noted that he and Demotech are bound by what the Academy's Board told them what is acceptable, not by what a competitor has said.

The Committee then returned to the pending Motion to waive the quorum requirement and unanimously approved said Motion. Before the Committee voted on the Model, Rep. Botzow asked Rep. Riggs to clarify the process going forward regarding amendments to the Model. Rep. Riggs stated that his Motion was and is to adopt the Model with the expectation that before the Executive Committee meets on Sunday, the Model would be amended to include the specific requirements that the Dodd-Frank Act lists for rating agencies to be recognized as an NRSRO in the Model's definition of "competent rating agency." And the language "The process shall include, but not necessarily be limited to, the following requirements:" will precede the listing of the requirements. The Committee then voted to adopt the Model with the expectation of those amendments by a vote of 9-3.

CONSIDERATION OF MODEL ACT PROHIBITING CONSUMER REPORTING AGENCIES FROM CHARGING FEES RELATED TO SECURITY FREEZES; AND AMENDMENTS TO NCOIL CREDIT REPORT PROTECTION FOR MINORS MODEL ACT

Rep. Riggs stated that identity and financial theft has been the atop the Federal Trade Commission's (FTC) complaint list for the past decade, and it has been getting worse, particularly with minors. Since the Committee passed the Credit Report Protection for Minors Model Act (Minors Model Act), there has been an epidemic of more identity theft. Thirty-eight Attorneys General wrote to the CEO's of Equifax, Transunion and Experian, urging them to not charge any security-freeze related fees. Rep. Riggs stated that those credit bureaus should not be able to profit from consumers requesting security freezes.

Wes Bissett from the Independent Insurance Agents and Brokers of America (IIABA) thanked Rep. Riggs for discussing these issues and stated that IIABA supports both the proposed new Model Act and amendments to the Minors Model Act. Mr. Bissett stated that this is a topic that NCOIL can provide leadership and guidance in. Security freezes are very important to consumers because they are essentially the only way of preventing a thief from opening a new line of credit in the victim's name. Victims of identity theft can also temporarily lift a security freeze if they need access to credit. The fees that credit bureaus charge for placing or lifting security freezes have been shown to be a barrier for some consumers, particularly because for a security freeze to be meaningful, a consumer should place one on their credit with each credit bureau. Mr. Bissett stated that the idea of free security freezes is starting to catch on – at least 8 States provide for that: Colorado, Indiana, Maine, Maryland, New Jersey, New York, North Carolina, and South Carolina. Additionally, such legislation has been introduced in other States and before Congress.

Rep. Keiser stated that as a business owner, he is amazed how often people want him to do something for free and asked Mr. Bissett if he knows how much it costs the credit bureaus to place and/or remove a security freeze. Mr. Bissett said that he did not know, but stated that the context is different for the credit bureaus as compared to other business owners because consumers don't have the ability to tell the credit bureaus to not collect their personal

information. Essentially, consumers are not really customers, in the true sense of the word, of the credit bureaus as they are with other businesses. Rep. Keiser asked if any States allow credit bureaus to charge only nominal fees, such as $2. Mr. Bissett stated that the fees range from $2 to $12 but a consumer would have to pay that three times – once for each credit bureau. Rep. Riggs appreciated Rep. Keiser's view as a business owner but stressed the fact that we are all not customers of the credit bureaus.

Rep. Park Cannon (GA) asked Rep. Riggs why "minor" was defined in the Credit Minors Model as an individual under the age of 16, and not 18. Rep. Riggs stated that his understanding is that 16 is the age the credit bureaus use for determining who can establish credit. Rep. Botzow noted that in Vermont, the House passed the NCOIL Credit Minors Act with "minor" defined as an individual under the age of 18, and that the credit bureaus have been lobbying the Senate to change the definition to 16. Rep. Botzow then noted that the issue of providing free security freezes is just the tip of the iceberg and urged the Committee to continue discussing the problems associated with identity and financial theft.

Rep. Martin Carbaugh (IN) then made a Motion to adopt the Model Act Prohibiting Consumer Reporting Agencies from Charging Fees Related to Security Freezes. Rep. David Livingston (AZ) seconded the Motion. The Committee then voted without objection by way of a voice vote to adopt the Model.

Rep. Martin Carbaugh (IN) then made a Motion to adopt the amendments to the Credit Report Protection for Minors Model Act. Rep. Botzow seconded the Motion. The Committee then voted without objection by way of a voice vote to adopt the amendments.

DISCUSSION/CONSIDERATION OF RESOLUTION ENCOURAGING THE ADOPTION OF VOLUNTARY DATA CALL PRINCIPLES

Frank O'Brien from the Property Casualty Insurance Association of America (PCI) stated that this Resolution is aimed at trying to establish best practices in the types of data calls that State Insurance Departments are either contemplating or seeking to execute. There are a number of States that have gone forward and put out a significant number of data calls, some of which can be unusual in that they deal with issues or terms that are not what data calls typically deal with. The proposed Resolution does not seek to eliminate an Insurance Department's ability to issue a data call. Rather, the Resolution aims to put some parameters around the data calls and ask that an Insurance Department consider the mechanisms for a data call, including how they are executed.

Joe Thesing from the National Association of Mutual Insurance Companies (NAMIC) agreed with Mr. O'Brien and stated that NAMIC supports the Resolution. Sen. Hackett also agreed with Mr. O'Brien and stated that the data calls are becoming an increased cost to insurance companies.

Rep. Keiser stated that about two years ago, the NAIC made a conscious decision to move as much as possible away from general market conduct exams and to do more specific targeting with data calls. Rep. Keiser asked if that has taken place. Mr. Thesing stated that he believes there has not been fewer market conduct exams and stressed that a lot of the data calls being conducted have nothing to do with solvency or consumer protection. The data calls are outside the scope of the core functions of the State Insurance Department and that is what the Resolution seeks to address. Sen. Seward stated that he has heard about these problems in New York and it is important to establish some guardrails around the data calls.

Rep. Keiser made a Motion to adopt the Resolution. Sen. Jerry Klein (ND) seconded the Motion. The Committee then voted without objection by way of a voice vote to adopt the Resolution.

DISCUSSION ON NAIC INSURANCE DATA SECURITY MODEL LAW

Ray Farmer, Director of the South Carolina Department of Insurance, stated that the NAIC recently adopted its Insurance Data Security Model Law. Since that time, the U.S. Treasury Report that examines the current regulatory framework for the asset management and insurance industries encouraged States to adopt the Model Law. Director Farmer stated that the Model will be introduced during the upcoming South Carolina legislative session and that it is his understanding that it will be introduced in other States as well. Director Farmer urged the Committee to introduce the Model in their respective States.

Frank O'Brien stated that PCI supports the Model but still has some concerns with it in the areas of exclusivity, confidentiality, and annual certification requirements. Mr. O'Brien applauded Director Farmer's efforts throughout the drafting process and stated that he expects the Model to be introduced in several States soon.

Joe Thesing thanked Director Farmer for his efforts throughout the drafting process and stated that fortunately, the final Model, as compared to previous versions, focuses on data security programs and not on specific protocols for consumer notification. However, NAMIC will not be actively supporting the Model and is concerned that the Model will be submitted as a requirement for NAIC accreditation. NAMIC shares PCI's concerns regarding exclusivity and confidentiality.

RE-ADOPTION OF CREDIT DEFAULT INSURANCE MODEL LEGISLATION

Rep. Keiser made a Motion to re-adopt the NCOIL Credit Default Insurance Model Legislation. Rep. Carbaugh seconded the Motion. The Committee then voted without objection by way of a voice vote to adopt the Model.

ADJOURNMENT

There being no further business, the Committee adjourned at 5:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MEETING MINUTES
PHOENIX, AZ - THURSDAY, NOVEMBER 16, 2017
12:00 P.M.-1:00 P.M.

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the Sheraton Grand Phoenix Hotel in downtown Arizona on Thursday, November 16, 2017 at 12:00 pm.

Vice Chair, Representative Richard Smith of Georgia presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR
Sen. Travis Holdman, IN
Rep. Joseph Fischer, KY
Rep. Jim Gooch, KY
Rep. Steve Riggs, KY
Rep. Michael Webber, MI
Rep. Lois Delmore, ND
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Asm. Will Barclay, NY
Asw. Pamela Hunter, NY
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Marguerite Quinn, PA
Rep. Bill Botzow, VT

Other legislators present were:

Rep. Bryon Short, DE
Rep. Rick Billinger, KS
Asm. Kevin Cahill, NY
Asm. Andrew Garbarino, NY
Rep. Leiws Moore, OK
Rep. Tom Oliverson, TX

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 from its July 15, 2017 Committee meeting in Chicago, Illinois.

THE NEW NORMAL: INNOVATIVE TRENDS SHAPING THE LIFE INSURANCE AGENCY

Rep. Smith, introduced Hal Schwartz, Co-founder and COO of Quilt. Mr. Schwartz explained a bit about Quilt and its business model and how it relates to the technology evolution that is going on in the Insurance Industry today. He stated that Quilt's focus was that of a simple platform for people who would prefer to purchase a traditional insurance product digitally. Quilt has a number of products, but primarily offers life and renter's insurance with the hope of moving into pet, travel and ancillary products. Quilt simplifies the insurance purchase, as well as the insurance product, and the process of educating clients on the cost of insurance. Their target audience are those in the age range of 25 to 40. Mr. Schwartz described their product as an innovative way to get life insurance through a "selfie" process. He stated that this

would allow a buyer to get a quote on life insurance by viewing different aspects of someone's face to determine their age, BMI, smoking, actual health, age, etc. He stated that it was their opinion, in the coming years, to expect to see this kind of information taken digitally as opposed to the collection of blood, cheek swabs, etc. He stated that the information gathered digitally include items like credit score, accident records, Facebook associations and telematics records among others. He added that if you know someone's telematics score, you are more likely to be able to judge whether or not they are more likely to have a car accident.

Mr. Schwartz stated that the biggest movement over the next five years will be the integration of live data to the historical data sets. He stated that technology can now record blood pressure and heart beats, and they are working on glucose levels without a finger prick. This will help provide the data that will determine specific risk because one will be able to move customers to what they call the "Sweet Spot" which is "Simplified with Digital and an Expanded Digital" approval processes for the sale of product which is better for the customer because of timeliness and better for the carrier because of the cost of providing the quote and coverage. He further stated that the industry would get to a point where they would be able to deliver a reduced price for those individuals who maintain a healthy life style as compared to those who do not. This would all be done by tracking live data. This would also help provide proof for those who are in an underserved market.

Rep. Smith inquired as to how regulation has impacted this model. Mr. Schwartz stated that the carriers work with the regulators on these matters and that they work with a company called "Lumico" which developed a digital underwriting program that has been approved by 44 state insurance commissions and by which the regulator understands the dynamics of going to a digital era. If a consumer does not meet certain criteria, he/she would then have to go in person to have a medical examination.

Senator Seward asked what type of insurance this data relates to. Mr. Schwartz responded by stating that this data was put together for life insurance. However, they do the same thing for P&C. Senator Seward stated that in the area of P&C, it would be different. NCOIL, and most states, enacted laws of how credit scores can be used in pricing a policy. Data would need to be used in a fair way. In the area of P&C, credit and addresses are used.

Rep. Botzow inquired about the types of data that would be available - How would the collection of data be acquired and kept secure? Will this be with permission of the individual? Will the individual be able to make corrections if it is wrong? Where does this fit in with data privacy laws that are extensive but different throughout the states? This is very personal information that is being collected and how does the company guard against vulnerabilities?

Mr. Schwartz, responded by stating that one of his primary focuses is on data security and privacy aspects. He went on to say that, to be very clear, they are an agency and not a carrier. The carriers that Quilt works with are required by state law, just as they are, to maintain high security levels. He stated that all the same permissions that are required on paper are still required only digitally. He went on to say that data is already available through publicly available resources, PHI transfer agreements, or it is available through
different sources like Lexus Nexus or data brokers. He did say that there are some areas where permissions are questionable like twitter and Instagram postings. He stated that the question on correction is interesting because all the federal laws in regard to financial reporting and health care records would build in correction capabilities that can be done through an

electronic system. The states should look at such items as how it relates to the Twitter and Facebook environment because those items are not included in the laws. Today, there is no way of correcting Twitter or Facebook.

Rep. Smith introduced John Mangan of the American Council of Life Insurers (ACLI). Mr. Mangan reported on what is being done at ACLI in regards to innovation and technology, noting that underwriting and analytics are two of the areas ACLI is looking at. Consumers are demanding a different approach, as they are expecting to be able to obtain products in an easy manner. ACLI thinks that data analytics can be very helpful in achieving better access. He further stated that ACLI felt that it would help reduce the cost of distribution and potentially increase the number of people who are ultimately covered. He stated that ACLI is looking to work with states that would allow them to work with their regulators in a program such as "Regulatory Sandboxes." This is a way for the states to allow technology companies and insurers to experiment with new processes in a safe environment before going to market.

The States of Illinois and Wisconsin have put together programs for ACLI to begin to do this. They are working with their regulators to ensure that they can test new processes before they go to market. They would still have to meet all the given requirements in any state before going live. Members are also pushing for all laws and regulations that exist to be looked at to determine where they can find areas that are creating barriers and to work with the states and the regulators.

Rep. Keiser, stated that he received a fax offering to sell him life insurance and the thought occurred to him, especially with the use of big data, that insurance is state based and state regulated. However, there are people selling insurance over the internet and crossing state lines. He questioned what can be done about the "race to the bottom" as to managing requirements of selling insurance across state lines. Mr. Mangan stated that ACLI is experimenting with several activities in the aforementioned "sandboxes" and that if something is not protective of consumers, and if it were not supplying the education and the information to the consumers to make an informed choice, then it would not go to market. Mr. Mangan stated that they are in collaboration with legislators and regulators to ensure that whatever ideas are explored, ACLI would be able to implement them in a way that is fair to consumers and that it does meet all of the standards that are in place with the laws everyone supports.

Rep. Keiser stated the laws vary from state to state. It could be conceivable to end up having all life insurance being sold from one state. What preventative measures is the ACLI implementing to prevent that from happening? Mr. Mangan responded by stating that the current system is preventive of that since it has 50 state regulators and in order to do business in that state the product would have to be approved. If approved in one state, the product would have to go to all states individually to have it approved. If a practice or a product becomes so well accepted, then perhaps it would become the subject of an interstate standard. Until then, each state will still have jurisdiction.

Professor Kochenburger stated that one of the values of state based regulation is that products/services must comply with the laws in the state which the product is being offered. He said that states would always be allowed to protect their constituents. Professor Kochenburger stated that Big Data is an absolute benefit and is already here but that there are obvious concerns - citing that some vendors look at social media and correlate it with risk and that risk classifications need constant monitoring. He used the example of someone who moves frequently, such as military personnel, noting that they

should not be penalized for it. He noted that staff cannot evaluate the risk without bringing in individuals who can evaluate the data and determine the risk in the underwriting models. He further noted that in today's day and age, individuals with the expertise to evaluate the data are needed. Actuaries alone are no longer sufficient to evaluate the sophisticated nature of these underwriting models and that data scientists, computer scientists and statisticians with this kind of expertise are heavily valued in this today's market. Prof. Kochenburger closed by stating that State legislators play a very important role in this arena by deciding what types of information can and cannot be collected.

UPDATE ON INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION (IIPRC)

Rep. Richard Smith Introduced Ms. Karen Schutter, Executive Director, IIPRC. Ms. Schutter reported that their annual legislative meeting would be held via conference call on November 27, 2017 and not during the NAIC meeting. Ms. Schutter went on to say that the US Treasury Department's Finance report of financial systems discusses economic opportunities for assets management in insurance and does discuss the state-based product approval and speed to market approval. There is also a section which discusses the Compact as part of its recommendation to increase consumer choice and decrease cost for both insurers and consumers.

INTRODUCTION OF LIFE INSURER NOTIFICATION BEFORE AN ADVERSE CHANGE IN NON-GUARANTEED ELEMENTS OF EXISTING POLICY

Asw. Pamela Hunter stated that in NY, the Department of Financial Services has proposed Insurance regulation 210, The Life Insurance and Annuity Non-Guaranteed Element Regulation and that this new regulation requires life insurers to notify DFS at least 120 days before an adverse change and non-guaranteed elements of an existing policy is made. Some of the specifics relative to this regulation starting in March 2018 state that the insurers must now notify consumers at least 60 days prior to an adverse change in premiums. Certain life insurers significantly increase the cost on older life insurance policies due to decreased profitability stemming from low interest rates and in some cases, adverse mortality experience. DFS drafted the regulation in response to these concerns raised by consumer groups that some insurers have not been implementing these increases in accordance with DFS-approved policy provisions and the relevant provision in accordance of the NY insurance law. In addition to notifying DFS, the final regulation required life insurers to notify consumers at least 60 days prior to an adverse change and non-guaranteed elements of an in-force life insurance or annuity policy. The new rule was adopted by DFS to take into consideration comments that were submitted by the insurance industry during two common periods. This new regulation codifies a process that DFS has preferred. She stated that she is in support of this regulation and recommends the committee consider looking into this issue for further discussion and perhaps even the development of a model law.

Rep. Richard Smith then introduced Michael Kreiter of the Life Insurance Settlement Association. Mr. Kreiter stated that he wanted to follow up on a trend that has developed around the country regarding large cost of increases for certain segments of policy holders. He said that the costs of insurance is a non-guaranteed element and that as a result of these increases, which are large and unjustified, a number of class action law suits are pending and they have seen a large number of consumer complaints around the country. He went on to say that considering these issues, the Life Insurance Settlement Association supports these efforts to curb these practices and respectfully encourages NCOIL

to develop a model law so that policy holders are protected. He stated that since 2015, there have been a documented number of insurance increases ranging from 2% to 200% and, in some cases, up to as much as 500%. This is happening to those who have dutifully paid their premium and are suddenly hit with an increase which, many times, they do not understand. The motivation, he stated in the letter he distributed, lies with the carriers to increase their profit margins. He stated that they applaud the actions taken by the DFS. He also noted that profit margin cannot be an experience factor as a way of seeking to increase these non-guaranteed elements. The Life Insurance Settlement Association believes that improvements can be made and that NCOIL can bring it into the spotlight and develop a model law that builds upon NY's efforts and that would effectively protect policy holders around the country.

ADJOURNMENT

There being no additional business the Life Insurance and Financial Committee meeting was adjourned at 1:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS STATE FEDERAL RELATIONS COMMITTEE AND INTERNATIONAL INSURANCE ISSUES COMMITTEE
PHOENIX, ARIZONA
NOVEMBER 17, 2017
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) State-Federal Relations Committee and International Insurance Issues Committee met at the Sheraton Grand Phoenix Hotel on Friday, November 17, 2017 at 9:15 a.m.

Senator Dan "Blade" Morrish of Louisiana, Chair of the State-Federal Relations Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR
Rep. Joseph Fischer, KY
Rep. Steve Riggs, KY
Rep. Michael Webber, MI
Rep. Lois Delmore, ND
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Sen. Neil Breslin, NY
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Michael Henne, OH
Rep. Bill Botzow, VT

Other legislators present were:

Rep. David Livingston, AZ
Rep. Richard Smith, GA
Rep. Martin Carbaugh, IN
Rep. Jim Gooch, KY
Rep. John Wiemann, MO
Asw. Maggie Carlton, NV
Asm. Kevin Cahill, NY
Rep. Tom Oliverson, TX

Also in attendance were:

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

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 13, 2017 meeting in Chicago, Illinois.

THE COVERED AGREEMENT – DISCUSSING THE ROAD AHEAD

Michael Consedine, NAIC CEO and former Commissioner of the Pennsylvania Department of Insurance, stated that the Covered Agreement (Agreement) is a unique mechanism borne out of Dodd-Frank created to resolve a situation between the U.S. and Europe that has been around for decades and has been a source of tension – European reinsurers were required to post collateral on a U.S. ceded business whereas a U.S. reinsurer wasn't. The NAIC had revised its Credit for Reinsurance Model in an attempt to rectify the problem by providing collateral relief if a European or other reinsurer outside the U.S. met certain jurisdictional and solvency requirements. However, that proved to not be enough which led to the Agreement mechanism in Dodd-Frank. The

negotiation process surrounding the Agreement started in the Obama Administration and continued in the current Administration – the process had flaws. The Agreement states that in exchange for U.S. reducing, if not eliminating collateral requirements for European reinsurers, the U.S. receives some certainty around European requirements for U.S. groups doing business in Europe related to governance and capital.

Cmsr. Consedine stated that the NAIC had reservations about the Agreement because it represents a Federal intrusion into the state-based system of insurance regulation, but nonetheless, the NAIC worked with the Obama and Trump Administrations, along with members of Congress, to identify some areas that, if some clarity and certainty was provided on, the comfort level with the Agreement would be better. The Trump Administration released a policy statement on the Agreement which the NAIC believes provided such clarity and certainty. The policy statement re-affirmed the primacy of state insurance regulation and indicated that the group capital calculation approach the NAIC is working on will be recognized under the Agreement. Once the European Parliament executes their requirements pursuant to the Agreement, that will start a five-year clock where States have to evaluate how to go forward with implementing the Agreement. Options include: a.) not implementing the Agreement which would result in the federal government stepping in in five years to preempt state law and implement the Agreement; b.) during the five-year period, the States will control their own destiny in figuring out how best to implement the Agreement in a way that preserves the primacy of state insurance regulation. The NAIC is currently discussing whether to amend its Credit for Reinsurance Model Law to implement the Agreement. One issue the NAIC is discussing is whether to recognize other similarly situated jurisdictions and not just the EU in the zero-collateral approach – jurisdictions such as Switzerland, Bermuda, and Japan. Cmsr. Consedine welcomed NCOIL participation throughout this process.

Sen. Morrish asked if the Agreement has been officially agreed upon between the U.S. and EU. Cmsr. Consedine stated that it has effectively been agreed upon – there are a few procedural aspects that the European Parliament must complete.

Christina Urias, former Director of the Arizona Department of Insurance, agreed with Cmsr. Consedine's statement that the policy statement on the Agreement was encouraging because it clarified some issues and supported the state based system of insurance regulation. Dir. Urias stated that there are three major areas in the Agreement: a.) reinsurance collateral – the Agreement seeks to make it equal in terms of what collateral is charged. In the past, U.S. reinsurers did not have to put up any collateral on the risks they undertook but European reinsurers had to put up 100% collateral. Notably, the Agreement allows for the parties to negotiate a separate collateral agreement; b.) group supervision – the Agreement eliminates the requirement for U.S. reinsurers doing business in Europe to comply with Solvency II requirements. U.S. groups are exempt from EU reporting requirements. U.S. groups can obtain information on EU reinsurers parent companies. And the NAIC group capital calculation standards will satisfy the Agreement's group capital assessment standards. Notably, the NAIC does not anticipate any changes to its Model Holding Company Act; c.) information exchange – the gold standard for that is the IAIS MMOU agreements although they are not specifically mentioned in the Agreement.

Dir. Urias noted the Agreement creates a joint committee consisting of EU and US members that would resolve disputes that may arise under the Agreement. The policy statement on the Agreement states that state insurance regulators will be "consulted"

about the disputes. Dir. Urias also noted that there will likely be a public hearing on the Agreement in February as to how best to proceed with changes to the NAIC Credit for Reinsurance Model Law to recognize the Agreement.

Rep. George Keiser (ND) asked Dir. Urias if she thought that Europe "won" the negotiations involved with the Agreement. Dir. Urias stated that she was not in favor of the Agreement - the best regulation is local in nature, and policyholders need the protection of collateral. But, it was a negotiation, and now that insurance is more global in nature, we must work with our counterparts. Dir. Urias stated that, having said that, she would not be in favor of any future Agreement's.

Sen. Bob Hackett (OH) asked if other States, in addition to Ohio, lowered the 100% collateral requirement for international reinsurers. Dir. Urias stated that other States had done that – the NAIC Credit for Reinsurance Collateral Model Law sets a sliding scale from 0 to 100 for collateral, based on the financial solvency of the reinsurer. Almost every State has adopted that Model. The Agreement does in fact remove the collateral requirements – although it still allows the parties to negotiate – so it is most important for U.S. regulators to work with European counterparts to make certain of the financial solvency of the reinsurer.

Rep. Joe Fischer (KY) asked what penalty the Federal government can impose on a State if it chooses not to comply with the Agreement. Dir. Urias stated that the Agreement provides for the creation of a Joint Committee that is charged with resolving disputes. Ultimately, Dir. Urias stated that she believes Treasury would determine if the Agreement preempts State law.

Sen. Morrish asked Dir. Urias if the Agreement mentions the state-based system of insurance regulation. Dir. Urias stated that yes, both the Agreement and accompanying policy statement mention it and support said system.

Dennis Burke of the Reinsurance Association of American (RAA) stated that 41 States have adopted the NAIC Credit for Reinsurance Model Law and that the five-year period for States to implement the Agreement is in reality shorter because each State's insurance department and legislature operate on different timelines. For example, Texas' legislature meets in regular session every other year. Mr. Burke stated that Rep. Fischer asked the right question earlier – the main issue is preemption of State law given how quickly the Agreement's five-year implementation period will move. Mr. Burke encouraged regulators, legislators and interested parties to work together to move as quickly as possible.

Dave Snyder from the Property and Casualty Insurance Association of America (PCI) stated that the Agreement should be a topic of discussion at NCOIL meetings in the future because there is a lot of work to be done for implementation. Mr. Snyder noted that there is pending Federal legislation that states future Agreement's cannot impose additional prudential requirements on U.S. companies besides those that currently exist in U.S. law. It is also important to make sure going forward that U.S. companies doing business in the EU get the full benefit of the Agreement.

Joe Thesing from the National Association of Mutual Insurance Companies (NAMIC) stated that NAMIC has long been an opponent to the Agreement. However, the policy statement on the Agreement is a positive step. Mr. Thesing stated that one thing to

keep an eye on in the future is that when collateral requirements go away, it is an open question as to whether small and regional companies will have the negotiating power to require any collateral. And, it is an open question as to how those small and regional companies will be viewed in the regulatory community.

DISCUSSION ON THE FUTURE OF SIFI DESIGNATIONS

Cmsr. Consedine stated that Dodd-Frank created the FSOC which has several roles, one of which is to identify and designate banks, insurance companies, and other financial services entities, as "systematically important." Such a designation involves additional regulatory supervision and capital requirements. After the financial crisis, AIG, Metlife and Prudential were the "designated" insurance company entities. From the beginning, there were concerns with the designation process because there was not a foundational basis to support the notion that insurance companies were systemically risky. Additionally, the designation process was flawed because state insurance regulators did not have voting authority. Recently, Metlife and AIG have been de-designated. The NAIC continues to advocate for changes to FSOC, including the reform of the SIFI designation, if not entirely eliminating it. Cmsr. Consedine noted that the recent U.S. Treasury report on the asset management and insurance industries is encouraging because it supports the state based system of insurance regulation.

Dir. Urias urged the Committee to review the Treasury report that Cmsr. Consedine mentioned. The recommendations set forth in the report are very strongly supportive of the state based system of insurance regulation. Regarding the evaluation of systematic risk, the recommendations state that the focus should not be on entity-based regulation but rather on products and the activities the companies are undertaking. Dir. Urias believes that insurance companies do not pose systemic risk. It remains to be seen whether FSOC will change or eliminate its evaluation and designation process. Similarly, it will be interesting to see what the Financial Stability Board (FSB) does with its designation of globally systematically important insurers (G-SII's) given the Treasury report's recommendation of activities-based approaches to risk evaluation. Dir. Urias noted that the NAIC initiated a macro-prudential surveillance initiative at its prior meeting this past Summer which focuses on new liquidity assessments.

Mr. Snyder stated that this morning, Treasury issued a detailed report on its recommended changes to the SIFI designation process. The report recommends an activities-based evaluation approach as opposed to designating large companies, and to involve state regulators more in the process after a systemic risk has been identified. The report also recommends a cost-benefit analysis as to whether additional regulation will provide a beneficial reduction in systemic risk, and the establishment of a clean "off ramp" for removal of the designation. Mr. Snyder noted that while the recommendations set forth in the report are supportive of the state based system of insurance regulation, that can turn on a dime, and it is therefore important for NCOIL to continue to be engaged in the process.

Rep. Keiser asked Mr. Snyder for clarification on what constitutes an activities-based evaluation approach. Mr. Snyder stated that is a good question and exactly what constitutes "activities" needs to be evaluated and clarified going forward to make sure that it doesn't put U.S. companies at a competitive disadvantage.

REVIEW OF FEDERAL INSURANCE FRAUD PREVENTION EFFORTS

Howard Goldblatt from the Coalition Against Insurance Fraud stated that the U.S. Senate Commerce Committee Subcommittee on Consumer, Product Safety, Insurance, and Data Security held a hearing on insurance fraud this past August. The purpose of the hearing was to examine insurance fraud trends in the United States and explore tools available to states, insurers and consumers to protect against these crimes.

One issue discussed that has gained traction since the hearing is the issue of sharing claims data among property-casualty insurers. Specifically, the Healthcare Fraud Prevention Partnership (HFPP), in which public and private health insurers and other stakeholders share data about medical schemes, has enabled $300 million in fraud savings. However, property-casualty insurers aren't privy to the HFPP data because of HIPAA restrictions. The issue of whether sharing such data being violative of HIPAA is not clear. Accordingly, it is arguable that this is an opportunity because many medical providers who defraud health insurers also file false claims with P&C and workers' compensation carriers. Mr. Goldblatt stated that the Coalition has been working with the Subcommittee to help property-casualty insurers gain access to that data.

DISCUSSION ON CONGRESSMAN DUFFY'S LEGISLATION (H.R. 3762, H.R. 3746, H.R. 3861) – REASSERTING THE STATE BASED SYSTEM OF INSURANCE REGULATION

Ray Farmer, Director of the South Carolina Department of Insurance, stated that H.R. 3762, H.R. 3746, and H.R. 3861 are part of a trend in Congress beginning to recognize that the state-based system of insurance regulation that has been in place for 150 years works well, and will continue to work well if Congress does not interfere. It is important to take advantage of this "window" that is now open to promote the state-based system of insurance regulation.

Mr. Snyder stated that H.R. 3762, and S. 1360, stand for the proposition that the state based system of insurance regulation is accountable and transparent, and that the international system should be the same. The legislation addresses that over 80% of international regulatory meetings are closed to U.S. consumers and companies. Additionally, the legislation states that the U.S. federal representatives in international negotiations need to coordinate, consult, and advocate a position that has been agreed to by the states. That is important because in the past, we have seen the federal government go in a difference direction from the states in terms of international insurance policy.

Mr. Thesing stated that NAMIC supports the three pieces of legislation introduced by Congressman Duffy and it is important to note that all three pieces are bi-partisan. H.R. 3861, the Federal Insurance Office Reform Act of 2017, right-sizes FIO – it caps the number of its employees, limits its subpoena authority, and requires more consultation with state insurance regulators. H.R. 3762, the International Insurance Standards Act of 2017, is a positive step in the right direction of improving the transparency and accountability of international insurance negotiations. H.R. 3746 clarifies the jurisdiction of the Consumer Financial Protection Bureau (CFPB) over the business of insurance. Peter Kochenburger, Associate Clinical Professor of Law and Executive Director of the Insurance LLM Program and Deputy Director of the Insurance Law Center at the University of Connecticut School of Law, stated that he is a firm supporter of the state based system of insurance regulation. However, said system is a means to an end, it is not the end, and it is important to look at legislation like this through the lens of not just

preserving the state based system of insurance regulation as an end to itself, but rather, does the legislation further the goals of said system which is to promote competitive markets and protect consumers. Prof. Kochenburger stated that he does not believe H.R. 3861 is necessary because FIO is already minimal in its authority and because the Federal government needs to have a role in the insurance industry since it is the largest such market in the world. Additionally, as the insurance market becomes more global in nature, States do not have the ability to communicate internationally as necessary. The proposed restriction on information gathering and reporting requirements does not serve the state based system of insurance regulation. Information is important, particularly on the national level. By limiting the number of employees in FIO we are shooting ourselves in the foot. There have been complaints that FIO does not properly understand the state based system of insurance regulation – the more we limit FIO's ability to gather information, the less informed it will be.

Mr. Snyder stated that FIO can continue to gather information but only through the channels that have been established under the state based system of insurance regulation, namely NAIC. Mr. Snyder urged NCOIL to continue to support Congressman Duffy's legislation and remain engaged.

Sen. Morrish asked what are the chances of the legislation advancing. Mr. Snyder stated that it is not clear at this moment which is why it is important for NCOIL to stay engaged. Mr. Snyder also noted that based on his conversations with members of Congress and their staff, NCOIL has made an impression with them on these issues.

Rep. Steve Riggs (KY) then provided a brief summary of the NCOIL D.C. fly-in that was held this past September. Nine state legislators, along with Cmsr. Tom Considine, NCOIL CEO, and NCOIL staff, attended. Congressman Duffy's legislation, along with the reauthorization of the NFIP, was discussed throughout over 50 meetings with members of Congress and their staff. Rep. Riggs stated that he looks forward to future NCOIL D.C. fly-ins since they help raise NCOIL's profile and promote issues that support the state based system of insurance regulation.

RE-ADOPTION OF MODEL LAWS

Rep. Riggs made a Motion to re-adopt the Exhaustion of Administrative Remedies Model Legislation. Rep. Fischer seconded the Motion. The Committee then voted without objection by way of a voice vote to adopt the Model.

Sen. Hackett made a Motion to re-adopt the Producer Compensation Disclosure Model Amendments to the Producer Licensing Model Act. Rep. Fischer seconded the Motion. The Committee then voted without objection by way of a voice vote to adopt the Model.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE
PHOENIX, ARIZONA
NOVEMBER 17, 2017
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at the Sheraton Grand Phoenix Hotel on Friday, November 17, 2017 at 3:00 p.m.

Senator Jason Rapert of Arkansas, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. David Livingston, AZ
Rep. Martin Carbaugh, IN
Rep. Matt Lehman, IN
Rep. Joseph Fischer, KY
Rep. Michael Webber, MI
Rep. Lois Delmore, ND
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Bill Botzow, VT

Other legislators present were:

Rep. Bryon Short, DE
Rep. David Santiago, FL
Rep. Park Cannon, GA
Rep. Peggy Mayfield, IN
Rep. Steve Riggs, KY
Rep. John Wiemann, MO
Asw. Maggie Carlton, NV
Asw. Pamela Hunter, NY
Rep. Marguerite Quinn, PA
Rep. Tom Oliverson, TX
Rep. Jim Dunnigan, UT

Also in attendance were:

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

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 14, 2017 meeting in Chicago, Illinois.

DISCUSSION ON NAIC INSURANCE DATA SECURITY MODEL LAW

Sen. Rapert asked how the NAIC thinks State receptiveness to the NAIC's recently adopted Insurance Data Security Model Law (Model) will be as State legislative sessions are fast approaching.

Ray Farmer, Director of the South Carolina Department of Insurance, stated that out of 56 jurisdictions that voted on the Model last month, only one opposed. The reason the NAIC got involved in drafting such a Model in the first place was because of the massive health insurer data breaches in 2014. The adopted Model went through six prior drafts and benefited from a wide range of input. Notably, the report recently issued by Treasury encouraged States to adopt

the Model. Dir. Farmer stated that the Model will be introduced in South Carolina's next legislative session and it is his understanding that it will be introduced in other States' upcoming sessions as well. The Model gives guidance to regulators, industry, and consumers, and contains important exemptions. Throughout the drafting process, the NAIC was concerned about the Model's applicability to small entities and independent agents. Accordingly, entities with fewer than 10 employees are exempt from the Model's requirements. Additionally, health insurers that comply with HIPAA's privacy requirements are deemed to have met the Model's requirements. The Model mirrors the recently promulgated New York Department of Financial Services cybersecurity regulations, and accordingly, compliance with the regulations means compliance with the Model.

Sen. Rapert stated that it is important that the financial services and insurance industries work together on these issues because if multiple silos are created regarding different ways of doing things, it could make the problems worse. Sen. Rapert also noted that he is concerned that such a large number of independent insurance agencies are exempt from the Model because such a large amount of important data is trusted with such agencies. Dir. Farmer stated that regarding coordination of efforts across industries, he sits on the Financial Banking Information Infrastructure Committee (FBIIC) and that there is a great relationship amongst all members in terms of sharing what different industries are doing with cybersecurity developments. Additionally, based on his experience, Dir. Farmer stated that the insurance companies are doing a good job of understanding the seriousness of the threat and working towards protecting themselves and in turn consumers.

John Doak, Oklahoma Insurance Commissioner, stated that Dir. Famer has done a tremendous job leading the drafting of the Model. Cmsr. Doak also noted that in Oklahoma, the Insurance Department has held meetings on cybersecurity for its domestic insurers and will continue to do so.

Rep. Matt Lehman (IN) stated that he appreciates the version of the Model adopted by the NAIC as compared to prior drafts but stated that if you look at the 14 largest data breaches, only one was to an insurance company – Anthem. Many of the entities that have been breached are governed by Treasury and accordingly Rep. Lehman questioned Treasury's endorsement of the NAIC Model. Rep. Lehman stated that more focus needs to be on the breach itself and asked Dir. Farmer if other industries that are represented on FBIIC are taking the breaches as serious as the insurance industry. Dir. Farmer stated that the other industries definitely are. Rep. Lehman asked if the market has been growing for cyber insurance. Dir. Farmer stated that the cyber-insurance market is still relatively a niche market but noted that it has been growing and that he expects it to continue to grow.

REVIEW OF NAIC & STANFORD UNIVERSITY CYBERSECURITY FORUM

Cmsr. Doak noted that the NAIC-Stanford University Cybersecurity Forum was a well-attended event and was held to provide insight into cyber threats and the role that insurance plays in mitigation of those threats. The forum was part of National Cybersecurity Awareness Month and one of the speakers was Richard Clarke – former National Coordinator for Security, Infrastructure Protection and Counter-terrorism for the U.S. There were also panels held to discuss underlying cyber risks, the range of cyber threat scenarios, and how to identify potential gaps in cyber insurance coverage. The NAIC is committed to better understanding the cybersecurity landscape, how insurance fits into that arena, and to ensure that consumers are protected from data breaches. Cmsr. Doak welcomed NCOIL participation at such events in the future.

Dir. Farmer stated that the Forum was important because a lot of the conversations focused on avoiding the breach in the first place rather than focusing on the aftermath. Everybody has to be focused on what they "click" on how they safeguard their information. Additionally, companies and/or agents doing business with a third party need to make sure the third party is properly secured – that is an aspect that often gets forgotten. Cmsr. Doak brought up the issue of ransomware and stated that a lot of work needs to be done in that area. Sen. Rapert agreed and stated that it is important to remember that, while the technical aspects of firewalls and the like are extremely important and necessary in protecting information, common sense goes a long way.

Rep. George Keiser (ND) asked if the National Security Agency (NSA) breach was discussed at the Forum. Dir. Farmer stated that it was. Cmsr. Doak stated that Richard Clarke noted that he has been through five separate data breaches himself and stressed better understanding of the prevalence of data breaches on an individual level.

Sen. Bob Hackett (OH) stated that in Ohio a Task Force was formed on cybersecurity and they learned that a lot of the concerns from companies centered around the fear that they could be breached even if they follow the best prevention systems in the world. Legislation was just introduced in Ohio that incentivizes companies to adhere to certain standards – if they do, they are provided with an "affirmative defense." Sen. Hackett asked if incentivizing adherence is a good approach. Dir. Farmer stated that every State has to address their own issues but that he would be reluctant to provide a safe-harbor.

Rep. Bill Botzow (VT) noted that State legislators need to aggressively respond to these issues even if they risk not getting everything perfect because State legislator's basic job is to protect the public.

Rep. Joseph Fischer (KY) stated that his concern with the NAIC Model is that it is silent on the issue of a private cause of action and asked if the NAIC is opposed to States adding a provision that specifically preempts a private cause of action. Dir. Farmer stated that was a repeated suggestion throughout the drafting process, but it was ultimately decided to not be included. Dir. Farmer noted that he supports States adopting the Model as-is, but acknowledged that it is in fact a "Model" and accordingly, States are free to modify it as they wish.

DISCUSSION ON NAIC GROUP CAPITAL CALCULATION ACTIVITIES

Sen. Rapert stated that one need look no further than the Texas, Florida and Puerto Rico hurricanes to appreciate the compelling public policy that insurance companies should have sufficient resources to pay claims when due, and asked Dir. Farmer and Cmsr. Doak if they could provide an update on what the NAIC has been working on recently with regards to possible ways of calculating group capital requirements.

Cmsr. Doak stated that in late 2015 the NAIC began exploring the potential approaches to group capital calculation. Group capital calculation is an additional regulatory tool for U.S. group supervision that is intended to provide additional data to the lead State within the holding company structure. The goals and objectives of the calculation from a regulatory perspective include: adding a valuable, analytical tool to compliment the U.S. holding company analysis; assisting the group supervisor in monitoring the overall financial flexibility and strength of the group as a whole since it captures the group capital information as well as the material legal entity capital information; providing a quantitative measure to be used by regulators in

conjunction with group-specific risk and stresses identified in ORSA and Form F filings that may not be captured in the legal entity's RBC filing. The basis for the calculation will be an RBC aggregation methodology. The calculation will require an inventory of the carrying value of the capital requirement of the material companies within the group. Once the companies are inventoried, the calculation requires the elimination of the carrying value and the capital requirement of any stacked entities as well as potential adjustments for captives and permitted practices. A number of the potential approaches to group capital calculation were considered at the start of the process. The NAIC rejected the use of a counting consolidation method for a number of reasons, including that it inaccurately assumes that capital is fungible throughout the group. The scope of the group is an informational consideration although the calculation itself must be first developed before the scope an be fully vetted and determined. The current thinking is that the calculation would apply to the ultimate controlling party in the group and its subsidiaries. Therefore, the scope of the group is initially set to be all legal entities within the group which is consistent with the scope including the NAIC Holding Company Models and Financial Analysis Handbook. Once the calculation is developed, the NAIC's Group Calculation Working Group can consider it and whether it is appropriate to exclude any groups within that group. As far as the implementation deadline for field testing, a tentative timeline has been established but there are no strict deadlines at this point. The NAIC has undertaken a baseline exercise with approximately 10 companies in 2017 to capture the specific data to help make the decisions on some of the details on the ultimate calculation. The baseline exercise allowed the working group to compare the capital requirements using RBC figures to compare against the alternatives. More formal testing is expected in 2018 through some type of beta-version. Treatment of captives along with the treatment of potential grouping of non-insurance affiliates are currently under discussion. Cmsr. Doak noted that Florida Insurance Commissioner David Altmaier is Chair of the Group Capital Calculation Working Group.

Sen. Rapert noted that the U.S. policy statement on the Covered Agreement states that the U.S. expects that the NAIC's group capital calculation will satisfy the 'group capital assessment' condition of Article 4(h) of the Covered Agreement, provided that the work is completed and implemented within five years of the date on which the Agreement is signed. Sen. Rapert asked if the NAIC expects that to be the case and if there is there any concern that the work won't be completed and implemented within five years. Dir. Farmer stated that NAIC fully expects its work in that area to be completed within that timeframe and to satisfy the Covered Agreement's 'group capital assessment' condition.

DISCUSSION ON NAIC INSURE-U USAGE INSURANCE ACTIVITIES

Dir. Farmer stated that the NAIC's "Drive Check" tool allows for an individual to go on the NAIC website and answer a few questions to determine of usage-based insurance (UBI) is appropriate for them. Dir. Farmer also noted that in the context of technology and the NAIC, after a natural disaster, it is almost impossible for individuals to remember what items were in their apartments or homes after it was severely damaged or destroyed. Accordingly, the NAIC came up with a home-inventory app – something that several insurers now have.

Cmsr. Doak stated that the "drive check" feature is a tremendous tool gaining popularity, and that in the context of innovation, it is amazing how Insurtechs are growing which is reflected by the increased participation in the recent Insurtech Conference. The first conference two years ago had approximately 1,500 attendees, this year there were 3,500 attendees, and next year 7,500 attendees are expected. Cmsr. Doak encouraged everyone to attend the conference as it is State insurance regulators and legislators job to keep abreast of how innovation is affecting the industry.

UPDATE ON PRESIDENT TRUMP'S HEALTHCARE EXECUTIVE ORDER AND CANCELLATION OF COST-SHARING REDUCTION PAYMENTS

Dir. Farmer stated that there are two types of subsidies. One is on the front-end for when consumers purchase premiums, and the other are the cost-sharing reduction (CSR) payments made directly to insurers. The Trump Administration has decided to stop making the CSR payments to insurers. For the insurers that already had their rates in effect, they will have to "eat" that expected CSR payment. Dir. Farmer stated that South Carolina citizens will experience a 31% increase in Exchange premiums due to the lack of CSR payments to insurers. Dir. Farmer noted that he and Cmsr. Doak, along with several others, testified before the HELP Committee and asked them to: a.) fund the CSR payments; b) provide for more flexibility in the 1332 waiver process; and c.) re-institute the reinsurance program. Dir. Farmer stated that unfortunately, partisan politics are a problem with those issues. Cmsr. Doak agreed with Dir. Farmer's statements and noted that Oklahoma citizens are experiencing similar rate increases due to the lack of CSR payments made to insurers.

Rep. Park Cannon (GA) asked if there are any pertinent lawsuits that State legislators should be aware of regarding the CSR payments. Cmsr. Doak stated that he believes there are and stated that NAIC staff can provide that information to the Committee after the meeting.

UPDATE ON NAIC LOST LIFE INSURANCE POLICY LOCATOR

Cmsr. Doak stated that in November 2016, the NAIC introduced the life insurance policy locator that provides for nationwide access for assistance with finding life insurance policies and annuities. Since introduction, $92.5 million has been returned to consumers which consists of 8,210 beneficiaries and over 40,000 searches. Cmsr. Doak urged the Committee members to promote the service in their respective States.

ADJOURNMENT

There being no further business, the Committee adjourned at 4:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY AND CASUALTY INSURANCE COMMITTEE
PHOENIX, ARIZONA
NOVEMBER 16, 2017
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at the Sheraton Grand Phoenix Hotel on Thursday, November 16, 2017 at 2:15 p.m.

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

Other members of the Committee present were:

Sen. Jason Rapert, AR
Rep. Richard Smith, GA
Rep. Martin Carbaugh, IN
Rep. Matt Lehman, IN
Rep. Peggy Mayfield, IN
Rep. Joseph Fischer, KY
Rep. Steve Riggs, KY
Sen. Dan "Blade" Morrish, LA
Rep. Michael Webber, MI
Rep. Lois Delmore, ND
Rep. George Keiser, ND
Asw. Maggie Carlton, NV
Sen. Neil Breslin, NY
Asm. Kevin Cahill, NY
Asw. Pamela Hunter, NY
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Michael Henne, OH
Sen. Jay Hottinger, OH
Rep. Marguerite Quinn, PA
Rep. Bill Botzow, VT

Other legislators present were:

Rep. David Livingston, AZ
Rep. Bryon Short, DE
Asm. Andrew Garbarino, NY
Rep. Lewis Moore, OK
Rep. Jim Dunnigan, UT
Rep. Tom Oliverson, TX

Also in attendance were:

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

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 14, 2017 meeting in Chicago, Illinois.

CONSIDERATION OF MODEL TOWING ACT

Rep. Matt Lehman, NCOIL Treasurer, stated that the Committee has discussed drafting a Model Towing Act for several years and the current draft represents the most progress towards a final Model thus far. There are two main parts to the current draft: the actual towing process; and the issues that arise once a vehicle has been towed and stored. Rep. Lehman stated that he believes the current draft is a strong framework but that it still needs some work through discussions from interested parties on both sides of the

issues. One of the Model's main sections is Section 5 – Emergency Towing Requirements – which, among other things, makes it a violation 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, 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, or unless the owner of the disabled vehicle previously provided consent to the towing company. The Model calls for the specific nature of the violation to be established by the adopting State.

Rep. Lehman further noted Section 6 of the Model – Private Property Towing Requirements – requires owners of private property that have established a private towaway zone, to post a sign that is clearly visible to the public and include on the sign a statement that the property is a tow-away zone, and a description of persons authorized to park on the property. Pursuant to Section 6, prior to towing a vehicle, 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, and the towing company shall record the time and date of the photographs and retain the records for at least two years after the date of which the vehicle was towed. Rep. Lehman stated that Section 7 – Estimate Requirements – and Section 8 – Itemized Invoice Requirements - are very important for consumers and that both sections can be improved through further discussions with interested parties.

Bart Giesler from the Indiana Towing and Wrecker Association thanked the Committee for allowing him to comment on the Model and stated that unfortunately representatives from the Towing and Recovery Association of America could not be here today due to scheduling conflicts. Mr. Giesler noted that the towing industry has not done a good job of explaining its functionality and that by understanding said functionality, the Model can be improved. Mr. Giesler stressed that it is difficult to generalize the towing industry – tows are different from State to State. In most but not all States, towers are on a "rotation" list administered by the State police department and in order get on that list, towers must submit their towing rates. Additionally, several factors affect the rates such as the type of equipment needed for different types of tows, as well as whether the tow is emergency or non-emergency (just like in the healthcare industry when comparing emergency vs. non-emergency prices). Further, a problem that the industry is facing is that of abandoned vehicles – a large number of those vehicles are never picked up by the owner which results in a tremendous amount of uncollected costs that ultimately have to be picked up by someone. At the end of the day, those factors drive up the cost of insurance.

Mr. Giesler stated that the Model should also differentiate between consensual and nonconsensual towing as that is a factor that effects the price. Mr. Giesler stated that there are also several concerns with the Model and its lack of consideration given to safety. For example, the Model requires, 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 – that would take a lot of time and could put those present at risk of a secondary accident. Mr. Giesler stated that he understands that Section 7B.a. tries to address that concern by allowing the itemized

estimate to be completed after the vehicle is attached and removed to the nearest safe shoulder or street, but noted that it does not address the problem of the person disputing the invoice. Ultimately, it will be a staring contest between the parties on the side of a road which is not safe. Additionally, if the driver is a teenager, they would most likely call their parents to come view the invoice which would result in more time on the side of a road. Another concern related to safety in the Model is the requirement to take photos of the vehicle prior to towing – there are no exceptions for inclement weather and, to capture the proper images in the photo, it may require the tower to be in unsafe positions on the side of a road.

Mr. Giesler stated that some of the Model's provisions will actually raise costs rather than lowering them, such as: 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. The Model states that no storage charges beyond the initial 24-hour charge can accrue until the notice requirement has been met. That will increase the cost of towing because towers will be forced to have employees working nights and weekends. Indiana has a 72-hour requirement that is more workable. Requiring towers to accept credit cards and checks as forms of payment will also increased towing costs, as will requiring that the towing company "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." (emphasis added). Mr. Giesler closed by requesting that the Model be tabled so that it can be improved through further dialogue between interested parties.

Joe Thesing from the National Association of Mutual Insurance Companies (NAMIC) stated that NAMIC has been in discussions with Rep. Lehman and other interested parties throughout the Model drafting process and there have been several attempts to respond to issues and concerns that have been raised. NAMIC believes that the current draft of the Model is a very strong framework and it is a good attempt to regulate an industry that is largely un-regulated at the moment. Safety is a concern for everyone involved but in response to Mr. Giesler's statement that the Model's itemized invoice requirements are not safe, as soon as the vehicle is secured, the police are in charge who can provide a safe environment. Accordingly, from a rational person's perspective, that would seem to provide towers with an opportunity to provide an itemized invoice. Mr. Thesing urged the Committee to move forward with the Model.

Rep. George Keiser (ND) asked why can't insurers notify consumers as to who are qualified and approved towers, similar to what North Dakota did when it had problems with auto glass manufactures. Mr. Thesing stated that is an interesting point and he will explore that with NAMIC's member companies.

Tim Lynch from the National Insurance Crime Bureau (NICB) stated that the problems consumers are facing in the towing industry is a national epidemic, with the brunt of the problems being in big cities. Only about a handful of States have taken action to address the problems so NCOIL's timing regarding consideration of Model legislation is very appropriate. Mr. Lynch stated that he believes there is room for compromise on these issues and he looks forward to discussing such issues with interested parties. One example of compromise is that Philadelphia recently enacted a law that grants an enforcement agency the ability to require a towing company to file an annual or other regularly updated list of all signs posted by the towing company – the sign shall give

notice of: that unauthorized parking is prohibited and unauthorized vehicles will be towed; that vehicles whose authorized parking time has elapsed will be towed; the name, address, and telephone number of the towing company; the charges for the towing and storage of towed vehicles; the place where the towed vehicle can be redeemed after paying the allowable charges and the hours of operation; and that towing related complaints shall be reported to 3-1-1. That was previously thought to be nonnegotiable.

Sen. Klein asked Mr. Giesler if he was satisfied with the work that has been done in other States on these issues. Mr. Giesler stated that he is not familiar with all of those State's towing laws, but that he and his colleagues are committed to working with NCOIL to ensure a good work product.

Rep. Lehman stated that one thing that NCOIL can offer the States on these issues is uniformity, and the quicker interested parties can get together and work on the Model, the better. Rep. Lehman stated that he would like the Committee to consider a final version of the Model at the NCOIL Spring Meeting in March 2017.

Rep. Keiser stated that it is difficult to have a one-sized-fits-all approach on these issues. A tow in North Dakota in the winter presents its own unique set of circumstances. Rep. Keiser stated that there seems to be a better strategy for solving the industry's problems than this much regulation. Rep. Lehman stated that he understood Rep. Keiser's concern about a lot of regulation, but at the opposite end of the spectrum, there cannot be little to no regulation which is the way the industry operates currently in most States.

Rep. Bill Botzow (VT) asked if the Model differentiates between large commercial vehicles and small private vehicles. Mr. Giesler stated that he believes the Model treats said vehicles the same.

DISCUSSION/CONSIDERATION OF AMENDMENTS TO NCOIL MODEL STATE UNIFORM BUILDING CODE

Rep. Lewis Moore (OK) stated that the proposed amendments to the NCOIL Model State Uniform Building Code are based on legislation he sponsored in Oklahoma - Oklahoma HB 1720, which was drafted and enacted in response to the tornadoes experienced in Oklahoma. The bill allows insurance companies to provide a discount, rate reduction or other related adjustment for new insurable property built to resist loss due to tornado or catastrophic windstorm events, only when the company determines the discount or reduction to be actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in the legislation. Rep. Moore stated that, being a supporter of the free-market, he did not want to impose a mandate on insurance companies to provide discounts, which is why the "actuarially justified" language was included.

Sen. Bob Hackett (OH) asked Rep. Moore to clarify if the legislation required insurers to provide the discount to policyholders or if it was voluntary. Rep. Moore stated that the legislation makes it voluntary for the insurers to provide the discount. Rep. Michael Henne (OH) questioned why something voluntary/optional has to be set forth in legislation.

Ken Waters, Warning Coordination Meteorologist from the National Weather Service, provided some background on the original fujita scale, and the new, enhanced fujita

scale. Mr. Waters stated that the original fujita scale was developed by Dr. T. Theodore Fujita in 1971 and published as “Proposed Characterization of Tornadoes and Hurricanes by Area and Intensity.” The scale was: F0 (gale); F1(weak); F2(strong); F3 (severe); F4(devastating); and F5(incredible). That scale was categorized by area and intensity with an estimated wind speed, and became the standard for tornado ratings. There were some limitations to the scale, such as: it was subjective since it was based solely on the damage caused by a tornado; there was no recognition in difference in construction; difficult to apply with no damage indicators, i.e. if the tornado does not hit any structures, what F-scale would be assigned; it was based on the worst damage (even if it is one building or house); it overestimated wind speeds greater than F3; it relied to much on the estimated wind speeds; it oversimplified the damage description; it did not recognize weak structures such as mobile homes or modified homes.

Because of those limitations, a new enhanced fujita scale (EF) was developed from 2000 to 2004 by cross-disciplinary experts and scientists, and first used in 2007. The EF identified 28 “damage indicators” (DI) which, importantly, can be added to or modified. Each DI has several Degrees of Damage (DOD). The wind speeds were also changed in the EF scale. For example, the old scale measured an F5 at wind speeds of 262-317 mph, whereas the new EF measures an F5 at wind speeds of 200-234 mph. Mr. Waters stated that the main strengths of the EF scare are: the 28 DI’s; it accounts for differences of structural integrity within a DI; winds speeds are determined from damage; there is continuity from the old F scale; and its expandability, flexibility, and extensibility. However, limitations to the EF scale include: changings scales may introduce artifacts into the historical record; complexity; wind speeds are subject to change for each rating. For further information on the EF-scale tools, Mr. Waters recommended reading “A Recommendation for the Enhanced Fujita Scale” and the EF-kit.

John Doak, Oklahoma Insurance Commissioner, stated that legislation like OK HB 1720 is not a partisan issue and it is something that needs to be given more attention since natural disasters are becoming more common across the country. In Oklahoma, after tornadoes hit in 2013, there were nearly 100,000 insurance claims filed in response with insurance payments totaling more than $1.1 billion. If homeowners construct or retrofit their homes to meet stronger building code standards, those numbers would be drastically less. In 2016: the U.S. had 1,059 tornadoes; 43 States had one or more tornado; and only 6 States saw zero tornadoes. Cmsr. Doak then discussed the Insurance Institute for Business & Home Safety (IBHS), and stressed that the Fortified Home Program is something that was thought of and promoted by IBHS which is funded by the insurance industry. Cmsr. Doak stated that legislation such as OK HB 1720 calls for a “backwards mandate” – meaning that when the company determines the discount or reduction to be actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in the legislation, the consumer gets the discount; if those requirements are not met, the consumer does not get the discount – it is that simple. Cmsr. Doak also noted that results show that switching from a conventional construction standard to a Fortified designation increases the value of a home by nearly 7%, and that we cannot continue to build homes the same way in the same areas and expect different results when natural disasters occur. Cmsr. Doak stressed again that this is not just an Oklahoma issue – it is a national issue of incentivizing consumers to build to a higher standard.

Rep. Lehman asked what the cost estimates are for consumers to build/retrofit to the standards. Cmsr. Doak stated that he can get that specific information to Rep. Lehman

after the Committee adjourns but that, approximately, it is 2 to 5% of the cost of the house. Rep. Moore stated that for a roof, which is the biggest exposure for a homeowner, it adds about $500 to the cost.

Frank O'Brien from the Property Casualty Insurance Association of America (PCI), stated that PCI is not supportive of legislation like OK HB 1720. It has been styled as a mandatory-voluntary discount. PCI believes in market-driven discounts and therefore cannot support the proposed amendments to the NCOIL Model as currently drafted. Mr. O'Brien stated that there is of course room for negotiations and looks forward to discussions after the Committee. Cmsr. Doak noted that when OK HB 1720 was introduced, PCI was neutral, so something has obviously has changed since between then and now.

Mr. Thesing stated that building codes are a very important issue and that Rep. Moore, Cmsr. Doak, and others, did a tremendous job of gathering support for OK HB 1720. However, Mr. Thesing stated that such legislation might not be a good idea for every State. NAMIC does not believe such legislation is supportive of the free-market, and instead supports voluntary decisions by individual insurers to provide discounts, rate reductions, or other financial incentives to policyholders who meet the criteria established by that insurance company.

Cmsr. Doak stressed again that this is a bi-partisan issue and is what's best for consumers. When looking to natural disasters in places like Oklahoma, someone needs to lead on this issue.

REMARKS FROM ARIZONA SPEAKER OF THE HOUSE – J.D. MESNARD

Rep. David Livingston (AZ) then introduced Rep. J.D. Mesnard – Arizona Speaker of the House. Speaker Mesnard thanked everyone for visiting Arizona and for working on important insurance-related issues.

DISCUSSION ON FLOOD INSURANCE MARKET DEVELOPMENTS INCLUDING IMPACT OF RECENT HURRICANES ON INSURERS AND POLICYHOLDERS

Cmsr. Doak stated that although there is limited interest in the admitted market, there is growing interest in the surplus lines insurance market to provide private flood insurance. In recognition of the growing private flood insurance market, the NAIC has required insurers to include in their financial statements their level of flood insurance activity to provide State insurance regulators with a comprehensive overview of the size of the private flood insurance market and insight into market growth. The initial filings are positive. The NAIC hopes to partner with States to promote growth of the private flood insurance market and, and believes in the re-authorization of the National Flood Insurance Program (NFIP). The NAIC supports the notion of providing consumers with more choices related to flood insurance. Specifically, the NAIC supports H.R. 1422 – the Flood Insurance Market Parity and Modernization Act, sponsored by Reps. Dennis A. Ross (R-FL) and Kathy Castor (D-FL). This bill clarifies state insurance regulators' authority over private flood insurance and provides a clear definition of private flood to remove the confusing language in current law to help prompt more insurers to enter the market if they are willing. Facilitating the entry of additional carriers into the market will provide consumers with access to additional options for flood insurance products. Over time, this additional competition and shift of risk from a federal program to the private

market could help lessen the exposure of U.S. taxpayers to the types of catastrophic flood losses that now reside as unpaid debt on the NFIP's books. The bill also includes important provisions ensuring that private flood insurance meets the continuous coverage requirement so policyholders have a choice to return to the NFIP without penalty, including not losing any subsidy they previously had with the NFIP.

The NAIC also recommends reauthorization legislation require the Federal Emergency Management Agency (FEMA) to reinstate its prior rules allowing policyholders to cancel their NFIP policies mid-term and receive refunds on a pro-rated basis if they decide to replace their NFIP policies with private flood insurance. FEMA's policy change discourages consumers' use of private flood insurance. The Government Accountability Office has also noted concerns about this change and recommended FEMA reconsider these rules in its July 2016 report, "Potential Barriers Cited to Increased Use of Private Insurance." The NAIC does not believe consumers should be penalized by a prohibition on pro-rata NFIP refunds because they chose to obtain a private flood insurance policy mid-term and encourage support for including language to reestablish the prior rules. In order to help facilitate the growth of the private flood insurance market, Congress should also encourage FEMA to share its NFIP data with state insurance regulators and insurers to provide meaningful statistical information to help the private market be able to accurately assess flood risks. Further, the NAIC supports requiring FEMA to eliminate the non-compete clause to allow the Write Your Own insurance companies to sell private flood insurance outside of the NFIP.

Rep. Keiser asked if the NAIC had concerns as to whether adverse selection would occur with growth of the private flood insurance market. Cmsr. Doak stated that the NAIC is in favor of such growth as long as adequate consumers protections are present.

Frank O'Brien stated that on Nov. 14, the House passed H.R. 2874 which will reform and reauthorize the NFIP – the bill includes provisions from H.R. 1422. PCI is concerned that the reauthorization package reduces write-your-own reimbursement for administration by 3% over three years. H.R. 2874 includes claims reforms; sets up a program for States to address affordability issues; addresses mapping and map appeals issues; and allows lenders to require flood insurance even if outside the floodplain. Most importantly, H.R. 2874 extends the NFIP to September 30, 2022. Mr. O'Brien stated that unfortunately it is still questionable as to how the Senate will react to the legislation, and there are not a lot of working days between now and the end of the year, in addition to there being other reform efforts Congress is considering.

Ned Dolese, President of Coastal American Insurance Company, stated that Coastal American is the first insurance company to insure flood on a homeowner's policy. Mr. Dolese stated that doing business in this manner allows flood insurance to be regulated on a State level because as an admitted carrier, the State Insurance Commissioner sees everything they do before they do it. When including flood on a homeowner's policy rather than a standalone policy, a lot of the chatter that comes with discussing the NFIP and FEMA goes out the window. Coastal American, along with its actuaries, designed an algorithm that is meant for any State with a coastline. The three main components of the algorithm are: the distance between the household and any body of water; the elevation of the household; and how many times that area has previously flooded. Mr. Dolese stated that his experience is that if you provide a product that has affordable rates, people will buy it.
Rep. Henne asked Mr. Delose what the Company's limits on flood were. Mr. Delose

stated that the limits are all the limits on the homeowner's policy.

Amy Bach, Executive Director of United Policyholders, stated that consumers need more options in the flood insurance market and that unfortunately, politics is playing a big part in discussions surrounding the reauthorization of the NFIP and the growth of the private flood insurance market. Ms. Bach stated that when looking at the recent hurricanes, the role of the lending industry is critical in spreading flood risk appropriately. Additionally, there is a lot of room for innovation in the flood insurance mitigation market. An example is a company called Smart Vent – the vents will open and allow water into the interior space. By allowing water in, they equalize the pressure on the foundation walls so that the home does not collapse with the force of the water against the weakest section of the home's foundation. Purchasers of a vent can receive a reduction in their flood insurance premium. Ms. Bach closed by stating that whatever one thinks of climate change, flood incidents are on the rise and all signs point to that continuing. Now is a great opportunity for State legislators to work on innovative efforts to help consumers.

Cmsr. Doak then provided a summary of the impact that the recent hurricanes have had on policyholders and insurance companies, and noted that the NAIC has worked hard to help those affected. Cmsr. Doak noted that regarding Hurricane Maria, the NAIC has worked closely with the Office of the Insurance Commissioner of Puerto Rico and the U.S. Virgin Islands' Office of the Lieutenant Governor – Division of Banking, Insurance and Financial Regulation to provide communications to consumers, media and the insurance industry. Insurance regulators in Puerto Rico and the U.S. Virgin Islands, with the help of the NAIC, have responded to more than 100 toll-free calls and provided more than 8,000 users with emergency bulletins and other information through NAIC-hosted websites.

RESOLUTION ENCOURAGING THE AMERICAN LAW INSTITUTE TO MATERIALLY CHANGE THE PROPOSED RESTATEMENT OF THE LAW OF LIABILITY INSURANCE

Sen. Breslin stated that Restatements, authored by the American Law Institute (ALI), are supposed to state what the law currently is in a specific area – not what the law should be. This past May, Commissioner Tom Considine, NCOIL CEO, wrote to the ALI expressing concern over its proposed Restatement of the law on Liability Insurance (proposed Restatement). Cmsr. Considine noted that several of the proposed Restatement's provisions are inconsistent with well-established law and purport to address matters which are properly within the legislative prerogative. That letter ultimately led to this morning's general session titled "Restatement or NEWstatement? Examining the ALI's Proposed Restatement of the Law of Liability Insurance" during which one of the Restatement's Reporters, Tom Baker, provided background on the proposed Restatement and the ALI in general. Sen. Breslin stated that based on the general session earlier today, no or minimal substantive changes to the proposed Restatement are anticipated before it is submitted to the ALI Council and then the ALI membership for final approval.

Accordingly, Sen. Breslin and Sen. James Seward (NY) offered a Resolution for consideration that encourages the ALI to materially change the proposed Restatement so that it is consistent with well-established insurance law and respectful of the role of state legislators in establishing insurance legal standards and practice. And if no changes are made, NCOIL will opposed the proposed Restatement and work towards

ensuring that the proposed Restatement not be afforded recognition by courts as an authoritative reference regarding established rules and principles of insurance law, as Restatements traditionally have been afforded. Sen. Breslin noted that it is his intent for the Resolution to be adopted by this Committee, but not for it to be considered by the Executive Committee this Sunday. Rather, a copy of the Resolution can be sent to ALI leadership along with a letter stating that the Executive Committee is prepared to adopt the Resolution and take the aforementioned actions if changes are not made to the proposed Restatement.

Rep. Richard Smith (GA) voiced his support for the Resolution and stated that it is important for the Committee to realize that judges across the country are already looking to the proposed Restatement for guidance even though it is still in draft form.

Rep. Matt Lehman (IN) stated that he agrees that this is a very important issue but questioned how far NCOIL should take the "fight." Sen. Breslin stated that a strong response in the form of this Resolution is needed since the ALI did not respond to Cmsr. Considine's letter and that this morning's general session indicated that the ALI will not make any changes.

Cmsr. Considine clarified that the Resolution, if adopted by the Committee, would not go to the Executive Committee for consideration on Sunday. Rather, it would be tabled so that a letter could be sent to the ALI along with a copy of the Resolution to initiate discussions. Rep. Steve Riggs (KY) voiced his support for the Resolution and stated that it is important for State legislators, and NCOIL, to be stay involved in this issue.

Upon a Motion made by Rep. Lehman and seconded by Rep. Riggs, the Committee voted without opposition by way of a voice vote to adopt the Resolution.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS COMPENSATION INSURANCE COMMITTEE
NCOIL ANNUAL MEETING, PHOENIX, ARIZONA
FRIDAY, NOVEMBER 17, 2017
4:30 P.M. - 5:45 P.M.

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Committee met at the Sheraton Grand Phoenix Hotel in downtown Arizona on Friday, November 17, 2017 at 4:30 pm.

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

Other members of the Committee Present were:

Rep. Matt Lehman, IN
Rep. Peggy Mayfield, IN
Rep. Joseph Fischer, KY
Rep. Michael Webber, MI
Rep. Lois Delmore, ND
Rep. George Keiser, ND
Asw. Maggie Carlton, NV
Asw. Pamela Hunter, NY
Asm. Andrew Garbarino, NY
Rep. Michael Henne, OH
Rep. Bill Botzow, VT

Other legislators present:

Rep. David Santiago, FL
Sen. Jerry Klein, ND
Rep. Tom Oliverson, TX

Also in attendance were:

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

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 13, 2017, meeting held in Chicago, IL.

DISCUSSION OF IMPACT OF DIRECT DISPENSE PROGRAMS ON STATE WORKERS' COMPENSATION SYSTEMS

Rep. Marguerite Quinn (PA) introduced Ms. Kathy Fisher, Assistant Director of External Engagement and Ms. Dongchun Wang, Economist, both of the Workers' Compensation Research Institute (WCRI).

Ms. Fisher reported on a study published in July 2017 regarding Physician Dispensing in 26 states. The key question addressed in the 2017 study was "Did Reforms Achieve their Intended Goals?" There were two main categories of reforms: price-focused reforms, which target higher-priced, repackaged drugs, capping reimbursement at the AWP; and limiting reforms, which limit the types of drugs that can be dispenses or limit dispensing to a short time frame. Rep. Quinn noted that the costs are usually never seen by the employee on the front end but rather the costs are seen on the back end

which is the root cause of pharmacy inflation.

When assessing whether the reforms met intended goals, the following areas were looked at: prices of the drugs; frequency of physician dispensing; cost Sharing (physician-dispensed drugs relative to all prescription costs); and patterns. The study compared measures between states that have had reforms with those that have not had reforms or with states where WCRI observed pre-reform data.

Ms. Fisher continued by saying that the overall findings concluded that prices of many of the most common physician-dispensed drugs decreased. Physicians dispensed fewer prescriptions in 2014 than in 2011. A combination of decreased prices and frequency reduced the cost share of physician-dispensed drugs in many states. CA, FL and IL were exceptions. Ms. Fisher went on to say that despite decreases, there was an increase in the physician dispensing of the higher-priced, new drug costs strengths, which was enough to offset the decreases in those states. Dispensing was still common in several states. Further, despite the decrease in dispensing, the percentage of total pharmaceutical costs in those states was 54 – 64%. There was a noticeable shift in pattern of dispensing from opioids to non-opioids as a result of the limiting reforms.

Ms. Fisher discussed the prices of frequently dispensed drugs in post-reform states – overall, there was a decrease. Decreases of up to 39% per pill were reported. The study therefore concluded that price-focused reforms were effective. Prices were more static or increased in non/or pre-reformed states. In contrast, price increases as high as 42% were reported. MD and NC were exceptions. Physicians dispensed fewer prescriptions in 2014 in most states. Cost share of physician-dispensed drugs to all prescription costs changed little or increased in CA, FL and IL. A decrease in cost share of over 30% were seen in CT, IN, KY and SC. Unsurprisingly, cost share also increased in some non- and pre-reform states. In Illinois, California and Florida, physician dispensing of higher priced, new drug strengths/formulations, of certain existing drugs: 7.5 mg Cyclobenzaprine HCL (Flexeril), 150 mg extended release Tramadol HCL (Ultram), 2.5-325 mg Hydrocodone-Acetaminophen (Vicodin) and Lidocaine-menthol (new formulation of pain patch). The increased dispensing of those new, higher-priced drugs offset the other reductions in CA, FL and IL. Accordingly, that calls into question the effectiveness of price-focused reforms in those States. Ms. Fisher noted that those new drug strengths are rarely seen filled at pharmacies.

Rep. David Santiago asked if the increase in total payments was because those drugs were physician dispensed as opposed to pharmacy dispensed. Ms. Fisher responded affirmatively stating that the cost increased when dispensed by the physician because the higher-priced, new drugs are not being filled at pharmacies.

Rep. Santiago asked what the strategy was that CA, FL and IL used to work around the reforms. Ms. Fisher responded that the reforms were aimed at just repackaged drugs that were already in existence and that the new drugs are being packaged by generic manufacturers.

Ms. Wang added that if you look at cyclobenzaprine HCL (Flexeril) there are commonly three different strengths. Two existing strengths are 5mg and 10 mg and the new strength is 7.5 mg. Before the 7.5 mg strength came to market, in FL, most of the physicians dispense 10 mg but when the new dosage came out in the market, if you look at the curve, you can see a steep increase for the new strengths. The high frequency

plus the higher prices offset the reduction for the existing drugs. Notably, the 7.5 mg was rarely prescribed to be filled at a pharmacy which suggests that some dispensing physicians had an economic incentive.

Mr. Paduda added that the supply chain for physician dispensing is incredibly adaptable and they can figure out a way of making money. He stated that if repackaging was cutoff, the same supply chain would look for another way of selling the product. In this case, be creating a new strength of the drug, i.e. 7.5 mg, the manufacturer is able to set any price they want and under the fee schedule, which is 112% of AWP in FL, the payer has to pay that as the legal requirement.

Ms. Fisher stated that the FDA will review and approve an array of strengths but only a few strengths are manufactured. When the drug goes off-patent and it's open to the generic market, the manufacturers can go back through the various strengths without going back to the FDA for approval.

Ms. Fisher noted that there was a shift in pattern of dispensing as a result of limiting reforms. In KY, there was a 12% decrease in dispensing of opioids. In FL, 2011 legislation banned physicians from dispensing Schedule II and III opioids. Ms. Fisher also noted that there were physician dispensing reforms enacted after the study period in states such as Pennsylvania, Kansas and North Carolina.

The NCOIL Model Act on Workers' Compensation Pharmaceutical Reimbursement Rates incorporates elements of many state reforms. The Model ties reimbursement to the original manufacturer's NDC number. It provides for states with fee schedules and it provides for alternatives if the NDC number is not available and looks for the average wholesale price of therapeutically equivalent drugs and also contains a limiting reform provision which limits the dispensing of repackaged or OTC drugs to one week in all of workers' compensation.

Ms. Fisher concluded by saying that fewer prescriptions were dispensed by physicians in all post-reform and most non-and pre-reform states. Reimbursement rules in many states did help to reduce prices. However, increased physician dispensing, of higher priced new strengths, offset or even outweighed those price reductions. This was especially seen in CA, FL and IL. Finally, it was observed that a shift in dispensing patterns from opioids to non-opioids were observed as a result of limiting reforms.

Mr. Paduda added that the opioid issue is critical and stated that several states have banned or limited physician dispensing of opioids and, after those implementations opioid prescriptions dropped dramatically. He went on to say that these opioids drugs should not have been prescribed to begin with and that they were being prescribed only to make money. He further stated that, in his opinion, banning physician dispensing of opioid drugs would be a good first step.

Rep. Santiago asked if the NCOIL Model legislation would solve FL's problem. Ms. Fisher responded by stating that it would not because it does not address the new strength drugs. Mr. Paduda added that the only way to stop the egregious profiteering is to allow employers to direct fulfillment of drugs to specific pharmacy networks which is already in place in a number of states – NY, MN, OH.

Rep. Quinn added that when she was the prime sponsor of the PA legislative reform bill

in 2014, her research led her to physician dispensing websites where profit calculators were being advertised to physicians to embrace the practice of physician dispensing. It was a convenience for physician's patients but it focused on a mathematical formula for the profit level.

Rep. Oliverson (TX) stated that he felt this problem was much bigger than "greedy" doctors and that healthcare providers are graded on their ability to treat pain effectively which can set the wrong incentives for providers to over-prescribe certain drugs. He noted that he was not discounting anything that had been said but asked if there was any data available on the grading and treatment of pain management.

Mr. Padua responded by stating that the treatment of acute pain is fundamentally different from treating chronic pain. Opioids for surgical purposes may be the best first line of defense. However long-term usage is dangerous, expensive and creates stronger pain the longer the patient uses them. Solid clinical studies show that non-opioids prescriptions can lead to the same results as opioids. He went on to say that long-term use of opioids is counter-productive and eventually leads to hyperalgesia.

DRUG COMPOUNDING: ANALYZING THE PREVALENCE OF COMPOUND MEDICATIONS IN THE WORKERS COMPENSATION INSURANCE INDUSTRY

Mr. Paduda stated that drug compounding is driven by a lot of the same financial motivations as physician dispensing. He went on to say that the physician examines and diagnoses a patient's complaint, and, if appropriate, prescribes a drug or treatment. There is no conflict of interest if the physician does not profit from the prescription. The patients, free of any undue influence by the prescriber, takes the prescription to the pharmacy of their choice and the pharmacist fills the prescription.

Mr. Paduda went on to describe that "compounding" is the preparation, mixing, assembling, packaging, or labeling of a drug – typically used for patients with allergies, specific medical conditions/limitations, and children. There are different types of compound drugs and compounding kits. He reported that many compounds are typically used for patients who are allergic to a binder or who have difficulties swallowing pills or unable to take an oral medication.

In some cases, compounding takes the form of compounding custom dosage forms of medications for patients with special needs which have very little oversight. There is no FDA approval process – it is a State regulated industry. Mr. Paduda also noted that in many cases, compounding has not proven effective. Many compounds are not medically necessary and duplicative and risky – many compounds contain multiple, similar drugs and are expensive. Many states have no effective controls or limits on price or number of scripts with compounds. Some questionable marketing practices are directly related to consumer advertising and or 1099 sales forces.

In workers' compensation, the primary issue is "topicals" – creams, gels, or ointments that are applied to the skin. And the use of "compounding kits" continues to increase in the workers' compensation population. These compounding kits are marketed to compounding pharmacies as a convenience to save time, decrease waste and improve compliance, reproducibility and accuracy. They essentially allow the physician to get around bans on compounds. These products typically are submitted by the dispensing pharmacy for processing through the PBM using the product NDC, rather than as a

compound. This action bypasses the pharmacy-benefits managers and many state workers' compensation requirements for review of appropriateness of compounds. Most states have no effective control on price of compounding drugs.

Mr. Paduda spoke about some potential solutions stating that there can be specific reimbursement limits per script. He went on to say that there are also limits per ingredient (API) which can be tied into the pricing limit and that there is a cap on the number of ingredients in a particular medication and the total cost per script which puts them all together. There are actions that by-pass some of these requirements. For example, if there is a limit of three ingredients, the physician now gives multiple scripts to equal the six ingredients in the original script. Ohio is fortunate because they have the "golden rule" and it is a monopolistic state for comp. They have a limit of paying up to $300 per month on scripts so they are very effective in reducing costs. Another potential solution is "retrospective review" – if the script is prescribed, dispended and the bill comes in, the employer can decide not to pay for it as not medically necessary. Another potential solution is Pre-Authorization – all compounds must be pre-authorized by the payer; the standard is compliance with evidence-based clinical guidelines (state by state basis); approval only if prescriber documents patient fails treatment with oral medications, is allergic to oral medication ingredients and/or cannot swallow. Another potential solution is Employer Direction where the employer can direct patients to network pharmacies and are not required to reimburse non-network pharmacies.

Rep. Santiago asked if an approved formulary would help. Mr. Paduda stated that a formulary is like having speed limits – you need enforcement of it. And the challenge with a formulary is that it needs to be specific to compounds broadly defined and not just the ingredients used in compounds. He concluded by stating that it has worked, to some degree, in Texas. If you adopt a formulary that specifically requires pre-authorization with informed consent, that it is a good path to take.

Rep. Quinn closed by urging Committee member to contact her and/or NCOIL staff to discuss how the issues of physician dispensing and drug compounding should be further handled.

ADJOURNMENT

There being no further business, the Committee adjourned at 5:45 P.M.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
PHOENIX, AZ
NOVEMBER 19, 2017

The National Council of Insurance Legislators (NCOIL) Business Planning and Executive Committee met at the Sheraton Grand Phoenix on Sunday November 19 at 9:30 a.m.

NCOIL President, Rep. Steve Riggs, KY, Chair of the Committee presided.

Members of the Committees present:

Sen. Jason Rapert, AR, Vice-Chair
Rep. Richard Smith, GA
Rep. Martin Carbaugh, IN
Sen. Travis Holdman, IN
Rep. Matt Lehman, IN
Sen. Blade Morrish, LA
Rep. George Keiser, ND
Sen. Jerry Kein, ND
Asw. Maggie Carlton, NV
Asm. Will Barclay, NY
Asm. Kevin Cahill, NY
Sen. Bob Hackett, OH
Rep. Marguerite Quinn, PA
Rep. Bill Botzow, VT

OTHER LEGISLATORS PRESENT:

Rep. David Livingston, AZ
Rep. Andrew Garbarino, NY
Rep. Lois Delmore, ND

ALSO PRESENT:

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

Rep. Riggs called the meeting to order at 9:32 a.m.

Sen. Holdman made a motion to waive the quorum rule. A second was made and it carried on a voice vote.

A motion was made to approve the minutes of July 15, 2017. A second was made and the motion carried on a voice vote.

FUTURE LOCATIONS

Rep. Riggs called on Commissioner Considine to discuss the 2020 meeting locations. Considine informed the body that the 2020 summer meeting would likely be in Jersey City pending New Jersey joining NCOIL, which is expected.

The spring meeting will likely be in Tampa, Florida pending their membership and the Annual meeting in Charlotte, NC in December. Both are contingent on becoming contributing member states. These conversations are ongoing and we expect a positive outcome given NCOIL meeting generate between $350,000 and $500,000 in local economic activity.

Rep. Riggs stated that the CIP meeting was in Jersey City in June and it was in a hotel with the view of Manhattan. Everyone that attended was impressed and satisfied.

RECRUITMENT OF NEW MEMBER STATES

Rep. Riggs stated that he spent much of his time as President on the recruitment of new members. Legislators have assignments but have to be more active so we can have reports from everyone. He further stated that we appreciate the partnership with IEC, the CIP, other industry and interested parties. This was clear during the SWOT exercise and has been successful thus far. Many Chairs and Vice Chairs need to be invested in NCOIL to get legislators to come. Rep. Riggs stated that the legislators he's reached out to are happy to have been asked.

APPOINTMENT OF NEW EXECUTIVE COMMITTEE MEMBERS

Rep. Riggs announced that AZ Rep. David Livingston is appointed pursuant to the bylaws since he is Chair of Insurance Committee and Arizona paid dues.

He then asked if any member wants to make a recommendation of new Executive Committee members.

Sen. Klein nominated Rep. Lois Delmore of ND. The motion was seconded and carried on a voice vote.

Assemblyman Cahill nominated Assemblyman Andrew Garbarino of NY. The motion was seconded and carried on a voice vote.

Rep. Riggs noted that pursuant to the bylaws, several executive committee members will cycle off for having missed 3 consecutive meetings. Staff reached out affirmatively to let them know and two members have been granted a waiver to remain.

Rep. Riggs thanked Rep. Livingston for his hard work and for the interesting tour of the Arizona state capitol.

BUDGET COMMITTEE REPORT

Rep. Lehman gave the report of the Budget Committee that met on Thursday. Told members they could see the budget on tab 6. The committee approved the 2018 budget and expenses.

Rep. Lehman noted that the spring and summer and spring meeting expenses have been separated into their own revenue and expense lines.

Rep. Botzow made a motion to accept that was seconded by Rep. Carbaugh. The committee adopted the report on a voice vote.

ADMINISTRATION REPORT

Commissioner Considine reported that there were 278 registrants. Included in that number were 55 legislators from 24 states. 5 legislators came on scholarship and 10 were first time attendees. This continues the upward trend in both registrant and legislator attendance. 8 Insurance Departments were represented.

Paul Penna gave a report on the unaudited receipt of financials through October 31, 2017. He noted NCOIL has revenue of $931,532.90 and expenses of $760,484.96 for an excess of $171,047.94.

Rep. Livingston made a motion to accept the administration report. It was seconded and carried on a voice vote.

NON-CONTROVERSIAL CALENDAR

Rep. Riggs asked if there were any members that wanted to remove any items from the noncontroversial calendar?

Asw. Carlton inquired as to the process of how items end up on the non-controversial calendar. Cmsr. Considine stated that everything adopted goes on it but can be moved off at the request of a member with a motion and second.

Asw. Carlton stated that the non-controversial calendar is not non-controversial. Cmsr. Considine stated that was a valid point and that maybe it should be changed to “Summary Calendar” or “Consent Calendar”. The reason being, members did not want to spend the time at the Executive Committee rehashing every topic that happened during the meeting.

Rep. Morrish, LA made a motion to accept the non-controversial calendar and Sen. Holdman, IN seconded. The motion carried on a voice vote. The consent calendar for the 2017 meeting is listed below:

Financial Services Committee

Re-adoption of Credit Default Insurance Model Legislation

Model Act to Support State Regulation of Insurance by Requiring Competition among Insurance Rating Agencies – Adopted w/expectation of amendments at Executive Committee.

Consideration of Model Act Prohibiting Consumer Reporting Agencies from Charging Fees Related to Security Freezes; and Amendments to NCOIL Credit Report Protection for Minors Model Act

Resolution Encouraging the Adoption of Voluntary Data Call Principles

State-Federal/International

Re-adoption of Exhaustion of Administrative Remedies Models Legislation

Re-adoption of Producer Compensation Disclosure Model Amendment to the Producer Licensing Model Act

Health, Long-Term Care & Health Retirement Issues Committee
NCOIL Out-of-Network Balance Billing Transparency Model Act

Model Act Regarding Air Ambulance Insurance Claims

Rep. Riggs noted that consideration of Model Act to Support State Regulation of Insurance Through More Informed Policymaking had been tabled at the request of the sponsor, Asm. Cooley, who was unable to attend due to official legislative commitments.

ARTICLES OF ORGANIZATION AND BYLAWS COMMITTEE REPORT

Asm. Barclay, NY went through changes to the bylaws, includes the recommendation by Rep. Riggs to change the name, but not the acronym of the organization, from National Conference of Insurance Legislators to National Council of Insurance Legislators. He noted that Rep. Botzow read definitions of both words and Council is more appropriate for what NCOIL is and does.

Sen. Rapert, AR made a motion to accept the report that was seconded by Rep. Botzow, VT. The motion carried on a voice vote.

OTHER SESSIONS

Rep. Riggs gave a report on the other sessions including the Institutes Griffith Insurance Education Foundation Legislator Luncheon, which was a Primer on Reinsurance by Professor Jim Hillard at Northern Arizona University.

He noted there were several featured speakers, including Kay Noonan, General Counsel, NAIC who gave a report on the NAIC accreditation process.

Arizona Speaker of the House JD Mesnard stopped by to welcome all NCOIL participants during the Property & Casualty Committee meeting.

U.S. Congressman Dave Schweikert delivered an interesting keynote address about tax and regulatory reform efforts. As a member of the Ways & Means Committee, he has been an instrumental player in these efforts. He also discussed his efforts with the Blockchain Caucus to protect data so all aspects of it can be electronic and portable.

There were three General Sessions. A Restatement or NEWstatement? – Examining the ALI's Proposed Restatement of the Law on Liability Insurance; Long Term Care Insurance Industry – How Big of a Risk? And Cybersecurity in the Wake of the Equifax Breach.

NOMINATING COMMITTEE

Sen. Holdman gave the report of the Nominating Committee. He noted there was unanimous approval for the following officer slate for 2017 – 2018:

President – Arkansas Senator Jason Rapert

Vice President – Vermont Rep. Bill Botzow

Treasurer – Indiana Rep. Matt Lehman
Secretary – California Assemblyman Ken Cooley

He also noted that Rep. Riggs and himself would remain ex-officio as Immediate Past Presidents and made a motion to accept the report of the committee. Rep. Riggs seconded it and it carried on a voice vote.

OTHER BUSINESS

Rep. Riggs noted the passing of NH Rep. Don Flanders and AR Sen. Greg Standrige. Both were active participants with NCOIL. He asked that the resolutions honoring each of them be adopted. Sen. Rapert made a motion and Sen. Hackett seconded. It carried on a voice vote.

NEW BUSINESS
Rep. Riggs was honored for his year as NCOIL President and presented a ceremonial gavel.

ADJOURNMENT

Sen. Rapert made a motion to adjourn and commented that as the new NCOIL President, as we enter 2018 he will be reaching out before the first of the year to several of the Executive Committee members about service as chairs and vice chairs of committees and hopes that many will continue to serve.

He is looking forward to 2018 and is going to continue the focus of the organization to work on difficult and emerging insurance issues and do good work. President Rapert stated that he believes we are past the transition phase now.

He further stated that he is gratified to see new members and big states like Texas and Florida participating more fully. It's very important to have high population states involved. He noted thatWV Sen. Mike Hall left the legislature and went to work as Chief of Staff for the WV Governor. We need to mentor in our states and have fuller participation like NY, Indiana and Kentucky. He wished everyone a great holiday season.

Motion was seconded and there being no other business the committee adjourned at 10:22 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
INTERIM COMMITTEE CONFERENCE CALL
JANUARY 5, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee held an interim meeting via conference call on Friday, January 5, 2018 at 2:00 P.M. (EST)

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

Members of the Committee present:

Rep. Sam Kito, AK
Rep. Deborah Ferguson, AR
Asm. Ken Cooley, CA
Rep. Matt Lehman, IN
Rep. Steve Riggs, KY
Rep. Greg Cromer, LA
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Sen. Neil Breslin, NY
Asm. Andrew Garbarino, NY
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Glen Mulready, OK
Rep. Marguerite Quinn, PA
Rep. Bill Botzow, VT

Also in attendance were:

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

DISCUSSION AND CONSIDERATION OF RESOLUTION ENCOURAGING THE ALI TO MATERIALLY CHANGE THE PROPOSED RESTATEMENT OF THE LAW OF LIABILITY INSURANCE

NCOIL President Sen. Jason Rapert (AR) thanked everyone for participating in this meeting and stated that upon first learning of the American Law Institute's (ALI) Proposed Restatement of the Law of Liability Insurance (Proposed Restatement), NCOIL became heavily involved due to the concern that several of the Proposed Restatement's provisions go beyond established law and address matters properly within the legislative prerogative. Sen. Rapert stated that the purpose of this Committee's meeting is to consider the Resolution that was adopted by the NCOIL Property & Casualty Committee on November 16, 2017 at the NCOIL Annual Meeting in Phoenix, Arizona. That Resolution encourages the ALI to materially change the Proposed Restatement so that it accurately reflects current law and respects the legislative process. If the Proposed Restatement is not changed, the Resolution calls for certain action to be taken to ensure that the Proposed Restatement is not afforded recognition by courts as an authoritative reference regarding established rules and principles of insurance law, as Restatements traditionally have been afforded.

Commissioner Tom Considine, NCOIL CEO, then provided a timeline of NCOIL's interaction with the ALI regarding the Proposed Restatement. On May 5, 2017, NCOIL sent its first letter to ALI Director Richard Revesz and ALI Deputy Director Stephanie Middleton. The letter: a.) noted several provisions of the Proposed Restatement that conflict with existing law; b.) asked the ALI

to defer voting on final passage of the Proposed Restatement; c.) welcomed a dialogue between NCOIL and the ALI; d.) warned that if our request and invitation were not met, NCOIL would pass a Resolution opposing the proposed Restatement as a misrepresentation of the law of liability insurance, and as a usurpation of lawmaking authority from State insurance legislators. Later that month, the ALI postponed adoption of the Proposed Restatement. Despite the postponement, numerous judges cited the Proposed Restatement in their opinions.

NCOIL held a general session on the Proposed Restatement at its Annual Meeting in November, during which the Restatement's primary Reporter, Tom Baker, participated along with Laura Foggan, Victor Schwartz, and Peter Kochenburger. Later that day, having not been satisfied with the explanations provided regarding how the proposed Restatement reflects current law, the NCOIL Property & Casualty Committee voted without opposition to adopt the Resolution referenced earlier by Senator Rapert, sponsored by Senators Breslin and Seward.

On November 28, Cmsr. Considine sent a letter to ALI President David Levi and ALI Council Chair Roberta Ramo which: a.) again pointed out the provisions in the Proposed Restatement that conflict with existing law; b.) notified them of the Resolution adopted by the NCOIL P&C Committee; c.) requested that they reply to NCOIL on or before December 18, addressing whether the ALI will make the type of substantive changes NCOIL has requested. On December 6, ALI President David Levi sent a letter to Cmsr. Considine which stated that a new draft of the Proposed Restatement would be distributed that week and that the new draft "contains several substantive changes to the Proposed Restatement…on points on which you and others have expressed concerns." Unfortunately, upon review, it did not appear that the new draft addressed any of NCOIL's concerns. Accordingly, on December 7, Cmsr. Considine wrote back to ALI President Levi saying such and requesting a reply by December 19 as to how the new draft addressed NCOIL's concerns.

Cmsr. Considine stated that, as of today, NCOIL has not received a reply, and it therefore seems that the ALI is headed towards final adoption of the Proposed Restatement at its upcoming Council Meeting in Philadelphia (January 18-19). Cmsr. Considine further stated that the November 28, 2017 letter requested that it be shared with all members of the ALI Council. However, NCOIL heard from several ALI members that the letter was not distributed. Accordingly, another letter was sent to the ALI Council on January 3, 2018, sharing with them the letter and notifying them of the pending Resolution. Cmsr. Considine noted that if adopted, the Resolution calls for the following steps to be taken: a.) NCOIL will urge state legislators across the country to adopt resolutions declaring that this Restatement should not be afforded recognition by courts as an authoritative reference regarding established rules and principles of insurance law, as Restatements traditionally have been afforded; b.) NCOIL shall develop and promulgate, as appropriate, model legislation intended to maintain the viability, predictability and optimal functionality of the insurance market and its practices; c.) NCOIL shall send copy of this Resolution to ALI Leadership, the reporters of the Restatement of the Law of Liability Insurance, and further published in such a manner to reach and inform ALI members; and d.) NCOIL shall send the Resolution to State Chief Justices, State legislative leaders and members of the committees with jurisdiction over insurance public policy, as well as to all State insurance regulators.

Sen. Neil Breslin (NY) stated that the Proposed Restatement is problematic because it is aspirational and not representative of what a true restatement typically is – a re-statement of what a specific topic of law is. Sen. Breslin stated that a strong response by NCOIL, such as

this Resolution, is needed since the ALI has not made any changes to the Proposed Restatement to alleviate any of NCOIL's concerns. Sen. Breslin recommended that the Committee adopt the Resolution and take the steps that the Resolution calls for in distributing and notifying the appropriate parties. Sen. James Seward (NY) agreed with Sen. Breslin.

Sen. Bob Hackett (OH) stated that he has not heard from a lot of insurance companies about the Proposed Restatement and asked if they are aware of it. Cmsr. Considine stated that the NCOIL national office has been inundated with reactions from insurance companies saying that the Proposed Restatement is very problematic for them. Cmsr. Considine further stated that, most importantly, the NCOIL national office has heard from State legislators across the country about their problems with the Proposed Restatement, in addition to academics who have offered differing viewpoints.

Sen. Rapert stated that the main problem surrounding the Proposed Restatement is simple – legislators are elected to enact laws and that authority should not be usurped by the ALI.

NCOIL Secretary, Asm. Ken Cooley (CA), stated that the Proposed Restatement, if passed by the ALI, could have dramatic affects on the entire insurance industry. Asm. Cooley referenced § 24 of the Proposed Restatement, *The Insurer's Duty to Make Reasonable Settlement Decisions*, and noted that said section seeks to move the law from the well-settled "reasonableness" standard, to a standard that would make an insurer liable for not accepting a settlement offer so long as *any* reasonable insurer would accept the settlement, even if a reasonable insurer would have rejected a settlement offer. Such a standard does not recognize that different insurers have different ways of doing business/litigating and could therefore alter the entire insurance marketplace. Asm. Cooley noted that while not directly on point, in 1979, the California Supreme Court held[2] that the California Unfair Trade Practices Act created a private cause of action directly against an insurance company by third party claimants, and held that a single violation of the Act was sufficient basis for a claim for punitive damages. As a result, an onslaught of litigation was unleashed in California courts which led to a dramatic increase in insurance costs for consumers. That case was overturned nine (9) years later[3] but it is an example of when insurance liability rules are materially changed, the affects can be drastic, and consumers ultimately bear the burden through increased costs.

Professor Peter Kochenburger, Associate Clinical Professor of Law and Executive Director of the Insurance LLM Program and Deputy Director of the Insurance Law Center at the University of Connecticut School of Law, and an NAIC funded consumer representative, first stated he is not sure whether the ALI distributed NCOIL's letters to ALI's members, but said letters were posted on the ALI website. Prof. Kochenburger stated that the latest draft of the Proposed Restatement did make a few minor changes to address some concerns that NCOIL and others had voiced. Prof. Kochenburger further stated that a Proposed Restatement in the area of liability insurance is tricky because the majority rule on certain issues isn't always easily identified and sometimes terms are used differently among States/courts. Prof. Kochenburger disagreed with Asm. Cooley's interpretation of § 24 of the Proposed Restatement and stated that the issue Asm. Cooley mentioned regarding third-party bad faith claims is not addressed in the Proposed Restatement. Prof. Kochenburger further stated that the Proposed Restatement

[2] *Royal Globe Ins. Co. v. Superior Court,* 592 P.2d 329 (Cal. 1979)

[3] *Moradi-Shalal v. Fireman's Fund Ins. Co.,* 758 P.2d 58 (Cal. 1988)

does not represent a usurpation of legislative authority because State legislators can always intervene at any time and pass laws, particularly since Restatements are primarily common law.

Sonja Larkin-Thorne, an NAIC funded consumer representative, disagreed with Prof. Kocheburger and stated that as a consumer advocate, and as a former underwriter, she does not understand the need for the Proposed Restatement. Ms. Larkin-Thorne stated that the Proposed Restatement will ultimately increase costs for consumers, and there is no justification for the radical changes that the Proposed Restatement contains. Ms. Larkin-Thorne stated that she supports the Committee's adoption of the Resolution.

John Ashenfelter from State Farm thanked NCOIL for binging attention to the Proposed Restatement and agreed with Asm. Cooley's earlier statements. The Proposed Restatement does not represent the ALI's modus operandi and it represents a usurpation of legislative authority. Courts will be overwhelmed by the changes sought by the Proposed Restatement and consumers will ultimately bear the burden through increased insurance costs. Mr. Ashenfelter stated that he supports the Committee passing the Resolution.

Upon a Motion made by Sen. Breslin and seconded by Sen. Seward, the Committee voted without objection by way of a voice vote to adopt the Resolution.

Cmsr. Considine asked the Committee for a sense of how they would like to proceed with notifying the ALI and other interested parties since the ALI has not yet officially adopted the Proposed Restatement. Sen. Breslin stated that the ALI should be notified immediately and then afterwards, letters should be sent to those that the Resolution mentions, i.e. State Chief Justices, State legislative leaders, etc. Sen. Rapert agreed and suggested that an NCOIL representative be present at the ALI Council Meeting later this month. Asm. Cooley agreed with Sen. Breslin and Sen. Rapert. Cmsr. Considine acknowledged and agreed.

ADJOURNMENT

Upon a Motion made by Sen. Breslin and seconded by Sen. Seward, the Committee adjourned at 3:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
INTERIM COMMITTEE CONFERENCE CALL
JANUARY 29, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee held an interim meeting via conference call on Monday, January 29, 2018 at 2:00 p.m. (EST).

Representative Richard Smith of Georgia, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert (AR)
Rep. Steve Riggs (KY)
Rep. Bob Foley (ME)
Rep. Michael Webber (MI)
Rep. Mark Noland (MT)
Rep. Lois Delmore (ND)
Sen. Bob Hackett (OH)
Rep. Michael Henne (OH)
Rep. Lewis Moore (OK)
Rep. Bill Botzow (VT)
Del. Steve Westfall (WV)

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

INTRODUCTORY REMARKS

Rep. Richard Smith (GA) stated that the purpose of this meeting is to further discuss proposed amendments to NCOIL's Model State Uniform Building Code that are sponsored by Rep. Lewis Moore (OK). Rep. Smith mentioned that the Committee had a good discussion on this issue at its last meeting in Phoenix where the Committee heard from interested parties on both sides of the issue. Rep. Smith stated that incentivizing homeowners to build or retrofit their homes in a stronger manner is an important and timely issue for NCOIL to be discussing considering the alarming frequency within which tornadoes, hurricanes and earthquakes seem to be occurring. Based on the discussion in Phoenix, Rep. Smith stated that everyone seems to agree that since these events are not going to stop happening, we need to do a better job of helping consumers prepare their homes for them. Rebuilding communities in the same places and in the same ways but expecting a different result is not the answer. Of course, there are disagreements as to how exactly that should occur, which is why the Committee is meeting to further discuss the issue and hopefully arrive at a workable solution.

CONTINUED DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL MODEL STATE UNIFORM BUILDING CODE

Rep. Lewis Moore (OK) stated that the proposed amendments to the NCOIL Model State Uniform Building Code are based on legislation he sponsored in Oklahoma – Oklahoma HB 1720 – which was drafted and enacted largely in response to the tornadoes experienced in Oklahoma. The bill requires insurance companies to provide a

discount, rate reduction or other related adjustment for new insurable property built to resist loss due to tornado or catastrophic windstorm events. Rep. Moore stated that there has been pushback from the insurers on the concept as they oppose mandatory discounts or rate deductions as not being supportive of the free-market. Rep. Moore noted that the Fortified Home High Wind and Hail Standards developed by the Insurance Institute for Business & Home Safety (IBHS) make a significant difference in protecting homes, particularly from tornadoes in the F1, F2, and F3 classification. The standards prevent a large amount of debris and therefore save in cleanup costs. Rep. Moore noted that in Oklahoma, they did not mandate the discount but rather put something in place that stated if a discount is offered, the discount should be based on the best possible standards. Rep. Moore noted that one concern is that if you have a dominant insurer in one State or area, it could make it difficult for them since giving everyone a discount would affect their portfolio.

Rep. Smith asked if there is anything preventing insurers from putting stipulations in for the discounts that are not attainable for consumers. Rep. Moore stated that insurers should be incentivized to give the discounts because they should want to attract new business. Rep. Moore stated that if insurers are going to give a discount they should be encouraged to give a discount to those that are the best risk. In Oklahoma, they were surprised they got pushback on the concept but acknowledged insurer's concern about being mandated to give discounts and not letting the free-market decide.

Rep. Smith asked what kind of verification must the consumer provide to the insurer in order to obtain the discount. Commissioner Tom Considine, NCOIL CEO, clarified that the proposed amendments to the NCOIL Model Uniform State Building Code state that for homes that are built to the IBHS Standards, insurers must provide a discount as long as the discount is actuarially justified. Rep. Moore agreed and stated that the proposed amendments represent what Oklahoma originally wanted – rebuild or retrofit your home in accordance with the IBHS standards and you get the discount. In response to Rep. Smith's question, a homeowner shows verification through a certificate from the contractor used to build/retrofit their home in accordance with the IBHS Standards.

Tyler Laughlin, Oklahoma Deputy Insurance Commissioner, stated that the concept set forth in the proposed amendments is very simple: if a consumer goes through all the steps necessary to fortify their home to withstand certain high wind events in accordance with the IBHS Standards, insurers are then required to crunch the numbers and see if a discount is "actuarily justified" and there is sufficient and credible evidence of cost savings, which can be attributed to the IBHS Standards. Insurers are not required to a give a discount if said discount is not "actuarially justified." Mr. Laughlin stated that the Oklahoma Insurance Department has already had several insurers file their discounts and noted that the proposed amendments before the Committee today are identical to the law passed in Oklahoma.

Rep. Smith asked about the proposed amendment's applicability to community buildings. Rep. Steve Riggs (KY) noted that Section 3 of the proposed amendments states that: "for purposes of this act, the term 'insurable property' includes single-family residential property….and also includes modular homes satisfying the codes, standards or techniques as provided in Section 1 or 2 of the act. Manufactured homes or mobile homes are excluded, except as expressly provided in subsection B of Section 2 of this act." Rep. Riggs asked why apartments are not eligible for the discounts. Rep. Riggs also asked if there are statutes or regulations in existence that require insurers to give

discounts if sprinkler or alarm systems are installed. Rep. Moore stated that he is not aware of any such statutes or regulations.

Josh Ashenfelter from State Farm stated that he could provide the Committee with the answer to that question prior to meeting in Atlanta and noted that such discounts, if voluntary, are a great opportunity for insurers to compete against each other. State Farm has been very competitive with providing discounts for installation of security systems.

Rep. Riggs then asked if the proposed amendments apply to both retrofitting and new construction. Mr. Laughlin stated that Section 1A. applies to new construction and Section 2A. applies to retrofitting.

Rep. Moore noted that the examples of sprinkler and alarm systems are different in that they are indoor features and generally only limit protection to that structure. With tornadoes and hurricanes, limiting debris is a major motivation for building to the IBHS Standards. Rep. Moore noted his resistance to impose any mandates on insurers, but stated that the public safety aspect of the proposed amendments, and Oklahoma HB 1720, makes this issue much different from alarm and sprinkler discounts. Rep. Riggs agreed and stated that supporting a free-market approach is generally not a problem until the markets start acting in ways that are harming consumers – that is sometimes why statutes and regulations are modified.

Rep. Smith asked if new IBHS Standards are implemented, how would that impact the consumers who have already built or retrofitted their homes to the old standards. Rep. Moore stated that it is a good question and that he would have to look into it.

Cmsr. Considine stated that with regard to a free-market approach, the proposed amendments are intentionally silent as to the amount of the discount. By requiring the discount only when "actuarily justified", the approach encourages competition as to the amount of the discount. Cmsr. Considine stated that under the concept stated in the proposed amendments, as an Insurance Commissioner in a State that followed the same approach such as Oklahoma, if the State's largest homeowner's carrier decided not to give the discount, he could require them to submit what their actuarial justification is for not providing the discount. If the carrier could not provide any such justification, as Commissioner, he could require them to provide some discount since that is the law of that particular State. That carrier could then provide a .10% discount, while other carriers offer a 10% discount – thereby encouraging competition as to the amount of the discount. The size of the discount rest with the insurer.

Mr. Laughlin stated that Cmsr. Considine is correct and that it is important to remember that when the insurer provides a discount, it means their risk has been reduced – it is not as if the insurer is simply taking a loss. The discount should correlate fairly close with the offset in risk. Rep. Smith agreed and noted a State such as North Dakota isn't going to have to deal with a hurricane, so if a consumer built or retrofit their home to meet the IBHS Standards, the insurer would more than likely be able to show that a discount is not actuarily justified.

Rep. Moore also noted that in Oklahoma, research showed that the value of a home that was built or retrofitted to the IBHS Standards increased the home's value by 6%.

Rep. Riggs stated that there could be a time when insurers go in the opposite direction and provide a discount, but one that is very large and does not meet the standard of actuarial justification. Perhaps the proposed amendments should be worded differently. Cmsr. Considine stated that he understood Rep. Riggs' point, but clarified that the requirement for the discount needs to be actuarially justified – there does not need to be a specific mathematical correlation. NCOIL models are not intended to arrive at that level of specificity – that would be better left to the regulatory community.

Rep. Moore then stated that another option could be to apply the discount to the home's deductible. Cmsr. Considine opined that the legislative level is not the proper forum to determine what kind of deductibles insurers can offer. Rep. Smith agreed and stated that he thinks the intent of the proposed amendments is to let the insurers decide what level and what kind of discount to offer.

Professor Jay Feinman from Rutgers Law School stated that in response to earlier comments, there does not appear to be anything in the proposed amendments requiring an insurer to explain their actuarial justification for not providing a discount. Therefore, it would be up to aggressive regulators monitoring the ratings and/or receiving consumer complaints to require an explanation from the insurer. Prof. Feinman suggested that, whether or not the insurers offer the discount, the insurers should be required to either include it in their rating plan or give notice to the Insurance Commissioner explaining why.

Birny Birnbaum from the Center for Economic Justice stated that the proposed amendments deal with insurance rating and may be more appropriately placed in a rating statute rather than building codes. Mr. Birnbaum also stated that every state has statutory requirements for rates - rates can't be excessive, inadequate or unfairly discriminatory which means rates have to properly reflect risk being insured. The reason such laws exist is to prevent companies pricing on an arbitrary basis. Mr. Birnbaum stated that he is mentioning that information to point out that there are laws in place that require insurers price risk accordingly if they have identified a difference of risk between two different groups of consumers. Therefore, in this instance, if the IBHS Standards are shown to lower risk, there should accordingly be a discount provided to the consumer who builds or retrofits their home to those standards.

Mr. Birnbaum also suggested that there is no reason to limit the required discount to residential properties. Commercial property owners or mobile home owners should also be encouraged to invest in - and be rewarded with a premium discount for – construction or retrofit to the IBHS Standards. Mr. Birnbaum stated that the concept of the proposed amendments are also a great benefit to States and local governments who can avoid tremendous amounts of disaster relief costs. CEJ is strongly in favor of the types of concepts that the proposed amendments set forth.

Mr. Ashenfelter then referred the Committee to the IBHS' statements in which they oppose mandatory discounts or rate reductions for homes built to the IBHS standards.

Buddy Combs, Oklahoma Deputy Insurance Commissioner, stated that it is important for the Committee to note that the IBHS is an insurance industry funded entity.

Mr. Ashenfelter stated that there is a great deal of competition relating to voluntarily discounts such as home security systems. If such discounts are mandated, that takes away the incentive to compete.

Mr. Laughlin stated that home security system discounts are much different than the discounts associated with IBHS Standards. The consumers that decide to make an investment in their homes to build or retrofit to those Standards have to document everything from start to finish and it is a rigorous process, as opposed to simply installing a security system. That is why there should be an incentive at the front-end of the process, so the consumer will have reassurance when investing in their home to make it stronger.

Larry Eckhouse from the American Insurance Association (AIA) stated that insurers have long supported strong building codes to protect property owners and accordingly support the IBHS Standards. However, AIA opposes counterproductive requirements such as mandated discounts. Such discounts do nothing to encourage additional capital investment on those markets. Market freedom often encourages new entrants, increasing competition to the benefit of consumers. Insurers often offer different types of incentives including premium discounts to policyholders who may prefer choosing from multiple options presented in the market like the opportunity to receive smaller deductibles. AIA does not support the proposed amendments but looks forward to discussing other ways to encourage mitigation.

ADJOURNMENT

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