TENTATIVE GENERAL SCHEDULE
NCOIL SUMMER MEETING
JULY 12 - 15, 2018

As of June 20, 2018, and Subject to Change

The Little America Hotel
Salt Lake City, Utah

NCOIL SUMMER MEETING
Salt Lake City, Utah
July 12-15, 2018
TENTATIVE SCHEDULE

THURSDAY, JULY 12TH

Registration *Exhibits Open: 8:00 a.m. – 5:30 p.m.*	7:00 a.m.	-	5:30 p.m.
Nominating Committee (Members Only)	8:00 a.m.	-	8:30 a.m.
Welcome Breakfast	8:15 a.m.	-	10:00 a.m.
Networking Break	10:00 a.m.	-	10:15 a.m.
Property & Casualty Insurance Committee	10:15 a.m.	-	11:45 a.m.
Life Insurance & Financial Planning Committee	11:45 a.m.	-	1:00 p.m.
The Institutes Griffith Foundation Legislator Luncheon	1:00 p.m.	-	2:15 p.m.
Innovation General Session Navigating the Future of Autonomous Vehicles: A Tech and Insurance Update	2:15 p.m.	-	3:45 p.m.
Joint State-Federal Relations and International Insurance Issues Committee	3:45 p.m.	-	5:00 p.m.
Budget Committee	5:00 p.m.	-	5:30 p.m.
Adjournment			5:30 p.m.
Welcome Reception	5:30 p.m.	-	6:30 p.m.

FRIDAY, JULY 13th

Registration *Exhibits Open: 8:30 a.m. – 5:00 p.m.*	7:00 a.m.	-	5:00 p.m.
Financial Services Committee	9:00 a.m.	-	10:15 a.m.
Networking Break	10:15 a.m.	-	10:30 a.m.
Fundamentals of Insurance Session I Life & Health Insurance Issues for Public Policymakers (to run concurrent with Health General Session)	10:15 a.m.	-	11:15 a.m.
Health General Session Breaking Down Silos: Innovative Solutions to Address the Opioid Epidemic	10:30 a.m.	-	12:30 p.m.
Luncheon with Keynote Address	12:30 p.m.	-	2:00 p.m.
Legislative Micro Meetings	2:00 p.m.	-	2:30 p.m.
Workers' Compensation Insurance Committee	2:30 p.m.	-	3:45 p.m.
Fundamentals of Insurance Session II Property & Casualty Insurance Issues for Public Policymakers (to run concurrent with Workers' Compensation Insurance Committee)	2:30 p.m.	-	3:30 p.m.
Networking Break	3:45 p.m.	-	4:00 p.m.
NCOIL – NAIC Dialogue	4:00 p.m.	-	5:30 p.m.
Adjournment			5:30 p.m.
IEC Board Meeting	5:30 p.m.	-	6:15 p.m.
CIP Member & Sponsor Reception	6:00 p.m.	-	7:00 p.m.

SATURDAY, JULY 14TH

Registration *Exhibits Open: 8:30 a.m. – 10:00 a.m.*	8:00 a.m.	-	9:00 a.m.

Audit Committee (Members Only)	8:00 a.m.	-	9:00 a.m.
Health, Long Term Care and Health Retirement Issues Committee	9:00 a.m.	-	11:00 a.m.
Networking Break	11:00 a.m.	-	11:15 a.m.
P&C General Session Arrive Alive: Legislative and Industry Trends to Stop Distracted Driving	11:15 a.m.	-	12:45 p.m.
Adjournment			12:45 p.m.
Tour of Utah State Capitol	3:00 p.m.		

SUNDAY, JULY 15TH

Registration *Exhibits Open: 8:30 a.m. – 10:00 a.m.*	8:00 a.m.	-	9:00 a.m.
Business Planning Committee and Executive Committee	9:00 a.m.	-	10:30 a.m.
Adjournment			10:30 a.m.

THURSDAY, JULY 12, 2018

Nominating Committee (Members Only)
July 12, 2018
8:00 a.m. – 8:30 a.m.

Chair: Sen. Jason Rapert (AR)

Welcome Breakfast
July 12, 2018
8:15 a.m. – 10:00 a.m.

1. Welcome to Salt Lake City
2. President Welcome – Senator Jason Rapert (AR)
3. Recap of D.C. Fly-in
4. New member welcome and introduction
5. Comments from NCOIL CEO Commissioner Tom Considine
6. Special Executive Committee Meeting
    a.) Election of NCOIL Vice President
    b.) Other Executive Committee Matters
7. Any Other Business
8. Adjournment

Networking Break
July 12, 2018
10:00 a.m. – 10:15 a.m.

Property & Casualty Insurance Committee
July 12, 2018
10:15 a.m. – 11:45 a.m.

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

1. Call to order/roll call/approval of March 2, 2018 committee meeting minutes
2. Consideration of Consumer Protection Model Towing Act
3. Consideration of Amendments to NCOIL Model State Uniform Building Code
4. Update on ALI Restatement of the Law of Liability Insurance
5. Discussion on the Role of Insurance in Public-Private Partnerships (P3s)

6. Re-adoption of Model Laws
    a. Model Act Regarding Auto Airbag Fraud
    b. Model State Uniform Building Code
    c. Model Act Regarding Disclosure of Rental Vehicle Damage Waivers
    d. State Flood Disaster Mitigation and Relief Model Act
    e. Model Anti-Runners Fraud Bill
    f. Property-Casualty Insurance Modernization Act
    g. Property-Casualty Insurance Domestic Violence Model Act
7. Any other business
8. Adjournment

Life Insurance & Financial Planning Committee
Thursday, July 12, 2018
11:45 a.m. – 1:00 p.m.

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

1. Call to order/roll call/approval of March 3, 2018 committee meeting minutes
2. The DOL Fiduciary Rule – Not All Quiet on the State Front
3. Presentation on Industry Trends in Retirement Planning: Solutions to Help Plan for the Future
4. Any other business
5. Adjournment

The Institutes Griffith Foundation Legislator Luncheon
Drones and Insurance: Changes and Challenges in the Regulatory Environment
Thursday, July 12, 2018
1:00 p.m. – 2:15 p.m.

Innovation General Session
Navigating the Future of Autonomous Vehicles: A Tech and Insurance Update
Thursday, July 12, 2018
2:15 p.m. – 3:45 p.m.

Joint State-Federal Relations and International Insurance Issues Committee
Thursday, July 12, 2018
3:45 p.m. – 5:00 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 March 2, 2018 committee meeting minutes

2. Discussion on the Impact of the General Data Protection Regulation (GDPR)
3. Examining the Trump Administration's "Plan" to Lower Drug Prices and Reduce Out-of-Pocket Costs
4. Discussion on Dodd-Frank Reform Law – The Economic Growth, Regulatory Relief, and Consumer Protection Act
5. Any other business
6. Adjournment

Budget Committee
Thursday, July 12, 2018
5:00 p.m. – 5:30 p.m.

Chair: Rep. Matt Lehman (IN)
Vice Chair: Rep. Lois Delmore (ND)

Welcome Reception
Thursday, July 12, 2018
5:30 p.m. – 6:30 p.m.

FRIDAY, JULY 13, 2018

Financial Services Committee
Friday, July 13, 2018
9:00 a.m. – 10:15 a.m.

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

1. Call to order/roll call/approval of March 3, 2018 committee meeting minutes
2. Continued Discussion on the Producer Appointment Process
3. Update on Health Savings Accounts (HSAs) Developments
4. Discussion on Resolution in Support of The Small Business Audit Correction Act of 2018
5. Any other business
6. Adjournment

Networking Break
Friday, July 13, 2018
10:15 a.m. – 10:30 a.m.

Fundamentals of Insurance Session I
Life & Health Insurance Issues for Public Policymakers
Friday, July 13, 2018
10:15 a.m. – 11:15 a.m.
(To Run Concurrent with Health General Session)

Health General Session
Breaking Down Silos: Innovative Solutions to Address the Opioid Epidemic
Friday, July 13, 2018
10:30 a.m. – 12:30 p.m.

Luncheon with Keynote Address
The 17th and Current Governor of Utah The Honorable Gary Herbert
Friday, July 13, 2018
12:30 p.m. – 2:00 p.m.

Legislative Micro Meetings
Friday, July 13, 2018
2:00 p.m. – 2:30 p.m.

Workers' Compensation Insurance Committee
Friday, July 13, 2018
2:30 p.m. – 3:45 p.m.

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

1. Call to order/roll call/approval of March 2, 2018 committee meeting minutes
2. Presentation on Utah Workers' Compensation Insurance Marketplace
3. Workers' Compensation Insurance for the "Gig Economy" – A Parallel to New York's Black Car Fund
4. "State of the Line" – An Update on the Status of and Trends in the Workers' Compensation Insurance Marketplace
5. Re-adoption of Model Laws
    a. Model Act on Workers' Compensation Coverage for Volunteer Firefighters
    b. Model Act on Workers' Compensation Repackaged Pharmaceutical Reimbursement Rates
    c. Construction Industry Workers' Compensation Coverage Act
    d. Model Act Regarding Workers' Compensation Insurance Coverage in Professional Employer Organization (PEO) Relationships
6. Any other business
7. Adjournment

Networking Break
Friday, July 13, 2018
3:45 p.m. – 4:00 p.m.

NCOIL – NAIC Dialogue
Friday, July 13, 2018
4:00 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 March 2, 2018 committee meeting minutes
2. Discussion on Cybersecurity Developments
    a.) Creation of NAIC Cybersecurity Insurance Institute
    b.) Other
3. Discussion on Licensure and Regulation of Pharmacy Benefit Managers (PBMs)
4. Discussion and Update on MAWG Activity
5. Discussion on Enabling Insurtech Innovation
6. Review of NAIC Insurance Summit
7. Any other business
8. Adjournment

IEC Board Meeting
Friday, July 13, 2018
5:30 p.m. – 6:15 p.m.

CIP Member & Sponsor Reception
Friday, July 13, 2018
6:00 p.m. – 7:00 p.m.

SATURDAY, JULY 14, 2018

Audit Committee (Members Only)
Saturday, July 14, 2018
8:00 a.m. – 9:00 a.m.

Vice Chair: Asm. Ken Cooley (CA)

Health, Long Term Care, and Health Retirement Issues Committee
Saturday, July 14, 2018
9:00 a.m. – 11:00 a.m.

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

1. Call to order/roll call/approval of March 4, 2018 and June 8, 2018 committee meeting minutes
2. Continued Discussion on Draft NCOIL PBM Licensure and Regulation Model Act
3. Continued Discussion on Reporting and Notification Requirements for Prescription Drug Manufacturers Related to Drug Pricing
4. Discussion on Idaho's Healthcare Marketplace Reform Proposals
5. Any other business
6. Adjournment

Networking Break
Saturday, July 14, 2018
11:00 a.m. – 11:15 a.m.

P&C General Session
Arrive Alive: Legislative and Industry Trends to Stop Distracted Driving
Saturday, July 14, 2018
11:15 a.m. – 12:45 p.m.

Tour of Utah State Capitol
Saturday, July 14, 2018
3:00 p.m.

SUNDAY, JULY 15, 2018

Business Planning and Executive Committee
Sunday, July 15, 2018
9:00 a.m. – 10:30 a.m.

Chair: Sen. Jason Rapert (AR)
Vice Chair: Rep. Bill Botzow (VT)

1.) Call to order/roll call/approval of March 4, 2018 and May 2, 2018 committee meeting minutes
2.) Future meeting locations
    -2020 Summer Meeting
3.) Recruitment of New Member States
4.) Administration
    a.) Meeting Report
    b.) Receipt of Financials and Audit
5.) Consent Calendar
    -Committee Reports Including Models Adopted/Re-adopted Therein
6.) Discussion of Model Act to Support State Regulation of Insurance Through More Informed Policymaking
7.) Other sessions
    a.) The Institutes Griffith Foundation Legislator Luncheon
    b.) Fundamentals of Insurance Sessions
    c.) Featured Speakers
8.) Any other business
9.) Adjournment

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

National Council of Insurance Legislators (NCOIL)

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

To be discussed by the NCOIL Executive Committee on July 15, 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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Manasquan, NJ 08736
732-201-4133
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 July 12, 2018
Sponsored by Rep. Matt Lehman (IN)

******Reminder: All parties are hereby on notice that the Sponsor, Rep. Matt Lehman (IN), reserves the right to make amendments to this Model prior to the July 12, 2018 meeting of the NCOIL Property & Casualty Insurance Committee Meeting******

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 services" - shall include, but not be limited to, the assumption of or reimbursement of the expense or a portion thereof for towing of a motor vehicle, emergency road service, matters relating to the operation, use, and maintenance of a motor vehicle, and the supplying of services which includes, augments, or is incidental to theft or reward services, discount services, arrest bond services, lock and key services, trip interruption services, and legal fee reimbursement services in defense of traffic related offenses.

"Recovery 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.

"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.

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

"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." The term includes towing for law enforcement purposes that is performed by a towing company under a contract with the State, a local unit, or a law enforcement agency of the State or local unit; or on behalf of the State, a local unit, or a law enforcement agency of the State or local unit.

"Motor vehicle" – any vehicle that is manufactured primarily for use on public streets, roads and highways (not including a vehicle operated exclusively on a rail or rails); and has at least four (4) wheels.

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

"Owner requested towing" – the request to tow a vehicle by or on behalf of the vehicle owner or operator.

"Private property towing" – the towing of a motor vehicle, without the owner's consent, from private property on which the motor vehicle was illegally parked, or for which some exigent circumstance necessitated its removal to another location.

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

"Seizure towing" – the towing of a motor vehicle for law enforcement purposes involving the maintenance of the chain of custody of evidence, or forfeiture of assets.

"Storage facility" – any lot, facility, or other property used to store motor vehicles that have been removed from another location by a tow truck.

"Tow truck" - a motor vehicle equipped to provide any form of towing service, including recovery service or flat bed service.

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

"Towing company" - any service, company or business that tows or otherwise moves motor vehicles by means of a tow truck or owns or operates a storage lot. A towing business, service or company shall not include an automobile club, car dealership or insurance company.

Section 4. General Provisions

The provisions of this Act 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 Act 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 Act 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 Act are not applicable to "seizure towing", the towing of a vehicle for law enforcement purposes.

The provisions of this Act 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.

In addition to any penalty imposed under Section 12 of this Act, any for-hire motor carrier engaged in the towing of motor vehicles who violates this Act is subject to sanctions imposed by the [regulatory body] in the State of XXXX.

Section 5. Emergency Towing

A. This Section applies to a towing company that engages in, or offers to engage in, emergency towing. Prior to removing a vehicle from a tow truck under this section, a towing company shall take photographs, video or other visual documentation to evidence the vehicle damages, debris, damaged cargo or property, and complications to recovery process.

B. Except as provided in Section 5(C), 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:

(i) soliciting an engagement for emergency towing services;

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

(iii) accruing charges in connection with an activity in subsection (i) or (ii)

C. 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 Section 5(B) 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.

(4) the towing company has reasonable belief that a motorist is in need of immediate aide. The towing company may not offer towing services in this circumstance unless conditions C(1), C(2), or C(3) of this section are met.

D. Except as provided in Sections 5(E) and (F), the owner or operator of a disabled motor vehicle may:

(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.

E. Section 5(D) 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

F. 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 Section 5(D) 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 is a hazard; impedes the flow of traffic; or may not legally remain in its location in the opinion of the law enforcement officer or authorized state, county, or municipal personnel.

G. If a disabled motor vehicle is causing or 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.

H. 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, to the extent available, consisting of:

(1) the first and last name, and 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.

I. 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, to the extent available, consisting of:

(1) the identity of the law enforcement agency or 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.

J. A towing company shall maintain a record created under Sections 5(H) or (I) and provide said record 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. A towing company shall also retain a record created under Sections 5(H) or (I) for a period of two (2) years from the date the disabled vehicle was towed from scene and, throughout said two (2) year period, make the record available for inspection and copying, not later than two (2) business days after receiving a written request from a law enforcement agency, the attorney general, the disabled motor vehicle's owner, or an authorized agent of the disabled motor vehicle's owner.

K. A towing company that performs emergency towing under this Act must properly secure all towed motor vehicles and take all reasonable efforts to prevent further damage (including weather damage) or theft of all towed motor vehicles, including a motor vehicle's cargo and contents.

Section 6. Private Property Towing

A. This Section applies to a towing company that engages in, or offers to engage in, private property towing. This Section does not apply to the towing of a motor vehicle from a tow-away zone that is not located on private property. Prior to removing a vehicle from a tow truck under this section, a towing company shall take photographs, video or other visual documentation to evidence the vehicle damages, debris, damaged cargo or property, and complications to recovery process.

B. The owner of private property may establish a tow-away zone on the owner's property. A property owner that establishes a tow-away one under this Section shall post at the location of the tow-away zone a sign that is clearly visible to the public. The sign

must include a statement that the area is a tow-away zone, pertinent contact information, and a description of any persons authorized to park in the area.

C. A towing company that tows a motor vehicle under this Section shall ensure that the motor vehicle is towed to 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, 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. ***Drafting Note: Depending on the population density of a State, legislators may consider altering this distance.***

D. 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 release the motor vehicle to the owner or operator, and give the owner or operator a receipt showing the full amount of the fee of the towing company normally charges for the release of a motor vehicle, and the amount of the fee paid by the owner or operator.

E. 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.

F. A towing company that performs private property towing under this Section shall properly secure all towed motor vehicles, and take all reasonable efforts to prevent further damage (including weather damage) or theft of all towed motor vehicles, including a motor vehicle's cargo and contents.

G. This Section does not affect a private property owner's rights under [insert State Statute with respect to abandoned motor vehicles] with respect to abandoned vehicles on the property owner's property.

Section 7. Estimates and Invoices for Towing Services

A. Prior to attaching a vehicle to a tow truck, the towing company shall furnish the vehicle owner, if the owner is present at the scene of a disabled vehicle, a rate sheet listing all rates for towing services included but not limited to, all rates for towing and associated fees, cleanup charges, labor, storage, and any other services provided by the towing company. A charge in excess of what is reflected on the rate sheet for any service shall be deemed excessive as described in Section 10A. The rate sheet shall also be posted at the towing company's place of business and be made available upon request to consumers.

B. 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, which may be an insurance company, not later than one (1) business day after the tow is completed, or 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.

C. The itemized invoice required by this Section must contain the following information:

a. an invoice number

b. the location from which the motor vehicle was towed;

c. the location to which the motor vehicle was towed;

d. the name, address, and telephone number of the towing company;

e. a description of the towed motor vehicle, including the:

(i) make;

(ii) model;

(iii) year;

(iv) vehicle identification number; and

(v) color

f. the license plate number and state of registration for the towed motor vehicle;

g. the cost of the original towing service;

h. the cost of any vehicle storage fees, expressed as a daily rate;

i. Other reasonable fees;

j. 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.

D. Any reasonable service or fee in addition to the services or fees described in Section 7C, 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.

E. A copy of each invoice and receipt submitted by a tow truck operator in accordance with Section 7 shall be retained by the towing company for a period of two (2) years from the date of issuance. Throughout said two (2) year period, the copy of each invoice and receipt shall be made available for inspection and copying not later than two (2) business daysafter 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 xxx State business locations;

d. the disabled motor vehicle's owner; or

e. the agent of the disabled motor vehicle's owner.

Section 8. Notice Requirements

A. Within two (2) business days of commencement of towing, the towing company or storage facility must commence a search of the National Motor Vehicle Title Information Systems data base, to obtain the last state of record of the vehicle and then obtain the most current name and address of the person who owns or holds a lien from the State's agency responsible for maintaining motor vehicle title data or an authorized vendor providing real time access to that state database, by electronic means, if available. No storage charges beyond the initial two (2) business days charge will accrue until the notice requirement has been met.

B. Upon obtaining the name and address of the owner and lienholder of the motor vehicle, written notice shall be given directly to the owner and lienholder, and, if known to the towing service or storage facility, the insurer of the vehicle, by certified mail with delivery confirmation within five (5) business days unless the ownership information could not reasonably be obtained within that time. 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 name, address, and telephone number 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 towing company or storage facility;

f. A description of the towed vehicle including but not limited to the make, model, year, vehicle identification number and color of the towed vehicle;

g. The license plate number and state of registration of the towed vehicle.

C. If the search result under Section 8(A) 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 comparable to 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 9. Releasing Towed Motor Vehicles

A. This section applies to towing companies that tow and store motor vehicles, and to storage facilities that store motor vehicles towed by a towing company, regardless of whether the towing company and the storage facility are affiliates.

B. Upon payment of all costs incurred against a motor vehicle that is towed and stored under this Act, the towing company or storage facility shall 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 responsible insurance company and the insurance representative provides proof of such, or, the owner of the motor 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 motor vehicle under normal business hours before accepting return of the motor 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 motor vehicle under this Section: cash; insurance check; credit card, debit card, money order, or certified check.

E. Upon receiving payment of all costs incurred against a motor vehicle, a towing service or storage yard shall provide to the person making payment an itemized receipt that includes the information set forth in Section 7, 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.

Section 10. Fees

A. A towing company shall not charge a fee for towing, clean-up services and/or storage of a vehicle that is excessive or unfairly discriminatory.

B. 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 (2) years, and shall make the records available for inspection and copying upon written request from law enforcement.

C. A towing company shall furnish a copy of its rate sheet as provided in Section 7A to (insert relevant regulatory body)

Section 11. Certification Requirements

Drafting Note: States that already have a towing certification process in place may wish to supplement its relevant insurance code or regulations with this Section.

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 12. Prohibited Acts

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

a. falsely represent, either expressly or by implication, that the towing company represents or is approved by any organization which provides emergency road service for disabled motor vehicles.

b. require an owner/operator of a disabled motor vehicle, to preauthorize more than 24 hours of storage, or repair work as a condition to providing towing service for the disabled vehicle.

c. charge more than one (1) towing fee when the owner/operator of a disabled vehicle requests transport of the vehicle be towed to a repair facility owned or operated by the towing company

d. tow a motor vehicle to a repair facility, unless either the owner of the motor vehicle of the owner's designated representative gives consent, and, the consent is given before the motor vehicle is removed from the location from which it is to be towed. This prohibition does not apply to a storage yard that has a repair facility on the same site so long as the vehicle is not moved into the repair facility without consent as stated above.

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

a. upon payment of all costs incurred against a motor vehicle that is towed and stored under this Act, refuse to release the motor vehicle to a properly identified person who owns or holds a lien on the motor vehicle, or a representative of the responsible insurance company.

(i) 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 a judicial order countermands its release.

b. refuse to permit a properly identified person who owns or holds a lien on a motor vehicle, or a representative of the responsible insurance company to inspect the motor vehicle before all costs incurred against the motor vehicle are paid or the motor vehicle is released.

c. charge any storage fee for a stored motor vehicle with respect to any day on which release of the motor vehicle, or 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.

Section 13. Penalties and Enforcement

Drafting Note: Legislators should consider provisions that establish rules that allow for the [regulatory body] to be responsible for the administration and enforcement, including inspections, investigations, penalties, and license revocations, of all towing businesses and towing service storage lots in the state of XXXX.

Drafting Note: Legislators should further consider provisions allowing for an independent cause of action for insurers to recover a motor vehicle that has been towed and subject to an unreasonable billing by the tower for any excessive towing/storage charges.

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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 July 12, 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 July 12, 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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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

RESOLUTION IN SUPPORT OF THE SMALL BUSINESS AUDIT CORRECTION ACT

To be discussed by the NCOIL Financial Services Committee on July 13, 2018
Sponsored by Senator Jason Rapert (AR)

WHEREAS, many types of financial institutions are in need of regulatory relief, including privately-held, small non-custodial brokers and dealers, which are often the gateway to the markets for Main Street businesses; and

WHEREAS, the Public Company Accounting Oversight Board (PCAOB) was established by Congress in the Sarbanes-Oxley Act of 2002 (Sarbanes-Oxley) to oversee the audits of public companies in an effort to protect the investing public; and

WHEREAS, the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank) expanded the PCAOB's oversight to include the annual audits of all brokers and dealers registered with the Securities and Exchange Commission (SEC), regardless of size; and

WHEREAS, prior to Sarbanes-Oxley, and as amended by Dodd-Frank, brokers and dealers were required to hire American Institute of CPAs (AICPA) registered auditors who followed Generally Accepted Accounting Standards (GAAS) when conducting audits; and

WHEREAS, the complex and expensive PCAOB audit requirements and guidelines were appropriately designed for large, public companies because the investing public and markets are potentially at much greater risk from those companies; and

WHEREAS, conversely, the PCAOB audit requirements and guidelines are not suited for small, privately-held firms that do not hold customer assets; and

WHEREAS, this one-size-fits-all PCAOB audit requirement has inhibited the growth and success of small broker-dealer businesses with limited resources; and

WHEREAS, the very name of the PCAOB should limit its oversight to public companies, not privately-held firms; and

WHEREAS, such small, Main Street firms, should be encouraged to focus on providing valuable services to their customers rather than exerting their limited resources on regulations that only provide enhanced consumer protection when applied to large, public companies; and

WHEREAS, H.R. 6021/S. 3004, the "Small Business Audit Correction Act of 2018" would exempt privately-held, small non-custodial brokers and dealers in good standing from the requirement to hire a PCAOB-registered audit firm, and reinstate audit requirements to the former standard for those types of firms which will in turn protect consumers and promote economic growth; and

WHEREAS, this bipartisan legislation is a common-sense step towards easing the regulatory burden on small businesses, a burden so great that many small businesses are struggling to survive; and

WHEREAS, NOW, THEREFORE, BE IT RESOLVED, that NCOIL supports H.R. 6021/S.3004, and urges members of Congress to take action on the proposal to provide significant and much needed relief for small businesses and their customers across the country; and

BE IT FINALLY RESOLVED, that a copy of this Resolution shall be distributed to the members of the U.S. House Financial Services Committee; the members of the Senate Banking Committee; the Speaker and Minority Leader of the U.S. House of Representatives; the Majority Leader and Minority Leader of the United States Senate; and the Chairs of the Committees of jurisdiction in each Legislative Chamber of each State.

115TH CONGRESS
2D SESSION

H. R. 6021

To amend the Sarbanes-Oxley Act of 2002 to exclude privately held, non-custody brokers and dealers that are in good standing from certain requirements under title I of that Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES
JUNE 6, 2018

Mr. HILL (for himself and Mr. GONZALEZ of Texas) introduced the following bill; which was referred to the Committee on Financial Services

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A BILL

To amend the Sarbanes-Oxley Act of 2002 to exclude privately held, non-custody brokers and dealers that are in good standing from certain requirements under title I of that Act, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Small Business Audit Correction Act of 2018".

SEC. 2. EXEMPTION.

(a) AMENDMENTS TO THE SARBANES-OXLEY ACT OF 2002.—Title I of the Sarbanes-Oxley Act of 2002 (15 U.S.C. 7211 et seq.) is amended—

(1) in section 101(e)(1) (15 U.S.C. 7211(e)(1)), by striking "brokers, and dealers" and inserting "brokers, dealers, and non-custody brokers or dealers that are privately held and in good standing"; and

(2) in section 110 (15 U.S.C. 7220)—

(A) in paragraph (3)—

(i) by striking "The term" and inserting "Except as otherwise expressly provided, the term"; and

(ii) by inserting ", except that the term does not include a non-custody broker or dealer that is privately held and in good standing" after "registered public accounting firm";

(B) in paragraph (4)—

(i) by striking "The term" and inserting "Except as otherwise expressly provided, the term"; and

(ii) by inserting ", except that the term does not include a non-custody broker or dealer that is privately held and in good standing" after "registered public accounting firm";

(C) by redesignating paragraphs (5) and (6) as paragraphs (8) and (9), respectively; and

(D) by inserting after paragraph (4) the following:

"(5) IN GOOD STANDING.—The term 'in good standing' means, with respect to a broker or dealer (as those terms are defined in section 3(a) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a))), that, as of the last day of the most recently completed fiscal year of the broker or dealer, as applicable, the broker or dealer—

"(A) was registered with the Commission;

"(B) was licensed by, and registered with, the Financial Industry Regulatory Authority or a national securities exchange that is registered with the Commission under section 6 of the Securities Exchange Act of 1934 (15 U.S.C. 78f);

"(C) was compliant with the minimum dollar net capital requirements under section 240.15c3–1 of title 17, Code of Federal Regulations, or any successor regulation;

"(D) had not, during the 10-year period preceding that date, been convicted of a felony under Federal or State law; and

"(E) was not barred from registering, or had not been expelled from registration, with the Commission, the Financial Industry Regulatory Authority, the Commodity Futures Trading Commission, or any State regulatory agency, without regard to whether the broker or dealer had, as of that date, filed an appeal challenging such a bar or expulsion, as applicable.

"(6) NON-CUSTODY BROKER OR DEALER.—The term 'non-custody broker or dealer' means a broker or dealer (as those terms are defined in section 3(a) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a))), as applicable, that—

"(A) as of the last day of the most recently completed fiscal year of the broker or dealer—

"(i) had not less than 1 and not more than 150 registered persons holding a securities license registered with the broker or dealer;

"(ii) cleared each eligible transaction with and for a consumer on a fully disclosed basis with a clearing broker or dealer or a member of a national securities exchange that is registered with the Commission under section 6 of the Securities Exchange Act of 1934 (15 U.S.C. 78f);

"(iii) did not, as a matter of ordinary business practice in connection with the activities of the broker or dealer, elect to receive customer checks, drafts, or other evidence of indebtedness made payable to the broker or dealer or a person other than the requisite registered broker or dealer carrying the account of a customer, escrow agent, issuer, underwriter, sponsor, or other distributor of securities;

"(iv) did not otherwise hold funds or securities for customers; and

"(v) if required under section 3(a)(2) of the Securities Investor Protection Act of 1970 (15 U.S.C. 78ccc(a)(2)), was a member of the Securities Investor Protection Corporation; and

"(B) during the most recently completed fiscal year of the broker or dealer, claimed exemption from section 240.15c3–3 of title 17, Code of Federal Regulations, or any successor regulation.

"(7) PRIVATELY HELD.—The term 'privately held' means, with respect to a broker or dealer (as those terms are defined in section 3(a) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a))), that the broker or dealer, as applicable, is not an issuer.".

(b) AMENDMENTS TO REGULATIONS.—Not later than 60 days after the date of enactment of this Act, the Securities and Exchange Commission shall make any necessary amendments to regulations of the Commission that are in effect as of the date of enactment of this Act in order to carry out this Act and the amendments made by this Act.

(c) EFFECTIVE DATE.—This Act, and the amendments made by this Act, shall take effect on the date that is 60 days after the date of enactment of this Act.

115TH CONGRESS
2D SESSION

S. 3004

To amend the Sarbanes-Oxley Act of 2002 to exclude privately held, non-custody brokers and dealers that are in good standing from certain requirements under title I of that Act, and for other purposes.

IN THE SENATE OF THE UNITED STATES
JUNE 6, 2018

Mr. COTTON (for himself and Mr. JONES) introduced the following bill; which was read twice and referred to the Committee on Banking, Housing, and Urban Affairs

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A BILL

To amend the Sarbanes-Oxley Act of 2002 to exclude privately held, non-custody brokers and dealers that are in good standing from certain requirements under title I of that Act, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Small Business Audit Correction Act of 2018".

SEC. 2. EXEMPTION.

(a) AMENDMENTS TO THE SARBANES-OXLEY ACT OF 2002.—Title I of the Sarbanes-Oxley Act of 2002 (15 U.S.C. 7211 et seq.) is amended—

(1) in section 101(e)(1) (15 U.S.C. 7211(e)(1)), by striking "brokers, and dealers" and inserting "brokers, dealers, and non-custody brokers or dealers that are privately held and in good standing"; and

(2) in section 110 (15 U.S.C. 7220)—

(A) in paragraph (3)—

(i) by striking "The term" and inserting "Except as otherwise expressly provided, the term"; and

(ii) by inserting ", except that the term does not include a non-custody broker or dealer that is privately held and in good standing" after "registered public accounting firm";

(B) in paragraph (4)—

(i) by striking "The term" and inserting "Except as otherwise expressly provided, the term"; and

(ii) by inserting ", except that the term does not include a non-custody broker or dealer that is privately held and in good standing" after "registered public accounting firm";

(C) by redesignating paragraphs (5) and (6) as paragraphs (8) and (9), respectively; and

(D) by inserting after paragraph (4) the following:

"(5) IN GOOD STANDING.—The term 'in good standing' means, with respect to a broker or dealer (as those terms are defined in section 3(a) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a))), that, as of the last day of the most recently completed fiscal year of the broker or dealer, as applicable, the broker or dealer—

"(A) was registered with the Commission;

"(B) was licensed by, and registered with, the Financial Industry Regulatory Authority or a national securities exchange that is registered with the Commission under section 6 of the Securities Exchange Act of 1934 (15 U.S.C. 78f);

"(C) was compliant with the minimum dollar net capital requirements under section 240.15c3–1 of title 17, Code of Federal Regulations, or any successor regulation;

"(D) had not, during the 10-year period preceding that date, been convicted of a felony under Federal or State law; and

"(E) was not barred from registering, or had not been expelled from registration, with the Commission, the Financial Industry Regulatory Authority, the Commodity Futures Trading Commission, or any State regulatory agency, without regard to whether the broker or dealer had, as of that date, filed an appeal challenging such a bar or expulsion, as applicable.

"(6) NON-CUSTODY BROKER OR DEALER.—The term 'non-custody broker or dealer' means a broker or dealer (as those terms are defined in section 3(a) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a))), as applicable, that—

"(A) as of the last day of the most recently completed fiscal year of the broker or dealer—

"(i) had not less than 1 and not more than 150 registered persons holding a securities license registered with the broker or dealer;

"(ii) cleared each eligible transaction with and for a consumer on a fully disclosed basis with a clearing broker or dealer or a member of a national securities exchange that is registered with the Commission under section 6 of the Securities Exchange Act of 1934 (15 U.S.C. 78f);

"(iii) did not, as a matter of ordinary business practice in connection with the activities of the broker or dealer, elect to receive customer checks, drafts, or other evidence of indebtedness made payable to the broker or dealer or a person other than the requisite registered broker or dealer carrying the account of a customer, escrow agent, issuer, underwriter, sponsor, or other distributor of securities;

"(iv) did not otherwise hold funds or securities for customers; and

"(v) if required under section 3(a)(2) of the Securities Investor Protection Act of 1970 (15 U.S.C. 78ccc(a)(2)), was a member of the Securities Investor Protection Corporation; and

"(B) during the most recently completed fiscal year of the broker or dealer, claimed exemption from section 240.15c3–3 of title 17, Code of Federal Regulations, or any successor regulation.

"(7) PRIVATELY HELD.—The term 'privately held' means, with respect to a broker or dealer (as those terms are defined in section 3(a) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a))), that the broker or dealer, as applicable, is not an issuer.".

(b) AMENDMENTS TO REGULATIONS.—Not later than 60 days after the date of enactment of this Act, the Securities and Exchange Commission shall make any necessary amendments to regulations of the Commission that are in effect as of the date of enactment of this Act in order to carry out this Act and the amendments made by this Act.

(c) EFFECTIVE DATE.—This Act, and the amendments made by this Act, shall take effect on the date that is 60 days after the date of enactment of this Act.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
STATE-FEDERAL RELATIONS COMMITTEE AND INTERNATIONAL INSURANCE ISSUES COMMITTEE
ATLANTA, GEORGIA
MARCH 2, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) State-Federal Relations Committee and International Insurance Issues Committee met at The Whitley Hotel in Atlanta, Georgia on Friday, March 2, 2018 at 11:45 a.m.

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

Other members of the Committees present were:

Rep. Sam Kito, AK
Asm. Ken Cooley, CA
Rep. Park Cannon, GA
Rep. Richard Smith, GA
Rep. Matt Lehman, IN
Rep. Steve Riggs, KY
Rep. George Keiser, ND
Sen. Neil Breslin, NY
Asm. Andrew Garbarino, NY
Sen. James Seward, NY
Rep. Glen Mulready, OK
Sen. Bob Hackett, OH
Rep. Tom Oliverson, TX

Other legislators present were:

Rep. Charisse Millett, AK
Rep. Deborah Ferguson, AR
Rep. Paul Mosley, AZ
Rep. Bryon Short, DE
Rep. Darlene Taylor, GA
Sen. Thomas Middleton, MD
Rep. Justin Hill, MO
Sen. Paul Wieland, MO
Sen. Ed Buttrey, MT

Also in attendance were:

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

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its November 17, 2017 meeting in Phoenix, Arizona.

DISCUSSION ON THE IMPACT OF FEDERAL TAX REFORM ON THE INSURANCE INDUSTRY

Bridget Hagan of The Cypress Group began by stating that there was a lot of background work that led up to federal tax reform but the actual drafting of the legislation occurred quickly, and noted that federal tax reform is always a zero sum game – you need to pay for tax benefits that will benefit some at the expense of others. Federal tax reform created $5.24 trillion in tax cuts over 10 years. To off-set that, taxes were raised

on others for a total of $3.77 trillion over 10 years, which means the total cost of the tax reform bill was $1.47 trillion over 10 years. Those numbers are important because, in the context of the bill's treatment of the insurance industry, Congress searched thoroughly for industries that could be the target for some of the off-sets.

Ms. Hagan continued that much of the animus behind the bill centered on corporate and international tax reform since the bill moved the U.S. from a worldwide classification to a territorial classification. The corporate tax rate was lowered from 35% to 21%, and the corporate alternative minimum tax (AMT) was repealed. Ms. Hagan stated she thinks the insurance industry was particularly targeted in the bill – not because of any concern over policy – but because of the need for sources of revenue under the bill, and due to a general lack of understanding of how insurance works and how it is regulated. In the life insurance industry there has been a longtime concern about the preservation of the tax treatment of certain products. Making sure retirement products are taxed in a way that underpins the social benefit they provide has always been important.

Ms. Hagan stated that the insurance tax increases in general totaled about $40 billion. The only other part of the economy that was targeted nearly as much was colleges. The life insurance industry was targeted to raise about $23 billion in revenue, and there is a lot of concern that there was not proper understanding of the current insurance industry in general which sets a troublesome precedent for when Congress is in need of revenue in the future. Ms. Hagan then discussed some life-insurance specific provisions in the bill, the first being the computation of life insurance reserves which raised about $15.2 billion over 10 years. The provision limits the tax-deductible reserves of life insurance companies to about 92.81% of actuarial reserves – that specific percentage was not arrived at due to any policy consideration but rather due to a targeted amount of revenue needed. Another provision is the change in treatment of deferred acquisition costs which raised about $7.2 billion over 10 years. Lastly, there was a modification to the dividends-received deduction in that the bill changed the proration rules for life insurance companies and limits that deduction to 70% - that raised about $1.6 billion over 10 years. There was also a change in the treatment of net-operating losses for only life insurance companies. Ms. Hagan stated that as a general matter, it was very positive to lower the corporate tax rate, but the life insurance industry nonetheless felt targeted.

With regard to the P&C industry, Ms. Hagan stated that besides some minor negative changes, the industry was treated positively, particularly since it has no change in its net operating loss structure. Ms. Hagan then stated that insurance companies so far have either had an immediate tax benefit or "hit" because of the bill's treatment of deferred tax assets, but that is mainly due to a quirk in the tax-transition. It is too soon to tell what the impacts of the tax reform will be but there certainly has been positive news of companies providing bonuses and increasing minimum wage. Ms. Hagan noted that such positive news in no way correlates to the accusation that some companies have received a "windfall" under the bill. Ms. Hagan closed by stating that any tax reform that benefits "c" corporations in America will benefit insurers which is appropriate, and the long-term challenge is making sure Congress properly understands the state-based system of insurance regulation and taxation.

Julie Gackenbach of Confrere Strategies began by discussing what is not in the tax reform, the first being a formal title, although it is commonly referred to in the press as The Tax Cut and Job Reform Act of 2017. The most immediate impact of the decreased corporate tax rate is that corporations either have deferred tax assets or liabilities. Many

insurers have a significant book of deferred tax assets in the form of credits such as un-used AMT credits. Under guidance that was issued by the SEC applicable to publicly traded companies, companies needed to book those changes by the end of 2017 to the extent they knew the changes and then going forward there is some flexibility. That does have an impact on capital for many insurers because that was considered capital on their books. That is an issue that the NAIC will address under risk-based capital requirements at its next meeting.

With regard to the repeal of the AMT tax, continued Ms. Gackenbach, many companies will carry off their AMT credits over the next few years which will significantly reduce and in some cases, eliminate the taxable liability for companies going forward because for the first two years you can offset up to 50% at which point they will become refunds. Another important aspect to note is how companies book their assets and capital because the U.S. budget sequester rules apply to tax refunds so much like federal government spending is subject to across the board sequester, so are corporate refunds. Last year the sequester amount was 6.6%. As part of the budget agreement, the PAYGO scorecard was reset to zero which should help eliminate some of that detrimental impact but over the next several years as the AMT credits are run-off, if Congress does not have budget discipline and that sequester comes back in, companies will be losing a percentage of that carry-back and would need to consider that as they book that in their financial statements.

Ms. Gackenbach stated that with regard to the net operating loss (NOL) limitation, Congress had always allowed corporations the ability to carry their net operating losses back two years and forward for 20 years, except for life insurance corporations which have different rules. In an attempt to move towards a more cash flow type method, Congress has decided to completely eliminate that ability for all corporate taxpayers to carry back net operating losses. The provision is effective for losses that occur after December 31, 2017, so on a going forward basis, with the NOL's that are sitting out there, Congress must address both old and new NOLs. However, the ability to carry-back was preserved for P&C insurers so in the case of consolidated groups that have both P&C and non-insurance entities, it gets more complicated, but it was undoubtedly a "win" for P&C insurers to preserve that ability. Ms. Gackenbach further stated that the bill also changed the tax treatment for people that have pass-through entities to allow for the deduction of up to 20% of qualified business income except for certain specified service providers.

With regard to the impact of the bill on the health insurance industry, Ms. Gackenbach stated that in order to comply with the budget reconciliation rules, repeal of the individual mandate would not have been possible since that would have been a policy-based change and not revenue related. Accordingly, the individual mandate is not eliminated but the penalty for noncompliance has been set to zero. Several States are now asserting that the ACA is rendered unconstitutional without any exercise of Congress' taxing power. Also, for years beginning after December 31, 2016, and ending before January 1, 2019, the bill reduces the medical expense deduction floor to 7.5% of adjusted gross income (from 10%) and eliminates the minimum tax preference.

Ms. Gackenbach then discussed the bill's impact on the life insurance industry and agreed with Ms. Hagan's statement that the industry was targeted for a significant amount of money. Congressional staff assert that while the industry was targeted, it ended up being nowhere near the amount initially proposed in Congressman David

Camp's initial draft. The biggest change is the modification to rules for computing life insurance reserves. Ms. Gackenbach stated that many Congressional staff members thought they were being helpful by simplifying the calculation, but the Joint Committee on Taxation unfortunately does not have a good track record of revenue-estimating in the insurance industry, and their estimates greatly conflicted with the industries calculations. The bill also repeals the small life insurance company deduction that allowed life insurance companies with assets below $500 million to deduct 60% of their first $3 million in income. The most significant change in terms of creating new policy is in the area of life settlement reporting. Congress has been very concerned about the proliferation of sales of life insurance products and has written in a new set of reporting mechanisms that will impose obligations on the purchaser of a life insurance product. The purchaser must report certain information to the IRS, to the insurance company that issued the contract, and to the seller. The requirements do not apply to transactions between what Congress views as a legitimate bona-fide relationship, only to unrelated third-party transactions. These changes were negotiated and not opposed by the life insurance settlement industry.

With regard to the P&C industry, Ms. Gackenbach stated that the bill amends IRC § 846, which provides rules for determining discounted unpaid losses, by extending the discount period and increasing the discount interested rate. The bill replaces the applicable federal rate (AFR) with a rate determined on the basis of the corporate bond yield curve that reflects the average, for the preceding 60-month period, of monthly yields on investment grade corporate bonds with varying maturities and that are in the top three quality levels available. Congress wanted to make that change because it felt that the AFR was a completely risk-free rate that did not affect company portfolios. Ms. Gackenbach also noted that the IRS is looking into the possibility of having split rates when looking at long term lines vs. short term lines. The bill also replaced the fixed 15% proration percentage with a formula that is tied to the highest corporate rate – 5.25% divided by the highest corporate tax rate. As a result, the applicable percentage reduction for tax years after December 31, 2017 is 25%. There had been proposals to increase that rate, but it was met with opposition from both industry and state and local governments who issued bonds because they did not want to disrupt that market because the P&C market is one of the most stable markets they have.

Lastly, Ms. Gackenbach stated that the bill established a new base erosion and anti-abuse minimum tax (BEAT) which is designed to restrict the ability of multi-national companies to erode the U.S. tax base through deductible related-party payments. Notably, premium or other consideration for reinsurance payments are specifically included in the definition of a base erosion payment so it will have a significant impact on how people cede with affiliated reinsurance. Also, unlike the AMT, the BEAT is not creditable, and as such does not reduce future regular income tax liabilities. For companies that have internationally affiliated transactions, this will be an interesting dynamic.

Frank O'Brien of the Property Casualty Insurance Association of America (PCI) stated that not long after the bill was passed, the Consumer Federation of America (CFA) sent a letter calling upon Insurance Commissioners across the country to take immediate action to prevent a windfall to the insurance industry for the reduction in the corporate tax rate. Many regulators, most notably the California Insurance Commissioner David Jones, took note of the letter and examined the implications of the corporate tax rate reduction and whether insurers should reduce their rates. Mr. O'Brien stated that the

impact of tax reform on individual companies will depend on the structure of that particular company, the marketplace in which it operates, and the type of products that it provides. Various Insurance Commissioners have communicated to the industry as a whole in their States that they expect the industry to look at their expense structures when determining their rates. Mr. O'Brien closed by stating that we are still in the implementation period of tax reform and the industry will soon see the intended and unintended consequences of said reform.

DISCUSSION ON THE STATUS OF THE NFIP AND STATE FLOOD INSURANCE MARKETS

David Maurstad, Assistant Administrator for Federal Insurance at the Federal Emergency Management Association (FEMA) stated that his responsibilities include handling the business operations of the National Flood Insurance Program (NFIP). 2016 and 2017 were demanding years for the NFIP. In 2016, the NFIP received more than 84,000 claims and paid out $4.3 billion to insured survivors. Last fall there were three consecutive category 5 hurricanes across the southeast and Caribbean, in addition to the wildfires in California which were followed by severe flooding and mudslides. The magnitude, frequency, and geographic dispersion of the 2017 events provided a rare stress-test to the NFIP and the changes implemented over the past several years. In all areas across the South, FEMA issued financial assistance to hurricane survivors in record sums and in record amounts of time. The NFIP received nearly 125,000 claims, amounting to more than $9.1 billion in total claims paid from just Hurricanes Harvey, Maria, and Irma.

The past two years of severe weather events have made it clearer than ever before how important flood insurance is for survivors. Reaffirmed are the notions that coverage matters and resilience matters. Part of a community's resilience, and part of a person's resilience, is taking actions necessary to reduce your risk, and for risks you can't reduce, you insure those. The NFIP is an important piece of that resilience puzzle – it helps identify flood risk; helps communities and individuals do what's possible to reduce their flood risk; and helps property owners insure their flood risk which can't be reduced. The NFIP is an important part of community and individual flood resilience. Residential flood insurance, the bulk of which is provided by the NFIP, is the best protection against major destroyers of homes.

Mr. Maurstad stated that 2018 marks the 50th anniversary of the NFIP and it has built a proud legacy. It has built a program that has a presence in 22,300 communities where they have chosen to protect themselves from floods by managing their flood plains. While most FEMA programs only arrive after a disaster is declared, through the NFIP's flood-plain management assistance and regulations to local governments, the NFIP impacts one its 22,300 communities every day by lowering the built-in environment's exposure to floods, saving the nation $1.6 billion per year in avoided losses. In many NFIP communities, their flood-plain management ordinance guiding building placement and construction is the only building requirement a community has. More than 1,500 communities have taken a more assertive approach to keep their neighbors safe by joining the NFIP's community rating system which provides them discounts for their flood insurance policies because their community achieved higher than the minimum standards that the federal government imposed. The NFIP has built a program that protects more than 4 million properties and 5.1 million policyholders from financial losses from flood. Thousands of property owners have been enabled to mitigate their riskiest

structures through more than $3.7 billion in flood grants to buy out or elevate flood properties.

The NFIP has determined the flood risk and communicated said risk to more than 95% of the nation, and all of the nation's populated areas. Before the NFIP, there was no scientific and systematic way to determine flood risk or let people know about it.
In 2015, the NFIP began a generational change in an effort to prepare for its second 50 years in existence. The NFIP is emphasizing customers first, reducing program complexity, updating policy product offerings, improving the ways it analyzes and communicates risk, and the way it rates insurance policies based on risk. The handling of claims and appeals is also being improved, in addition to improving customer transparency in way that clarifies each step of the customer transaction and confusing jargon is eliminated. These changes are being implemented in order to cultivate value in its policy, and trust in the program. The NFIP is also aiming to insure more homes, families, business properties and renters against flood losses so in the aftermath of a flood event, regardless of whether it is a presidentially declared disaster, there are more insured survivors. Substantial strides in data-accessibility has allowed the NFIP, in near real-time, the ability to improve the quality of its statistics, analysis, and information it provides its partners and to serve survivors before, during, and after a flood event.

Advanced data-analytics are being used to provide better information and more accurately portray and communicate flood risk. That information is used when discussing reinsurance, long term risk to the program, and affordability. There has also been a commitment to eliminating red tape and confusing policies. Mr. Maurstad stated that a re-design of the program's entire product offering has also been underway to better align with industry standards. As the NFIP continues to change and grow, the public needs to understand what it's doing more clearly. Accordingly, the NFIP aims to educate communities about flood risk and about the benefits of protecting their properties with flood insurance, in addition to educating about how to get the help they need after a flood event.

For example, in 2017, the NFIP communications team developed 26 new external communication tools in the first 30 days after Hurricanes Harvey and Irma to better understand their claims and coverages. The NFIP is looking to improve the claims-journey for policyholders. Advance payment tools have been improved to get money into the hands of those subject to a flood event faster. The process surrounding total-loss claims has also been revamped and improved. Additionally, a branch of the NFIP set up solely for handling appeals is in its second year of existence and has received positive feedback.

Mr. Maurstad stated that Brock Long, FEMA Administrator, has laid out three strategic goals for 2018: a.) building a culture of preparedness; b.) readying the nation for catastrophic disasters; and c.) and reducing the complexity of FEMA. With regard to NFIP and the culture of preparedness, closing the insurance gap is very important. For example, nearly 70% of the flood damage from Hurricane Harvey was uninsured. Mr. Maurstad stated that in building a culture of preparedness, we must change the social norm around flood insurance. Additionally, governments need to provide an effective regulatory environment, set and enforce building standards and codes, and promote and fund mitigation to reduce exposures. State legislators can thus join the effort in building a culture of preparedness and closing the insurance gap. Mr. Maurstad noted that the NFIP must be reauthorized by March 23. Last year, FEMA leadership set two ambitious

goals that align with building a culture of preparedness: a.) committing to doubling the number of contracts in force by 2023; b.) committing to quadrupling the public and private and investment in mitigation activities by 2023. Mr. Maurstad closed by urging State legislators to do all they can help FEMA achieve those goals.

Rep. Park Cannon (GA) asked why the submitted claims from Hurricane Maria in Puerto Rico were lower than those of Hurricanes Harvey and Irma. Mr. Maurstad stated that there is more private flood insurance sold in Puerto Rico than NFIP policies, and that without having the specific information in front of him, he suspects that it relates to property values that correlates to the number of claims, and also issues with the affordability of flood insurance policies there.

Rep. Cannon then asked if similar corrective measures were taken by the NFIP within the first 30 days after Hurricane Maria, as they were done after Hurricanes Harvey and Irma. Mr. Maurstad stated that the responses of the NFIP and FEMA met the needs of wherever the disasters occurred. The timing of responses is always going to be different depending on geographic location, accessibility, and specific information from adjusters and others as to where to go. FEMA and the NFIP have a commitment to responding as quickly as possible as allowable by the local jurisdictions.

Sen. James Seward (NY) asked what the plan is for the long term financial stability of the NFIP, keeping in mind that affordability of the policies plays a big part in that. Mr. Maurstad stated that the last re-authorization of the NFIP required FEMA to conduct a long-term affordability study – the study should be released soon. For the first time, FEMA worked with the IRS to get a solid understanding of its policyholder makeup. It was determined that there was a group of folks where purchasing flood insurance would be problematic and proposed affordability solutions are being circulated. That is part of the development of a sound, financial program moving forward. Overall, Congress designed the NFIP to charge reasonable premiums and handle average annual loss share. The events since 2004 have well-exceeded the average annual loss share and accordingly, the NFIP purchased reinsurance for the first-time last year and hopefully that can be expanded going forward. Last year, for the first time, Congress forgave $16 billion of the NFIP’s debt because there is an understanding it can’t sustain even the interest on the program. Funding of the NFIP is therefore a big topic of discussion surrounding its reauthorization.

ADJOURNMENT

There being no further business, the Committee adjourned at 12:45 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
ATLANTA, GEORGIA
MARCH 2, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Whitley Hotel in Atlanta, Georgia on Friday, March 2, 2018 at 1:45 p.m.

Representative Richard Smith of Georgia, Chair of the Committee, presided.

Other members of the Committees present were:

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Matt Lehman (IN)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Sen. Neil Breslin (NY)
Asm. Kevin Cahill (NY)
Asm. Andrew Garbarino (NY)
Sen. James Seward (NY)
Sen. Bob Hackett (OH)
Rep. Michael Henne (OH)
Rep. Tom Oliverson (TX)

Other legislators present were:

Rep. Sam Kito (AK)
Rep. Paul Mosley (AZ)
Rep. Bryon Short (DE)
Rep. Renitta Shannon (GA)
Rep. Darlene Taylor (GA)
Sen. Thomas Middleton (MD)
Rep. Joe Hoppe (MN)
Rep. Justin Hill (MO)
Sen. Paul Wieland (MO)
Sen. Ed Buttrey (MT)
Rep. Glen Mulready (OK)
Rep. Ron Tusler (WI)

Also in attendance were:

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

MINUTES

Upon a motion made and seconded the Committee unanimously approved the minutes of its November 16, 2017 meeting in Phoenix, Arizona, and its January 29, 2018 interim meeting held via conference call.

CONSIDERATION OF CONSUMER PROTECTION TOWING MODEL ACT

Rep. Matt Lehman (IN) stated that the towing industry is one of the last unregulated industries. Accordingly, a Model Law was drafted to deal with some of the issues in that industry such as: unsolicited tows; controlling costs; private towing; notifying the true owner of the vehicle; itemizing costs; allowing easier release of the vehicle; and regulatory requirements. A similar bill was also drafted in Indiana upon further

discussions with the towing and insurance industries. The version of the Model before the Committee today contains some amendments from the prior version discussed at its last meeting in Phoenix, many of which focused on emergency towing requirements.

Rep. Lehman then reviewed some of the provisions of the current version of the Model. Emergency towing is still dealt with, the biggest key being giving “owner choice.” That is, the owner has a right in consultation with law enforcement to say, “here is who I want to call to come and tow my vehicle.” In the past, there were situations where towers were on rotation and in Indiana, a Sheriff went to prison over taking bribes for including towers in the rotations. With regard to private towing, the Model requires private lots be very clearly marked as such and allows for the situation to be worked out at the scene rather than a mandatory towing of the vehicle and resolving it at the towing facility.

The Model requires: specific, descriptive itemized invoices for towing charges; towing companies to timely notify vehicle owners of the fact that their vehicle was towed and how to retrieve it; and implements requirements for the release of towed vehicles to the owners. The Model also contains certification requirements for towing companies, and a list of prohibited acts. The Model originally contained specific penalties for violating the Model, but it was determined that such language is better determined on a State by State basis. Some of the provisions that have been removed from the current version of the Model relate to: requiring towers to take pictures, document damage to the vehicle, and write estimates, as it was determined that more time spent on the road is not safe; and fees, as it was determined that fees should not be set in private contracts. Rep. Lehman closed by stating that he believes NCOIL’s role in drafting Model laws is to provide the States with a legislative framework that they can modify to their specific needs. In many instances, NCOIL should not let perfect be the enemy of the good and have drafts of Models on committee agendas for several years.

Erin Collins of the National Association of Mutual Insurance Companies (NAMIC) thanked Rep. Lehman for his work on the Model and stated that the Model contained important reforms. However, NAMIC believes that some of the provisions that were removed from the prior version of the Model should be in the Model that the Committee considers. Specifically, the issues of having an estimate available for the consumer and having fee controls are essential parts of any national Model.

Rep. Richard Smith (GA), Chair of the Committee, asked if there should be concern regarding competition among towers if fees are standardized. Ms. Collins stated that the language in the prior version of the Model would not have a chilling effect on competition but would rather create a ceiling on fees to stop them from being abused.

Tim Lynch of the National Insurance Crime Bureau (NICB) thanked Rep. Lehman for his work on these issues and stated that abuses with respect to towers, mainly at accident scenes, is a problem across the country. NCOIL’s timing on this issue is good because there are several States that have dealt or are dealing with it now. From NICB’s perspective, the problem is twofold: consumers who are abused at the accident scene and are overly solicited; and the excessive fees that take place afterwards. The Model has done a very good job of addressing the first point but NICB believes that the Model should contain some type of protections against estimates and fees.

Rep. Lehman stated that the estimate requirements were removed from the Model because that is very difficult to do at the scene of an accident. Rep. Lehman stated he is

receptive to including estimate requirements, along with photograph/video documentation requirements, in the Model's provisions dealing with private towing. As to fees, Rep. Lehman again stated that he believes that is an issue that cannot be imposed on private contracts, but States can try to do so should they wish.

Rep. Michael Henne (OH) stated that he thinks there needs to be safeguards in the Model about fees for consumers and insurers when dealing with towing companies. The free market does not exist on the side of the road and the consumer does not have a choice as to who tows their vehicle.

Sen. Bob Hackett (OH) stated that this issue was discussed in Ohio for several years and one of the issues for the towers is that they suffer when there is an accident on the interstate and the highway patrol calls several towers to respond to the scene. Sen. Hackett stated that he understands both NAMIC's concerns with wanting certain provisions included in the Model, and Rep. Lehman's view that the Model can be tweaked to respond to different State's concerns. Sen. Hackett would support the Model in either scenario.

Rep. Lehman stated that if the Committee would like legislatures to see the Model in their upcoming legislative sessions then it is important to move it to the Executive Committee. Rep. Lehman also stated that the Committee could always return to the Model later to amend it, as is being proposed with the NCOIL Model State Uniform Building Code. Rep. Lehman then made a Motion for the Committee to consider the Model which prompted a Motion to waive the quorum requirement, made by Rep. George Keiser (ND) and seconded by Sen. Hackett. The motion regarding the quorum was approved without objection by way of a voice vote.

John Ashenfelter of State Farm stated that the proposed amendments submitted by NAMIC should be further considered, and discussions should be held on fee provisions. Mr. Ashenfelter stated that he does not think that the estimate and documentation provisions that were removed from the Model are unreasonable. The documentation requirements are important because it is common for there to be further damage to the vehicle after it is hooked up to the tow truck.

Rep. Keiser stated that he thought the issue of costs was the main driver behind this issue being discussed at NCOIL, and if that is correct, then the Model should not be sent to the States for consideration without any such provisions. Rep. Lehman stated that he views the problem as twofold: the actual towing activities; and the storage fees.

With regard to storage fees, Rep. Lehman stated that in his experience with his constituents, that is one of the biggest problems, and the Model contains important provisions on that issue. Rep. Lehman stressed that he thinks the most important provision is allowing consumers to decide who will tow their vehicle. Mr. Lynch noted that estimate provisions that were removed from the Model are law in California and Missouri.

Jim Taylor, President of Auto Data Direct (ADA), stated that ADA ties into state databases in order to retrieve real-time owner and lienholder information. Towing companies and insurers are two of their biggest clients and ADA compliments NCOIL for analyzing these issues. Mr. Taylor stated that certified mail should be required for notification of towing and noted that in several states, the insurer of record is notified in

addition to the owner/lienholder. Mr. Taylor further stated that the Model should specifically reference “motor vehicle data bases” when discussing search requirements. The National Motor Vehicle Title and Information System is a valuable tool for determining where the vehicle is titled.

Sen. James Seward (NY) made a motion to defer consideration of the Model until the NCOIL Summer Meeting in July. Sen. Neil Breslin (NY) seconded the Motion.

Rep. Lehman requested that a meeting be held among all interested parties between now and the NCOIL Summer Meeting in July to make sure that a final version of the Model is ready for consideration at the July meeting. The Committee voted without objection in favor of the Motion by way of a voice vote.

CONSIDERATION OF AMENDMENTS TO NCOIL MODEL STATE UNIFORM BUILDING CODE

Tyler Laughlin, Oklahoma Deputy Insurance Commissioner, stated that the proposed amendments to the NCOIL Model State Uniform Building Code are taken from legislation that was passed in Oklahoma. Similar legislation is also in place in Alabama and Mississippi. Essentially, the proposed amendments state that if an individual wants to build a new home or retrofit their existing home to the Insurance Institute for Business & Home Safety (IBHS) standards, the insurer must provide that homeowner with a premium discount upon determining that it is actuarially justified. Mr. Laughlin stated that 90% of the damage from the 2013 Moore, Oklahoma tornado could have been avoided if IBHS standards were utilized. If a homeowner makes an investment to build or retrofit to the IBHS standards, the discount should be given because the risk to the home has been lowered. Mr. Laughlin noted that this is in fact a mandate on insurers, but every law passed is some type of mandate, and this is a slightly different mandate because consumers end up bearing the cost of most mandates. In this case, this can be termed as a “reverse mandate” because it is forcing the company to do something by passing cost savings on to the consumer. From Oklahoma’s standpoint, with the number of tornadoes it has experienced, it has reached the point of either mandating building codes throughout the state or trying to encourage citizens who want to make the investment in strengthening their home to get an actuarially justified premium discount.

Rep. Henne stated that this type of law will reduce claims, so insurers will want to write this type of business, but insurers don’t need the government telling them how to write a profitable business. Government should not get involved in this issue. If an insurer chooses to offer these types of discounts, then others will follow to remain competitive.

Mr. Laughlin stated that he respects Rep. Henne’s opinion but states like Oklahoma have seen for far too long the lack of incentives for consumers to strengthen their homes. Without this type of law, there is no way to ensure that this type of discount would permeate the marketplace and in fact, insurers may enjoy consumers making an investment to strengthen their home without being required to provide a discount since their risk is lowered and the premium remains constant.

Rep. Keiser stated that hail storms are prevalent in North Dakota and when he replaced the shingles on his roof with those that are hail-resistant, the installer told him to check with his insurance company to see if he would get a discount. The insurance company did not provide a discount because their research showed that the hail-resistant shingles

did not perform any better than regular shingles when the hail reached a certain size. Rep. Keiser stated that when one of his employees did the same thing, his insurance company did give him a discount. Rep. Keiser asked if there is any data on the return on investment of strengthening a home to IBHS standards because in the case of his employee, it will take 15 years to see a return on the investment. These same arguments also apply to security system installation. In the case of shingle installation, Rep. Keiser stated he had a choice to switch insurers if he wanted to, and regulators should not be determining this type of activity, the private market should.

Buddy Combs, Oklahoma Deputy Insurance Commissioner, stated that this can be viewed as a "chicken or the egg" situation. In Oklahoma, the Insurance Department had frequently heard that insurance companies will eventually get to the point of offering these types of discounts, but given the number of tornadoes experienced, the severity of damage they inflict, and the amount of lives lost, how much longer should we wait for insurers to voluntarily get to that point. Mr. Combs stated that it is important to note that these proposed amendments are an effort to try and make this work for all involved since insurers only have to offer the discount when it is actuarily justified. Rep. Keiser replied that if Oklahoma feels that strongly, a building code should be mandated.

Rep. Lehman asked if there are any other examples of requiring premium discounts for using and/or adding safety features to a home or building. Mr. Combs sated that he is not aware of any other examples, but that one of the reasons this specific type of discount was chosen is because the IBHS was created by the insurance industry.

Ron Jackson of the American Insurance Association (AIA) stated that AIA supports mitigation efforts such as strengthening homes to IBHS standards, but competition among insurers is very important. There may be different ways that insurers would like to respond to homes that are strengthened to IBHS standards so when the government requires all insurers to react in the same way, an important part of market competition is removed.

Paul Martin of NAMIC stated that he is personally a strong supporter of the IBHS standards as his home was retrofitted to said standards with great success. However, the free market should drive issues like this, not government mandates. Insurers already voluntarily provide discounts for things such as security systems and hail-resistant shingles.

Rep. Glen Mulready (OK) then made a Motion to delay consideration of these proposed amendments, and to extend the underlying NCOIL Model State Uniform Building Code, due to his colleague and sponsor of these proposed amendments, Rep. Lewis Moore (OK), being unable to be here today, and there seeming to be further discussion needed on this topic. Sen. Neil Breslin (NY) seconded the Motion.

The Committee then voted without objection by way of a voice vote to proceed in that manner.

UPDATE ON ALI PROPOSED RESTATEMENT OF THE LAW OF LIABILITY INSURANCE

Commissioner Tom Considine, NCOIL CEO, provided the Committee with an update on the status of the of the American Law Institute's (ALI) Proposed Restatement of the Law

of Liability Insurance (Proposed Restatement). At the 2017 NCOIL Annual Meeting in Phoenix, Arizona, a general session was held discussing the Proposed Restatement, which led to the NCOIL P&C Committee adopting a Resolution in opposition to the Proposed Restatement. The Resolution was then adopted by the NCOIL Executive Committee in January 2018 and sent to ALI leadership, which led to a dialogue between NCOIL and the ALI.

Cmsr. Considine stated that the ALI Council met in February to discuss the current draft of the Proposed Restatement and based on his and others understanding, the ALI Council gave the drafters of the Proposed Restatement guidance to make certain changes. Accordingly, it was thought best to tread lightly and not take all the actions called for in the Resolution due to that encouraging news of changes being made, and that there is no final version of the Proposed Restatement available for review. However, a letter was sent out this past week to the State Presiding Jurists across the country alerting them of the Proposed Restatement and encouraging them to voice their concerns since as State Presiding Jurists they have an influential role in the ALI. Cmsr. Considine stated that a new draft of the Proposed Restatement is expected next month, followed by an ALI meeting in May where final adoption of the Proposed Restatement is expected to be considered. Cmsr. Considine stated that nature of the changes in the next draft will dictate NCOIL's next steps.

Rep. Keiser stated that this a scenario that requires NCOIL to consider drafting Model Laws to counter the provisions of the Proposed Restatement that are contrary to settled law because if the Proposed Restatement ends up being adopted by the ALI without substantial changes, courts across the country will look to the Proposed Restatement for guidance, not to the NCOIL Resolution.

Sen. Breslin stated that if the Proposed Restatement is adopted without substantial changes, he believes that courts would take notice if NCOIL sent a response to every court in the country citing the Proposed Restatement's provisions that conflict with settled law. Restatements are "secondary" sources of law, judges are already hesitant to use such sources in deciding legal issues. Accordingly, if such a "secondary" source was then denounced by NCOIL as not being an accurate restatement of settled law, the consequences to ALI would be devastating.

Sen. Breslin stated that he is concerned by the nature of the ALI's responses to date, and therefore it is critically important to the industry and to the validity of the law to ensure that the ALI makes the proper changes to the Proposed Restatement. Rep. Keiser agreed but stated that NCOIL needs to be prepared to act with Model Laws should the ALI refuse to make noteworthy changes.

INTRODUCTION OF THE ROLE OF INSURANCE IN PUBLIC-PRIVATE PARTNERSHIP PROJECTS

Rep. Lehman stated that in Indiana, there was a $1 billion public-private partnership (P3) project on a highway extension that went belly-up. It was discovered afterwards that the bonding requirement was less than 20%. A bill was filed in Indiana to make that bonding requirement 100% but then there is an issue of how many contractors out there can post a $1 billion bond. Rep. Lehman stated that the construction industry sought guidance as to what the correct percentage of bonding should be - this could be an area that NCOIL

could offer such guidance in. Rep. Lehman encouraged the Committee members to come forward with any material related to this issue at any future meetings.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
NCOIL SPRING MEETING – ATLANTA, GA
FRIDAY, MARCH 2, 2018
3:15 P.M. – 4:15 P.M.

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Whitley Hotel in Atlanta, GA on Friday, March 7, 2018 and was called to order by Senator Jerry Klein at approximately 3:15 PM.

Senator Jerry Klein of North Dakota presided

Other Members of the Committee present were:

Sen. Jason Rapert, AR
Asm. Ken Cooley, CA
Rep. Matt Lehman, IN
Rep. Steve Riggs, KY
Rep. Bart Rowland, KY
Rep. George Keiser, ND
Sen. James Seward, NY
Rep. Michael Henne, OH
Rep. Tom Oliverson, TX

Other legislators present were:

Rep. Sam Kito, AK
Rep. Deborah Ferguson, AR
Rep. Paul Mosley, AZ
Rep. Bryon Short, DE
Rep. Joe Hoppe, MN
Sen. Ed Buttrey, MT
Sen. Bob Hackett, OH

Also in attendance were:

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

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its November 17, 2017 meeting in Phoenix, AZ.

CONTINUED DISCUSSION ON PHYSICIAN DISPENSING AND DRUG COMPOUNDING

Kevin Tribout of OptumRX stated that physician dispensing of repackaged drugs has reached a tipping point and 42 states have taken some type of action to combat against it, but loopholes still remain. Florida, Pennsylvania and Wyoming are the latest states to pass such legislation. Some states have day-supply limits, some have caps on reimbursements, and some have visit requirements. Mr. Tribout stated that despite some loopholes, where these reforms have taken place, the results have been effective. A 2017 report from the Florida Division of Workers' Compensation (FDWC) stated that the total spending on physician dispensed repackaged medications was down from $50 million in 2012, to roughly $9.4 million in 2016. The report also shows that the FDWC's

compounding spending amounts have dropped from $8.8 million in 2012 to about $4.2 million in 2016. Mr. Tribout further stated that in 2012, the FDWC had about 320,000 prescriptions of repackaged drugs that were dispensed by a physician, and that was down to about 52,000 in 2016. However, the FDWC report shows that the actual cost has remained relatively stable so the access issue that you sometimes hear about is a misnomer.

Mr. Tribout stated that loopholes continue to exist in state legislation and regulations. Varied doses of medications are becoming more prevalent. Rather than 5mg or 10mg, we are now seeing 6mg or 7.5mg that has a unique NDC that is being repackaged. As states have targeted repackaged physician dispensed drugs, compounded drugs have become widespread. About half the states have addressed the issues surrounding compounded drugs. Mr. Tribout stated that policy on these issues going forward should be what is contained in the proposed amendments to the NCOIL Model Act on Workers' Compensation Repackaged Pharmaceutical Reimbursement Rates (Model). That is, there should be restrictions on the number of days' supply of the medication. There are instances where an injured worker needs to initiate treatment right away, so the physician obviously should be able to dispense directly, but unless it's some type of infusion or specialty medication that you can't get at a pharmacy, 30 days later that treatment is just the same as if you are taking your blood pressure or cholesterol medication from a pharmacy.

Mr. Tribout stated that some states such as CA and NY, which did require legislation to give them the authority to create a formulary, are addressing physician dispensing and compounding in their formularies by requiring prior authorization. Mr. Tribout complemented the proposed amendments to the Model that deal with prior authorization. Requiring the physician to specifically indicate what the medical necessity is for dispensing specific medications, including compounded drugs, is an important reform and encouraged the Model to contain such reforms. In Texas, such a requirement was not implemented for compounded drugs and over 6 years, their compounds increased 106% in costs. However, in July, that will be changed to require prior authorization for all compounds.

Erin Collins of the National Association of Mutual Insurance Companies (NAMIC) expressed NAMIC's support of the proposed amendments to the Model. The language represents strong steps that address the cost drivers in the system and concerns about the utilization of these medications in general. Formularies and treatment guidelines are something that they are also interested in. NAMIC's comments on the Model focus on expanding it to include reforms on physician dispensing and compounded drugs. NAMIC consistently hears from its members that because there are loopholes, the most appropriate solution may be for a directed network of preferred providers and that might help close some of the loopholes in an organic way.

Matthew Smith of the Coalition Against Insurance Fraud stated that the Coalition supports the proposed amendments to the Model as an important step in fighting fraud. The Coalition has worked with Rep. Marguerite Quinn (PA), Chair of the NCOIL Workers' Compensation Insurance Committee, on this issue: House Bill 18 and Senate Bill 936. These issues have gotten so bad in Pennsylvania that until recently, one of the largest compounding pharmacies in PA was owned by one of PA's largest workers' compensation law firms. Mr. Smith noted that with compounded drugs, especially compounded creams, it as no longer a matter of medical care or medical necessity but

rather greed and financial gain. Recently, there have been two deaths identified with compound creams that were improperly formulated. Compound creams also result in billions of dollars in financial fraud that harms consumers. Tricare, which provides healthcare services to active and retired military members, found that in 2010, $23 million was paid out for compound pharmaceuticals; in 2014 it rose to $513 million. In the first 9 months of 2015 they had been billed $1.7 billion. In 2006, the CA workers' compensation department reported $10 million dollars paid out for compound pharmaceuticals and in 2013 it had risen to $145 million.

Mr. Smith stated that studies show that many compounds are nothing more than over the counter pharmaceuticals mixed in with something else which is sometimes not identified or fully disclosed. Studies show that the actual value in many of these compounded creams is between $60 - $70 on average but are billed out anywhere from $2,000 to $5,000 per tube. There are reported instances of per-tube prescriptions going as high as $30,000 to $40,000. The proposed amendments to NCOIL's Model will help with many of these issues. In Florida, a $175 million compounding fraud-ring was broken up that involved 3 physicians, 2 prior convicted felons and kickbacks. Similar operations have taken place in Texas and Nevada. In California, there was recently a $125 million fraud-ring involving compounded drugs broken up. In Georgia, a $10 million financial recovery was recently made involving compounded drugs and fraudulent billing practices. This is a workers' compensation issue but it also crosses over into bodily injuries, auto injuries, slip and fall injuries, and any type of injury where potential medical fraud is involved.

Rep. Tom Oliverson (TX) stated that it was time to start cracking down on some compounded drugs as they present a lot of danger to the public.

Sen. Jason Rapert (AR), NCOIL President, asked if there is a place at all for compounded drugs. Mr. Smith stated that the Coalition only focuses on the fraudulent abuses of compounded drugs.

Mr. Tribout added that if you look at compounds from a clinical perspective, most studies indicate that it is about 3-5% of group health which utilizes compounds. There is a need for compounded drugs in some cases, such as ophthalmological needs and for burns. Mr. Tribout stated that it is important to look at the U.S. Postal Services OIG report from 2016 where it found that the cost was going to go to $1.9 billion in compounds and after an investigation, pharmacists and doctors were prosecuted for fraud. Some pharmacies provide great services and they are not all bad actors. However, loopholes have been found, they have been frequently exploited, which is why prior authorization showing medical necessity for compounds should be required.

Rep. George Keiser (ND) stated that this has been a recurring issue with the workers' compensation industry and asked if it was an issue with Medicare, Medicaid and with the general health insurance market. And if not, what are the drivers in workers comp. Mr. Tribout stated that he did not think it was an issue with Medicare or Medicaid because there is usually have some sort of prior authorization or there is a formulary in place that the doctors have to prescribe to and most of those plans and even group health plans have a "flag" as to why that compound is being prescribed. There are no flags at the State workers comp level because it is just not being flagged and there is nothing to stop those pharmacies from processing the claims.

Ms. Collins added that in terms of some of the reforms in the proposed amendments to the Model that are viewed as critical, requiring critical evaluation, physician documented medical necessity, or utilization review, of compounded pharmaceutical products prescribed for patients is essential. That will enable recognition of pharmacies that are operating correctly and directing business to them.

Sen. Jerry Klein (ND) closed by stating that this discussion will continue at the NCOIL Summer Meeting in July.

DISCUSSION ON PRESUMPTIVE PTSD LEGISLATION

John Hanson, Senior Consultant at Willis Towers Watson, stated that GA and NY created cancer benefits programs for firefighters as opposed to having those claims flow through the comp pools. The programs are fully insured with a carrier that manages those benefits. Firefighters had lobbied heavily in those states to create a cancer presumption for them. There is a trend in of taking an issue and driving it into the workers' comp pool via occupational presumption. He stated that there are 38 states that have cancer presumptions for firefighters and virtually every state has certain presumptions for policeman and firefighters. PTSD legislation currently exists in 3 states. 5 years ago, it was in 1 state. Last year ME and VT created presumption legislation for PTSD for first responders. It is important to note that first responders is a group of more than just firefighters – EMT's, police, firefighters, volunteer firefighters, and in some instances correctional officers. Accordingly, some are not even employees of a city or county.

Mr. Hanson stated that it is important to consider the parties involved in presumption legislation: cities; counties; states; first responder associations and unions; politicians; workers' comp pool managers; lobbyists; and lawyers. PTSD presumption legislation has a very similar cast to all the other presumptions that precede it. There is a desire to provide first responders with what some believe is a right to have some type of easier evidentiary access to workers' comp benefits. In 2017, the following states passed specific PTSD legislation for first responders: Colorado; South Carolina; Texas; New York; Vermont; and Maine. Vermont and Maine created a true occupational presumption for PTSD. Florida, Connecticut, Minnesota, New Mexico, and Ohio considered PTSD first responder legislation, but nothing passed. Arizona and New Hampshire are also considering such legislation in 2018. He stated that there were identifiable trends in PTSD presumption legislation and that the structure of this type of legislation is becoming very similar. Most of the legislation has similar legislative intent; defines "traumatic event" and "mental health professional"; provides a basis to rebut the presumption; and provides for a fiscal impact. Mr. Hanson noted that Arizona is considering not only PTSD presumption legislation but also a therapy program that would last up to 48 sessions. The estimated cost of the program has been reported to be anywhere from $8 million to $90 million.

Mr. Hanson continued by saying as PTSD presumption legislation moves through the system, it is starting to establish a framework with similar language and that certain evidentiary requirements are appearing. New Hampshire's bill is almost identical to Vermont's. Mr. Hanson also noted that in the past few years, it was understood that only a psychiatrist or psychologist utilizing the DSM could diagnose PTSD to create a presumption. However, new legislation is starting to extend that diagnosing ability to social workers and drug counselors. In Arizona's bill, anyone who is a licensed therapist

can diagnose PTSD, and the entity that is required to provide 48 separate therapy sessions cannot hire or employ an independent medical examiner to rebut the diagnosis until it gets to workers' comp. There is a trend of making it easier to get a diagnosis of PTSD and making it very difficult to counter said diagnosis. Mr. Hanson stated that he expects several states to introduce PTSD presumptive legislation this year.

Rep. Steve Riggs (KY), NCOIL Immediate Past President, stated that he spoke with a large disability carrier in Kentucky who said that their disability policy covers this sort of issue and he was not sure why workers' comp was being pushed into this field to create overlap. Mr. Hanson stated that there is overlap and that it is different among cities, counties and states. Most disability policies have a two-year mental nervous rider, and PTSD would be picked up under that. Mr. Hanson stated, with the rise of PTSD presumption legislation, it may be a central misconception on the part of first responder service that presumption is actually the best way to do this because first responders have a significant amount of benefits available to them, including disability, line of service, lump sum cancer, pension, and retirement. When you look at cancer, and PTSD, the illnesses have a broader field and there is an immediate want for coverage but if you ask a first responder if they have any kind of coverage, their understanding of it is very thin.

NY feels that presumption through the workers' comp program seems to be what most of the first responders feel is the best means to acquire that disability and medical benefit. The reality is that every bit gets litigated. Accordingly, part of the discussions with first responders may be to say that workers' compensation may not be the best avenue for what they are looking for. Most first responders are looking for early access to a benefit, within a week or 2 of diagnosis, and then some sort of benefit that would supplement the other benefits they have which includes everything from county/city/state benefits and voluntary benefits that are sold to police/fire departments. Mr. Hanson stated that the challenge is coordination and communications of the benefits available to them. Further, Mr. Hanson stated that volunteer fire departments might not be able to afford a lot of the benefits and they could start to fold. 70% of firefighters are volunteers.

Sen. Bob Hackett (OH) stated that this type of legislation was blocked in Ohio. In Ohio, with post-traumatic stress syndrome you have to be injured to collect the benefits. He further stated that entire bill was for first responder observers who viewed an accident to qualify for benefits and the workers' comp system in Ohio stated that it would cost $180 million. Sen. Hackett then asked about equal protection under the law – what if a bank teller saw their best friend get shot. How do you carve out first responders? Mr. Hanson responded stating that the issue of equal protection was central to all the presumption issues. There is some sense of anxiety that there will be some other group that will ask for the same benefits as first responders such as sanitation workers. He continued by saying that taxpayers could not continue to be forced to cover these expenses. He added that a lot of first responders do have medical plans so the idea going forward with PTSD is that rather than presumption, there is an opportunity to create a suite of products that do not exist today. Eventually, every state will have to grapple with this issue.

In response to Rep. Riggs' question, Rep. Keiser stated that that most workers' comp programs have an exclusive remedy clause so that that is the reason why additional coverage may need to be added or not added in the workers' comp industry when discussion PTSD presumption legislation.

Mr. Hanson added that it may, in fact, be an exclusive remedy but it is also being highly litigated. Mr. Hanson closed by stating that he believes first responders will continue to lobby to improve/broaden existing workers' compensation laws, with a specific broadening of volunteer first responder coverage. Public entities and insurance markets will also develop alternative approaches to fit legislative requires.

ADJOURNMENT

There being no further business, the Committee adjourned at 4:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE
ATLANTA, GEORGIA
MARCH 2, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Whitley Hotel in Atlanta, Georgia on Friday, March 2, 2018 at 4:15 p.m.

Senator James Seward of New York, Vice Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Sam Kito (AK)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Bart Rowland (KY)
Rep. Justin Hill (MO)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Sen. Bob Hackett (OH)
Rep. Glen Mulready (OK)
Rep. Tom Oliverson (TX)

Other legislators present were:

Rep. Deborah Ferguson (AR)
Rep. Paul Mosley (AZ)
Rep. Darlene Taylor (GA)
Rep. Steve Riggs (KY)
Sen. Thomas Middleton (MD)
Rep. Joe Hoppe (MN)
Sen. Ed Buttrey (MT)
Rep. Ron Tusler (WI)

Also in attendance were:

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

MINUTES

Upon a motion made and seconded the Committee unanimously approved the minutes of its November 17, 2017 meeting in Phoenix, Arizona.

UPDATE ON NAIC TRAVEL INSURANCE WORKING GROUP

Sen. James Seward (NY), Vice Chair of the Committee, asked for an update on the progress of the National Association of Insurance Commissioners (NAIC) Travel Insurance Working Group (Working Group). Mike Chaney, Commissioner of the Mississippi Insurance Department, stated that the last meeting of the Working Group took place on February 26 and its progress has been steady. The Working Group's next scheduled meeting is on March 12, and it has been using the NCOIL Travel Insurance Model Law as a starting point in developing an NAIC Travel Insurance Model Law. Sen. Seward stated that having two separate Model laws from two separate organizations on the same topic is not in anyone's best interests, particularly in states that have already adopted the NCOIL Model or that have had it introduced for discussion. Sen. Seward

stated that it would be best for NCOIL and NAIC to work together on this issue. Cmsr. Chaney stated that a lot of the discussions in the Working Group have been focused on the Sales Practices provisions of the Model and how best to protect consumers. Sen. Seward stated that as NCOIL's Model starts to be introduced in States, and as NAIC is developing its own Model, there are no codified standards for travel insurance. Accordingly, Sen. Seward asked what the basis is for the Market Action Working Group (MAWG) actions directed at the travel insurance industry.

Cmsr. Chaney stated that one of the lead states in MAWG had conducted a market conduct exam on some in the travel insurance industry, and they entered into some forward-looking agreements that not everyone agreed with. States should not be entering into forward-looking agreements for the rest of the country. Cmsr. Chaney noted that he refused to sign any such agreements in Mississippi because in Mississippi, travel insurance is classified as inland marine which is not regulated by the insurance department. Cmsr. Chaney also noted that his department has received just one complaint about travel insurance throughout his tenure as Commissioner, and it was resolved in 12 hours.

Rep. Steve Riggs (KY), NCOIL Immediate Past President, stated that the procedure for the development of Model laws between NCOIL and NAIC needs to be improved. The process should be similar to how it is often done in states, that is, state insurance departments will advise legislators on what needs to be improved or implemented in a certain industry. If the NAIC thinks that an NCOIL model needs improvement, it should discuss those improvements with NCOIL rather than creating a separate Model. Cmsr. Chaney stated that he understands Rep. Riggs' concerns but that the NAIC is committed to adopting a travel insurance Model law now, while the time is right, to ensure the industry has proper guidance. The worst thing to do is to delay the process further. Sen. Seward closed by reiterating the need for better collaboration between NCOIL and NAIC going forward.

DISCUSSION ON LONG TERM CARE DEVELOPMENTS

Sen. Seward asked for an update and background on the amendments to the NAIC Life and Health Guaranty Association Model Act. Ray Farmer, Director of the South Carolina Department of Insurance, stated that according to the Federal government, 12 million of the current senior citizens in the U.S. will need some form of long term care by 2020. Long term care insurance is a way to defer to those expenses, which has been around since the 1960s, but now there are only about a dozen companies that sell the product. In 2002, there were approximately 754,000 policies and in 2014 that number was down to about 129,000. Dir. Farmer stated that when the product came into the market in the 1960s, it was overpromised, underpriced, and oversold. Other factors have also played a role such as decreased mortality and increased persistency rates.

Dir. Farmer stated that long term care is one of the most important issues in his department and it is troubling that the insurers can probably justify their rate increases but citizens simply cannot pay those amounts. Dir. Farmer still believes in the product. The product is sold as a life product but for purposes of the guaranty fund, the health insurers bear the brunt of it. Accordingly, the NAIC amended its Life and Health Guaranty Association Model Act to make the guaranty fund assessments more equitable among those involved, in addition to assessing HMO's for the first time. Dir. Farmer noted that there have been discussions about placing both solvent and insolvent long

term care books of business in run-offs, which has worked well in the property & casualty industry, but at this point there are more questions than answers surrounding that process and the NAIC has not taken a position yet on whether run-off facilities are a viable solution to the problems in the long term care insurance industry. Dir. Farmer stated that consumers believe they were told in the beginning that their rates would never go up.

Rep. George Keiser (ND) asked if Dir. Farmer could provide the Committee with a sense of the general market condition of the long term care insurance industry without going outside the domain of confidentiality. Dir. Farmer stated that there is some good news in that the product is being revamped in certain ways. Companies are starting to use their imagination to come up with new products but a lot of the rate requests that he sees are on closed blocks of business.

Sen. Jason Rapert (AR) asked how many states have adopted the amendments to the NAIC Life and Health Guaranty Association Model Act. Dir. Farmer stated that the amendments are new so the NAIC does not have that information yet.

Sen. Bob Hackett (OH) asked if the NAIC is seeing more involvement from managed care in the private industry long term care industry because such involvement has increased with Medicaid. Dir. Farmer stated that he has not seen such involvement.

Cmsr. Chaney stated that he has seen such involvement mostly with Medicaid and that the real issue with long term care is that most states do not regulate the rates for long term care. In Mississippi, they have been trying to find solutions that result in the consumer keeping their policy without their premiums increasing. Cmsr. Chaney stated that he thinks the problem is that actuaries sold the industry a bill of goods. Some new models are now coming out that are based upon whole-life models which specifies the pay-out amount. Cmsr. Chaney noted that health and long term care insurance costs will never be controlled until we figure out a way to control healthcare costs.

Kate Kiernan of the American Council of Life Insurers (ACLI) announced that they submitted to NCOIL staff information on what states have adopted and introduced the NAIC's amendments to its Life and Health Guaranty Association Model Act.

DISCUSSION ON AHP AND STLD FEDERAL REGULATIONS

Sen. Seward asked what the NAIC thinks about the proposed Federal regulations concerning association health plans (AHPs) and short term limited duration health plans (STLDs). Ralph Hudgens, Commissioner of the Georgia Office of Insurance and Safety Fire Commissioner, stated that carriers continue to leave the individual market and states continue to make sure that everyone has at least one option. In Georgia, Blue Cross Blue Shield was the only provider and last year they had asked to reduce their involvement to only 1 county that has about 1,100 policies in it. After negotiations, in 85 counties, BCBS is the only option. In Georgia, the overriding concern is that premiums continue to rise, and networks continue to narrow. The individual mandate has been reduced to 0 effective January 1, 2019 which means we will see deterioration in the risk pools, higher premiums and more carriers pulling out of ACA compliant markets.

With regard to STLDs, the rule has just been released for comment, and it seeks to change the length of time which they may last, from 3 months to 1 year. STLDs are not

subject to ACA requirements. The proposed AHP regulations seek to expand the definition of what is considered an AHP. The NAIC has urged Congress to: ensure that the cost-sharing reduction payments will be made going forward; provide federal reinsurance funding; make the section 1332 waiver process more efficient and flexible; and reinstate the moratorium on the federal premiums tax. Cmsr. Hudgens stated that he believes AHPs are good policy and that comments on the proposed AHP regulations are due on March 6th.

Dir. Farmer stated that the NAIC has had discussions with DOL about the its concerns with the AHP regulations and that NAIC will be submitting formal comments by the deadline. Dir. Farmer stated that he has some concerns about the AHP regulations definition of "employer" that could create ambiguity regarding the ability of states to regulate multiple employer welfare arrangements (MEWAs) – which have been problematic for states in the past.

Rep. Keiser asked if there is anything preventing an individual from buying multiple STLD plans from multiple carriers. Cmsr. Hudgens stated that he believes there are no limits on such a practice in the proposed regulations.

REVIEW OF NAIC PUBLIC HEARING ON COVERED AGREEMENT

Sen. Seward asked for an update on the recent public hearing held by the NAIC to discuss the Covered Agreement. Dir. Farmer stated that the international groups generally want the states to strongly consider qualified jurisdictions - extending the same benefits to other jurisdictions that were not part of the covered agreement. The NAIC has begun the process of examining its Credit for Reinsurance Models to see if amendments are necessary. Notably, there are still some states who have not passed that Model yet, namely, South Carolina. Hopefully, necessary amendments will be ready by the NAIC Fall National Meeting.

THE GROWING SIZE OF THE ERISA HEALTHCARE MARKET: WHAT ARE STATE REGULATORS DOING?

Rep. Dr. Tom Oliverson (TX) stated that last year in Texas a law was passed that required mental health parity in benefits but there are a growing number of citizens in Texas that are enrolled in a plan that falls under ERISA jurisdiction. Accordingly, Rep. Oliverson asked what the NAIC's perspective is about what we should be doing to ensure that the states are governing insurance, not the Federal government. Cmsr. Chaney stated that the growing ERISA market is an issue for state regulators and the problem that arises in situations such as Farm Bureaus forming AHPs is that the consumer does not understand what they are buying. Whether you support Obamacare or not, Cmsr. Chaney believes that the essential health benefits (EHBs) are a good thing and that there should be mental health parity. When you start to pick away at the EHBs, you are left with a policy that is not worth much. Rep. Oliverson stated that state legislators and regulators should work together to ensure that the state-based system of insurance regulation is preserved. Cmsr. Chaney stated that a deep and involved dialogue is needed going forward on just AHPs and STLDs alone to determine their impact on the state-based system of insurance regulation.

Cmsr. Hudgens asked who will regulate health insurance when it is permitted to be sold across state lines. Rep. Keiser opined that it will be the domicile state.

Rep. Darlene Taylor (GA) stated that problems arise when more and more plans are classified as being under the jurisdiction of ERISA as MEWAs were several years ago. Rep. Taylor sated that she is anxious to see how the Tennessee Farm Bureau will be monitored and regulated under the new AHP regulations.

Cmsr. Chaney stated that he has cautioned the Mississippi Farm Bureau to crawl before they can walk with regard to ERISA plans, and at some point, states will need to be able to regulate ERISA solvency or else there will be a lot of unpaid claims. Rep. Oliverson stated that this is an opportunity for NCOIL and NAIC to work together to demand more oversight over ERISA plans. Cmsr. Chaney agreed and stated that if regulators and legislators are to fulfill their duty of protecting consumers, they must regulate ERISA plans.

Rep. Justin Hill (MO) stated that ERISA plans are becoming popular because of the mandates. In Missouri, instead of fighting federal law, they are trying to entice people or employers to get back into the individual market by reducing mandates and incentivize STLD plans because they can be underwritten. Rep. Hill encouraged the committee members and the NAIC representatives to encourage the use of STLD plans in their states and bring back underwriting.

Asm. Ken Cooley (CA) encouraged the NAIC representatives to have their legal counsel look into prior opinion letters from the DOL from the early days of ERISA. Buried in those letters issued throughout the past decades, there may very well be a path towards state regulation of ERISA plans. The emergence of 401(k) plans grew out of that procedure.

DISCUSSION OF PHARMACEUTICAL BENEFIT MANAGER REGULATION

Sen. Rapert stated that he hopes that the NAIC will be involved as NCOIL begins the process of developing a Model Law focusing on the regulation of pharmaceutical benefit mangers (PBMs). All parties involved in this issue are regulated, except for PBMs. PBMs have ignored certain laws in Arkansas which has led to the Arkansas Attorney General opening an investigation. The problems associated with PBMs are not unique to Arkansas which is why the time is now to have NCOIL and NAIC involved in developing a Model Law. There needs to be a referee in place to make sure everyone plays fair. Sen. Rapert believes that state Insurance Commissioners are best suited to be that referee.

The Committee then recognized Cmsr. Hudgen’s retirement and thanked him for his years of service and his hard work.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE AND FINANCIAL PLANNING COMMITTEE
ATLANTA, GEORGIA
MARCH 3, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance and Financial Planning Committee met at The Whitley Hotel in Atlanta, Georgia on Saturday, March 3, 2018 at 8:45 a.m.

Representative Deborah Ferguson of Arkansas, Chair of the Committee, presided.

Other members of the Committees present were:

Sen. Jason Rapert, AR
Asm. Ken Cooley, CA
Rep. Richard Smith, GA
Rep. Matt Lehman, IN
Rep. Steve Riggs, KY
Rep. Bart Rowland, KY
Rep. Justin Hill, MO
Rep. Joe Hoppe, MN
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Asm. Andrew Garbarino, NY
Sen. Bob Hackett, OH

Other legislators present were:

Rep. Paul Mosley, AZ
Rep. Bryon Short, DE
Rep. Darlene Taylor, GA
Sen. Tom Middleton, MD
Sen. Ed Buttrey, MT
Sen. Neil Breslin, NY
Rep. Michael Henne, OH
Rep. Glen Mulready, OK
Rep. Tom Oliverson, TX

Also in attendance were:

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

MINUTES

Upon a motion made and seconded the Committee unanimously approved the minutes of its November 16, 2017 meeting in Phoenix, Arizona.

DISCUSSION ON REQUIRING NOTIFICATION BEFORE ADVERSE CHANGES IN LIFE INSURANCE PREMIUMS AND ANNUITY POLICIES

Darwin Bayston, President and CEO of the Life Insurance Settlement Association (LISA) stated that LISA is in support of NCOIL developing a cost of insurance (COI) Model Act. As of 2015, there were 142 million policies on individuals totaling $12.3 trillion in face value. For people aged over 65, that figure is 42 million policies and $2.5 trillion in face value. Consumers place a massive amount of trust in the life insurance industry to provide them resources against the risk of premature death and the financial losses that would occur. They have also placed a great deal of trust in being treated fairly and knowing what to expect. Since 2015 there have been a growing number of COI

increases that have been random and excessive. LISA urges that this issue be given strong consideration by the Committee.

Michael Brohawn of ITM TwentyFirst stated that life insurance trusts are used for estate planning purposes. The average policy is 15 to 20 years old, and the trustee has a fiduciary responsibility to maximize the value of the policy for the beneficiary. Mr. Brohawn then discussed a couple of troubling trust owned life insurance (TOLI) cases, the first being an 89-year-old husband and wife who had $15.5 million in survivorship universal life policies (issued in 1995). In 2016, they experienced a 99% increase in COI. Overnight, the annual carrying costs went from $400,000 per year to $981,707. In that example, after paying premiums for 21 years, from age 90 to 100, the trust would pay approximately $1.30 for every dollar of pure death benefit.

In the second case, there was $8.775 million in a single life universal life policy taken out on an 82-year-old woman in September of 2003. She put in $3,945,791 in contributions designed to carry the policy to age 98, at which point the expected outlay would be $197,000 to get to 100 years of age. Instead, she is now 96 years old and the current cash value of the policy is $600,000 and they cannot get illustrations from the carrier showing the current assumptions, only guaranteed assumptions. But by reverse-engineering the policy, Mr. Brohawn and his colleagues know that it will cost about $80,000 per month for the policy going forward. The options then are to surrender the policy for $600,000; pay the policy to maturity (with a guaranteed cost of $12 million); or change the policy to a "reduced paid up" option which would arrive at a death benefit of $747,000. Notably, when the carrier sent out its notice of the COI increase, that last option was not offered to the consumer. The end result is that 14 years ago, $4 million was put into a policy and they received $747,000 in death benefits. And it is important to note, that result occurred with a fiduciary trustee managing the policy with the help of experts – it could have been much worse.

Mr. Brohawn noted that he frequently hears from his colleagues who have been in the life insurance industry for a long time and they are saying they have never seen such behavior by carriers. In some instances, there are COI increases as much as 200%. In many instances, policyholders are simply surrendering their policies because they don't know what else to do.

Steven Sklaver, an attorney at Susman Godfrey, L.L.P., first stated that his presentation is handcuffed due to a lot of the evidence in the litigation he is involved in being under a protective order. Mr. Sklaver first discussed the practice of "shock lapsing" which is a term for when a carrier raises rates purposefully to induce customers to not pay their premiums so that the carrier will benefit in the universal life industry. Shock lapsing can be designed in certain ways. Typically, the healthy policyholders will lapse because the sicker policyholders are unable to get new coverage, so rates will need to be raised even higher – that is called "anti-selective lapse." Mr. Sklaver noted that the big selling point in universal life is the guaranteed interest. Because interest rates dropped, carriers lowered that guarantee, and when they hit the minimum mark, they eviscerate the benefits of that guarantee by raising rates, thereby rendering the guarantee meaningless.

Mr. Sklaver then discussed the litigation surrounding the Aetna/Voya COI increases. Aetna issued policies in the 1980s and the contract at issue stated that "the monthly COI rates may be adjusted by Aetna from time to time. Adjustments will be on a class basis

and will be based on Aetna's estimates for future cost factors, such as mortality, investment income, expenses and the length of time policies stay in force." It is important to focus on the terms "class basis" and "Aetna." In 1998, Aetna sold a block of policies, engaging in a 100% indemnity reinsurance contract with Lincoln. That means that Aetna has no costs since they are now borne by Lincoln. When Lincoln tried to increase rates, the New York Department of Financial Services (NY DFS) requested to see Aetna's experiences, who replied with Lincoln's experiences. Additionally, it was discovered that Aetna had merged all cohorts as the class for purposes of their rate increase request. The NY DFS stated that such practices violated New York law which led to Aetna withdrawing their rate increase request in New York, but they did implement it in the other 49 States. Mr. Sklaver stated that raises another issue because if the contract states that COI adjustments will be on a "class basis" – how can a COI adjustment take place in only 49 States. Mr. Sklaver stated that New York's diligence in adopting the regulations is paying off because carriers are not seeking COI increases in New York. It is best to be proactive on issues like these rather than litigating them because you never know how a judge will decide certain issues.

Mr. Sklaver then discussed a COI increase implemented by AXA on certain universal life policies before the NY DFS Regulations were adopted. The COI increase was implemented only on a subset of those policies – policyholders aged 70 and above; at least $1 million in face value; issued between 2004 and 2007. The NY DFS stated that COI increases were unobjectionable but the AXA COI contract language states that "changes in…cost of insurance deductions…will be on a basis that is equitable to all policyholders of a given class, and will be determined based on reasonable assumptions as to…mortality [and] investment income." It was later discovered in litigation that AXA's average-expected ratios of issue age 70+ and with more than $1 million in face value show lighter mortality than face amounts less than $1 million, yet policies with less than $1 million in face value were not hit with the COI increase. Mr. Sklaver stated that they are drawing a circle around that subset of policies probably because they are life settlement owned policies and they are trying to punish life settlement investors. The carriers don't like customers paying their bills on time. Mr. Sklaver referenced a document from AXA in 2013 where they were studying non-individually owned life insurance (NIOL). They were studying who owns their product because they want to see who is minimally funded in order to induce them to lapse.

Mr. Sklaver further noted that with AXA, the policies in questions were sold between 2004 and 2007 but there are documents from 2006 that indicate AXA was already planning to implement COI increases on the policies in order to induce shock lapsing – but illustrations must reflect the insurer's current best estimates. Mr. Sklaver closed by stating that all of these examples show the value of diligent regulatory and legislative oversight. Such oversight is much more valuable and effective then leaving it up to attorneys to try and persuade judges about specific contract language.

Kate Kiernan of the American Council of Life Insurers (ACLI) read from a prepared statement due to the pending litigation on these issues. Ms. Kiernan stated that the issues before the Committee today are being driven by sophisticated institutional investors who hold large quantities of large face amount life insurance policies. Those investors base their yield projections based on paying low minimum premiums which have over the course of time increased, hurting their profit margins. Ironically, protecting or enhancing profit margins is the same accusation that they are leveling against life insurers in litigation. As a matter of fact, at a LISA conference this week, there was a

session on COI increases. The session was presented as a panel to discuss the trends and patterns that indicate a likelihood of a COI increase in carrier's existing books of business and its relationship to longevity risk from an investor's perspective. Included in the investor's techniques that they discussed was fine tuning carrier specific and product specific risks, including machine learning applications - applying data-analytics to large books of business to figure out which blocks might have a COI increase. In response to these issues being raised by investors, last year the NY DFS promulgated Regulation 210. Having been recently adopted, the full impact of the regulation is not yet known and the first filings to the department under the Regulation are due in April. What we do know is that the Regulation is highly technical, complex, and has caused voluminous implementation problems for companies and countless conversations between the insurance companies, trade associations and the NY DFS for guidance on exactly what they are looking for.

Ms. Kiernan stated that ACLI believes extending Regulation 210 to a Model Law is unnecessary and definitely premature at this time. Policies designed to be in force until the death of the insured have non-forfeiture value to ensure that policyholders get fair value for the premiums they have paid. This principle allows the consumer to discontinue the policy if they do not believe that the COI increase is warranted. For instance, a consumer may surrender the value amount to purchase a new policy. Similarly, if the institutional investors are not happy about the rate increases, they can surrender the policies for the cash values that have accumulated. However, they have invested more into the policies than the average consumer has. The non-forfeiture values aren't based on what they paid for the polices to the consumers, but rather what the consumer paid for the policies to the insurance company - so the equitable surrender value to the consumer does not feel equitable to the settlement companies. That, however, is not the fault of the insurer. Basically, the settlement companies paid more than the policy was worth hoping that the difference between the future premiums paid and the death benefit they will receive will completely pay them back for their initial investment and also generate a profit. However, they will always generate a deficit if they surrender the policy before death. The average consumer does not have this dynamic since they always receive a fair value for the premiums paid to date. The bottom line is that insurers should not have to pay the bad bets made by the settlement companies and investors.

Regulation 210 has fatal flaws sometimes seen in a hastily developed regulatory response. First, it is too complicated – compliance has so far been an expensive nightmare for companies. The Regulation requires that companies inform the NY DFS about changes to non-guaranteed cost factors in an extremely complex way. ACLI believes that any regulatory response to COI increases should be more simplified and emphasize policyholder notice and information so that they can make informed decisions. Regulation 210 should not be a Model since its emphasis is on actuarial disclosures and rate regulation and not on policyholder information and protection from policy breakdown. The objective of Regulation 210 is ideal and noble, but its mechanism is flawed and impractical. The potential impact of Regulation 210 on the market must also be considered. If Regulation 210 discourages justifiable premium increases such that the industry bears all of the cost of a low interest rate environment and deteriorating mortality, the result could be an industry product portfolio consisting mainly of participating whole life and guaranteed cost whole life and term as in the 1960s where cost factors are guaranteed but policies are much more expensive than today, and the market is much smaller – that is not beneficial to consumers. In summary, ACLI

believes that no action should be taken on Regulation 210 until the current litigation is resolved, and any regulatory or legislative response should be focused on notice and not actuarial assumptions that are not understandable.

Rep. Deborah Ferguson (AR), Chair of the Committee, asked Mr. Brohawn if there is a way for the consumer when looking at the illustration to adequately assess whether the assumptions are true. Mr. Brohawn stated that with regard to the interest rate assumption, most policies that had the COI increases were current assumption universal life policies and the interest rates when the policies were taken out were probably not the interest rates that were paid because the interest rates have dropped. Second, with COI, there is typically a guaranteed column on the illustration but nothing that is going to tell the consumer whether or not the costs of insurance are going to increase. In the contract there is a contractually guaranteed rate that shows the highest rate they can take the COI to but nothing in the illustration. Mr. Brohawn stated that the illustrations are confusing. Rep. Ferguson asked how long the non-guaranteed elements in a policy are guaranteed for. Mr. Brohawn stated typically a year.

Rep. George Keiser (ND) responded to Mr. Sklaver's remarks and stated that it does not seem to be a viable argument that the carriers are violating their contracts when implementing COI increases on a "class basis" in only 49 of 50 States. Mr. Sklaver stated that in the Voya case, Voya voluntarily withdrew the COI increase in NY despite their contract stating that COI increases must be on a "class basis" – that term was defined by the carrier when the contracts were written. Rep. Keiser stated that term was defined prior to the NY DFS Regulations being drafted. Mr. Sklaver stated that the carrier cannot shape a contract term like a ball of clay over time to do what fits its needs.

Sen. Bob Hackett (OH) stated that the original illustration, especially when done with a trust company, is not the important illustration – it is the in-force illustration that you get year after year. Sen. Hackett asked if the examples given earlier were the first COI increases they had seen and whether or not they saw it coming particularly since interest rates were decreasing. Mr. Brohawn stated that if you purchase a life insurance policy the COI will increase every year as you age. However, there is a current COI that is built into the policy illustration that has increased over and above what was expected. So, as an example, if you go in and look at a policy, the COI at age 80 might be $1,000 and at age 81 might be $1,050, but now, overnight, the COI went from $1,050 to $1,500. To say that policyholders should have known that their COI was going to increase is true, but not overnight to such a large extent. Sen. Hackett stated that his point is that every year you get the in-force illustration which shows the COI increases going forward. Mr. Brohawn stated that what's happening here is that the COI increases are as large as 50% and they are being implemented overnight. Sen. Hackett stated that the new inforce illustration will then show that increase and those going forward. Mr. Brohawn replied yes and compared it to a mortgage on a house. If the mortgagor is paying 4.5% interest the can get their amortization table but if one day the bank calls and says the rate has increased to 8%, the amortization table has changed dramatically overnight.

Sen. Hackett then asked how Model language in this area would be applied throughout the country. Ms. Kiernan stated that no Model is necessary. Mr. Sklaver stated that he sees the issue no differently than any other statute or regulation applied throughout the States – there are standard non-discrimination clauses applied nationwide. Mr. Sklaver also noted that there is no approval process for COI increases. There is a notification process and then it is up to the Insurance Commissioner to investigate if they so choose.

Asm. Andrew Garbarino (NY) asked if the policyholders know that the rate increases can occur. Mr. Brohawn stated that he can't say what happens at the sales table, but that most people remember the good things about a transaction and not the bad things. The reality is that most people do not understand life insurance. As far as whether someone thinks or knows something will change in a policy: first, no one should be selling based off an illustration, and a consumer should know better than that; second, from a contract perspective, carriers should not be able to change contractual terms. Mr. Sklaver stated that insurers do not argue that they have unfettered discretion to raise rates – they are bound by contracts. This is all about ensuring that rate increases are done in the right way.

Rep. Glen Mulready (OK) asked the panel to clarify: carriers can raise rates at any time, they just must have the data to support the increases; no regulatory permission is required. Mr. Sklaver stated that in most states, regulatory approval for rate increases in life insurance is not required.

Rep. Joe Hoppe (MN), Vice Chair of the Committee, stated that he believes this is a case of two sophisticated industries involved in litigation and this is not the proper time for NCOIL to consider Model legislation. Rep. Hoppe made a Motion for the Committee to wait and see how the litigation plays out and to maybe discuss these issues at a later date. Sen. James Seward (NY) seconded the Motion. The Committee agreed without objection by way of a voice vote.

THE DOL FIDUCIARY RULE – NOT ALL QUIET ON THE STATE FRONT

Ray Farmer, Director of the South Carolina Department of Insurance, provided the Committee with an update on the NAIC Suitability in Annuity Transactions Model Regulation (Model). The Annuity Suitability Working Group (Working Group) was formed by the NAIC in recognition of a growing consensus for an updated and consistent standard for providing personalized investment advice to consumers. In April of 2016, the DOL completed regulations broadening its definition of fiduciary investment advice under ERISA and the IRC. Those regulations expand the scope of who is considered a fiduciary to ERISA retirement plans and IRA's which will include a broader set of insurance agents, brokers and insurers.

The first phase of implementation of the DOL Fiduciary Rule was set to be applicable in April 2017, but the Trump Administration issued a Presidential Memorandum ordering the DOL to reevaluate the Rule. As a result, implementation has been pushed back. At the same time, the SEC has been developing its own fiduciary standards as well. Accordingly, the NAIC decided to update its Model to consider potential improvements. The NAIC believes it is important to have a consistent and compatible standard for all entities and individuals with jurisdiction in this area. The NAIC has been encouraged with its interactions with the DOL, SEC and others. The Working Group released a draft of revisions to the Model this past November. Comments were received in January and the Working Group plans to meet later this month with the goal of having revisions to the Model being completed by the NAIC Summer Meeting, and to have the NAIC Life Insurance and Annuities Committee consider the Model by the NAIC Fall Meeting.

Bruce Ferguson of ACLI stated that there were important lessons learned from the DOL Rule, namely that it was the wrong rule implemented by the wrong regulator. From the outset, it was clear that what they were proposing did not make sense from a market

perspective. Even though the Rule is only partially implemented, there has already been a detrimental impact to low and median income savers. The movement towards fee-based arrangements has pushed a lot of individuals out of the market which is not a good thing especially since many are underprepared for retirement. It should not matter to consumers whether they are dealing with an insurance producer, investment advisor, broker dealer, or financial planner – there should be a common standard of care that individuals with whom they are dealing with are acting in their best interests. That will require a coordinated effort among many entities, most importantly state legislators.

Wes Bissett of the Independent Insurance Agents and Brokers of America (IIABA) stated that NCOIL has been an impactful voice in this area, particularly due to Arkansas Sen. Jason Rapert's Resolution opposing the DOL Fiduciary Rule. Among other things, that Resolution noted that the Rule is an example of excessive government regulation that hurts average consumers. Instead of supporting the Rule's repeal, some regulators have stated that the best-interest fiduciary standard should be extended to products within the clear jurisdiction of state regulators and to products that don't even have an investment component. The most notable element of the revisions to the NAIC Model is that it would establish a fiduciary best interest standard that would apply to any form of annuity. Such a standard is ambiguous and creates uncertainty which could lead to litigation. It also would impose costs on agents without providing any clear benefit to consumers.

Mr. Bissett stated that the revisions to the Suitability Model also place some odd restrictions on compensation – a producer would be prohibited from receiving more than reasonable compensation when making a recommendation – that is very vague and will probably end up with officials far removed from the process such as regulators and judges determining what is reasonable. Further, it is unclear why the NAIC would want to harmonize its Model with the DOL Rule particularly since that Rule is not in full effect and is likely to be altered.

Sen. Rapert asked Dir. Farmer if the NAIC is essentially taking up the cause that the DOL Rule is seeking to further. Dir. Farmer stated that the Working Group's activities are a work in progress and nothing is set in stone. Sen. Rapert requested that the NCOIL Resolution opposing the DOL Rule be re-distributed to all NCOIL member legislators in order to clarify NCOIL's position as the NAIC works on this issue.

Mr. Ferguson thanked Sen. Rapert for his leadership on this issue and stated that NAIC is doing the wise-thing by looking to improve its Model in order to make it a workable rule without the onerous impacts of the DOL Rule.

Dir. Farmer closed by stating this is another example of the benefits of having a continued and open dialogue between NCOIL and NAIC.

ADJOURNMENT

There being no further business, the Committee adjourned at 10:00 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES COMMITTEE
ATLANTA, GEORGIA
MARCH 3, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services Committee met at The Whitley Hotel in Atlanta, Georgia on Saturday, March 3, 2018 at 1:15 p.m.

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

Other members of the Committees present were:

Rep. Sam Kito (AK)	Rep. George Keiser (ND)
Sen. Jason Rapert (AR)	Sen. Jerry Klein (ND)
Asm. Ken Cooley (CA)	Asm. Andrew Garbarino (NY)
Rep. Joe Hoppe (MN)	Rep. Bill Botzow (VT)

Other legislators present were:

Rep. Charisse Millett (AK)	Sen. Thomas Middleton (MD)
Rep. Paul Mosley (AZ)	Sen. Paul Wieland (MO)
Rep. Bryon Short (DE)	Sen. Ed Buttrey (MT)
Rep. Darlene Taylor (GA)	Rep. Glen Mulready (OK)

Also in attendance were:

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

MINUTES

Upon a motion made and seconded the Committee unanimously approved the minutes of its November 16, 2017 meeting in Phoenix, Arizona.

PRESENTATION ON PROMOTING FINANCIAL EDUCATION FOR INSURANCE CONSUMERS

Professor Brenda Cude, Ph.D., of The University of Georgia, stated that insurance is often taught in schools but typically only as part of a personal finance course, which itself is typically part of another course. In 2015, 45 states included personal finance in their K-12 standards. In 2018, the number is still 45. Many state that personal finance should be taught at home, but Prof. Cude noted that some parents are uncomfortable talking about money, and often when she hears from her students what their parents told them, the parents are wrong. Prof. Cude stated that every state includes economic education in their K-12 standards, and while that is important, she thinks that teaching personal finance is much more important. Prof. Cude further stated that it is actually surprising that personal finance is taught as much as it is across the country given the number of different topics that are lobbied to be put in curriculum. A lot of the focus now is on “soft skills” such as social engagement and showing up on time. Prof. Cude stated that of

those 45 States that include personal finance in their K-12 standards, there is not always a requirement that it be taught. In 22 states there is a requirement that a high-school course be offered that includes personal finance education; in 17 of those states there is a requirement that students must take that course; and there are 7 states that require a standardized test on personal finance. In Georgia, every school district has to teach economics and personal finance must be included therein. Every student must take and pass the economics class which includes a separate test on personal finance.

Prof. Cude stated that The Council for Economic Education (CEE) issues a report every two years wherein they identify state progress in teaching personal finance. The most recent report identified 5 states as having done an exceptional job in promoting economic and personal finance education: Georgia, Michigan, Missouri, Texas, and Utah. Utah is the only one of that group that requires separate personal finance and economic courses to be taken. Prof. Cude urged the legislators to look at the report to see what their states are doing in these areas and noted that States such as Montana and California are not recognized in the report because there are no State-level requirements – there may schools in those States that are teaching economics and personal finance voluntarily.

Prof. Cude stated that at a conceptual level, it is clearly important to teach personal finance, and there is research that shows high-school personal finance education corresponding to increased personal savings and investing. Research also shows that individuals from states that require personal finance education have higher credit scores. The research, however, can be difficult to analyze because students come from different economic backgrounds so passing a personal finance class may represent a different level of significance among different students. Prof. Cude noted that two organizations have written proposed standards for personal finance: the CEE, and the Jump$tart Coalition for Personal Finance Literacy (Coalition). Among the topics included in the standards are: earning income; buying goods and services; using credit; saving; financial investing; protecting and insuring. However, those standards are different from state standards. In Georgia, standards were added such as government taxing and spending, consumer protection, and identity theft. Prof. Cude noted that in Georgia, the personal finance portion of the economics class is about 3 weeks, so it is difficult for students to learn a significant amount of insurance in that timeframe. Michigan is an interesting contrast because while two of its six required standards in the personal finance course are arguably not related to personal finance (scarcity and opportunity costs; marginal benefit and cost), one of the requirements is risk management.

Prof. Cude then noted that even in states that are recognized as “exemplary” by the CEE, a large proportion of high school graduates don’t experience personal finance education because some attend private schools, take advanced placement courses, or are home-schooled. Accordingly, Prof. Cude stated that, while she believes it is much better to teach personal finance than not, it is difficult to determine whether the requirements are making a difference. Prof. Cude also stated that specifically teaching insurance literacy is difficult. Teachers often lack confidence in teaching personal finance, let along insurance fundamentals, and many of the speakers that are invited to classes are biased in trying to sell their products. It also seems to be difficult to motivate students into wanting to learn about insurance. Additionally, some of the basics concepts in insurance are not easily transferable, such as deductibles in the P&C and health industries. Prof. Cude closed by urging the committee members to: learn what their state’s requirements are on personal finance and insurance education and work to

improve them; find out who provides leadership in their states and join them; support state insurance departments and others to provide unbiased education; support existing personal finance curricula; support programs that provide teacher in-service education; and support good research to evaluate personal finance education.

Sen. Bob Hackett (OH) asked Prof. Cude how Georgia worked to require standardized testing on personal finance. Prof. Cude stated that it took several years, and that the standardized test is part of the larger test for the economics class. Prof. Cude also stated that there is a growing emphasis on requiring personal finance education in colleges, particularly because many want "just in time" education. Sen. Hackett stated that teaching simple concepts at an early age such as "cash flow" and "living within your means" can go a long way in promoting financial health and independence in the long run.

Sen. Thomas "Mac" Middleton (MD) stated that in the Maryland Senate Finance Committee, they are currently working on issues related to the GED program in their correctional systems. However, Sen. Middleton stated that the Committee has noticed that there is nothing in the GED program about personal finance and asked Prof. Cude if there are any model GED programs that include personal finance requirements. Prof. Cude stated that she was unable to name any specific programs but that she is confident they exist and offered to discuss the issue with Sen. Middleton further.

DISCUSSION ON THE ELIMINATION OF THE PRODUCER APPOINTMENT PROCESS

Michael O'Malley of the American Insurance Association (AIA) began by stating that a producer appointment is a legally required registration/filing notifying an insurance department that a licensed producer is authorized to represent an insurer. States typically charge a fee for appointments, and the National Insurance Producer Registry (NIPR) charges a processing fee. States typically require notification to the insurance department within a set time after first transacting business or entering into a contract with a producer. Appointments may apply to individual producers, agencies, or both.

The NAIC has adopted a Producer Licensing Model Act (PLMA) which includes the appointment process as an optional provision. Nine (9) states do not have an appointment requirement – AK, AZ, CO, IL, IN, MD, MO, OR, and RI.
In addition to processing appointment transactions, insurers also must notify the insurance department of appointment terminations. Many states also require annual appointment renewals. Mr. O'Malley stated that producer appointments are no small matter – they cause millions of transactions generating hundreds of millions in fees. According to NIPR, the 2,427,382 licensed producers across the U.S. generated more than 18.6 million appointment transactions over the last two years. In just the 27 states where NIPR collects appointment fees, it has remitted more than $650 million in appointment fees to states over the past two years. Looking to specific examples: the Connecticut Insurance Department reports processing more than 490,000 company appointments annually, and the Virginia Bureau of Insurance collected more than $15.7 million in 2016, which equals more than $1.86 for every man, woman and child living in Virginia that year.

AIA believes that there are inefficiencies associated with producer appointments. The process is redundant since both the agent and insurance company are licensed which

means both have already been fully vetted by the insurance department during the licensing process. There is a lack of uniformity in the process as each state has its own set of rules for addressing appointments of individuals and/or business entities or appointment per each line of authority or sub-agent appointments. The process also adds costs to any company that uses agents. AIA also believes that the process does not add any material consumer protections to the regulatory system. Eliminating appointments would not affect a regulator's authority to address issues in the marketplace, including the authority to deny, revoke, suspend or refuse to renew a provider's license and/or levy civil penalties. That lack of material consumer protections raises cost-benefit issues.

Mr. O'Malley stated that the biggest issue when discussing appointments is state revenue as the process is clearly a big revenue raiser. AIA believes that even if insurers continued to pay fees to the states, insurers using agents and the independent agency system would benefit from greater efficiencies in the distribution system by eliminating the work of submitting appointments. Accordingly, AIA would like to open a dialogue with NCOIL regarding the possibility of eliminating producer appointments in a manner that would be revenue-neutral to the States.

Ray Farmer, Director of the South Carolina Department of Insurance, stated that there are good policies behind the producer appointment process. The formal appointment process helps to clearly establish the principal-agent relationship between an insurance company and a producer. By tracking appointments, a state that takes regulatory action against a producer will readily know what other companies have appointed that producer. The appointment process places a duty upon an insurer to notify insurance departments of producer terminations. Dir. Farmer stated that his department's investigative staff takes their job seriously and the appointment process helps them. Other companies also benefit from the appointment process as well since the insurance department can promptly notify them of any producer wrongdoings. Dir. Farmer stated that all it takes is for one consumer to be helped by the appointment process to justify any cost-benefit analysis. Dir. Farmer stated that the NAIC is open to dialogue on this issue but that they believe elimination of the producer appointment process will not benefit consumers.

Wes Bissett of the Independent Insurance Agents and Brokers of America (IIABA) stated that appointments affect agents in several ways. They affect the ability of agents to be responsive to clients, particularly for multistate agents. Companies are also sometimes reluctant to appointment new agents because of the associated costs. There are also some jurisdictions that require agents to pay the associated fees which IIABA believes is contrary to the law. IIABA wonders whether the appointment process would exist today if the insurance code was re-written as it is in some ways a vestige of a different time since agents used to be licensed by the companies. Mr. Bissett stated that a lack of uniformity in the appointment process is also problematic and inefficient. Some states also require appointments for different lines of insurance which IIABA believes is inefficient. Mr. Bissett stated that in the states that have eliminated the appointment process, there have been no adverse effects, and those insurance departments have been able to preserve resources and divert staff to other matters. Mr. Bissett closed by stating that at the very least, states could benefit from uniformity in the appointment process.

Sen. Hackett asked if it has been revenue-neutral for the states that have eliminated the

process. Mr. Bissett stated that in an effort to avoid losing all of the revenue, one state eliminated the appointment process section of the insurance code but still required companies to internally maintain a register of agents and continued to require notice of terminations. That state also implemented an annual fee based on the number of agents that are in that registry.

Dir. Farmer stated that it would be very difficult for elimination of the process to be revenue-neutral. Mr. O'Malley stated that there is no question that elimination being revenue-neutral is the trickiest part of the proposal but there are ways to do it, such as through the process Mr. Bissett mentioned. Mr. O'Malley also noted that the issue of notifying the insurance department of terminating a producer for cause is independent of the appointment process, and the AIA supports that requirement being maintained.

DISCUSSION ON PREVENTING FINANCIAL EXPLOITATION OF THE ELDERLY IN THE BANKING AND FINANCIAL SERVICES INDUSTRIES

Diana Noel of the American Association of Retired Persons (AARP) stated that there are common issues across states when dealing with elder financial exploitation (EFE). One is caregiving: those trying to care for elders may not have experience with managing money along with doctors' appointments and medications. The issue of EFE is bipartisan and stretches across all three branches of government, but it is unfortunately not a "hot" issue unless and until there is a crisis or tragedy. There is no one-size-fits-all solution to EFE and solutions will take time to implement. There is also a lack of data and research on EFE because there is no uniform system of gathering the data. The last study that the industry knows of and accepts was from 2011 by MetLife which stated that $2.9 billion was being exploited from elders, which itself was an underestimated amount. Further, there is a need for policy experts and those on the frontline to come together to better communicate these issues to legislators and regulators.

Ms. Noel stated that there has importantly been an increase in collaboration on EFE, such as specified task forces and multi-disciplinary teams studying the issue. State courts are also taking a more active approach by working on improvements to guardianships. Twenty-five states have established a group of Working Interdisciplinary Networks of Guardianship Stakeholders (WINGS) which is a state court-community partnership to improve guardianships. One of the biggest improvements has been in the area of access to information so individuals know where to go when there is a problem. The Federal government has also started to take on a bigger role.

Ms. Noel then cited some important steps for state legislators to consider when combatting EFE: strengthening adult protective services; enhance criminal and civil penalties; implementing guardianship and power of attorney reforms; improved training; and better education. Ms. Noel stated that the Uniform Law Commissioner recently adopted an Adult Guardianship and Protective Proceedings Jurisdiction Model Act for states to consider. The Model focuses on alternatives to guardianship, provides for a person-centered approach, and sets standards for professional guardians. Ms. Noel closed by stating that the committee members can reach out to their state AARP office for further information.

Julie Gackenbach of Confrere Strategies stated that for the past few years, Congress has been trying to enact a bill called the Senior Safe Act which would provide liability protection for financial institutions and insurance companies/agencies, among others,

that see or are concerned about EFE. There is a great concern in Congress about bank secrecy laws and other privacy protections preventing reporting of EFE. Financial institutions in this country want to be good partners in helping to prevent EFE. Ms. Gackenbach also noted that the Securities and Exchange Commission (SEC) has adopted recommendations from the Financial Industry Regulator Authority (FINRA), which became effective on February 8th. The rules allow financial institutions to: put temporary holds on accounts when they suspect EFE; make certain information available to law enforcement; and to permit financial institutions to require information at the time of opening an account regarding a “trusted contact person” that the institution can reach out to when suspicion of EFE arises.

Additionally, several states have adopted the North American Securities Administrators Association (NASAA) Model Legislation or Regulation to Protect Vulnerable Adults from Financial Exploitation (Model). Some trends common in these initiatives that are picking up steam include: trying to provide liability protection for financial professionals who see potential EFE; improving training among financial professionals so that they can quickly spot EFE; obtaining “trusted contact person” information; and improving the understanding of the different ways in which EFE can occur. Ms. Gackenabch stated that a lot of work on these issues will fall to the states despite Federal involvement.

ADJOURNMENT

There being no further business, the Committee adjourned at 2:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE AND HEALTH RETIREMENT ISSUES COMMITTEE
ATLANTA, GEORGIA
MARCH 4, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health, Long Term Care and Health Retirement Issues Committee met at The Whitley Hotel in Atlanta, Georgia on Sunday, March 4, 2018 at 8:45 a.m.

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

Other members of the Committees present were:

Rep. Sam Kito (AK)
Rep. Deborah Ferguson (AR)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Richard Smith (GA)
Rep. Matt Lehman (IN)
Rep. Bart Rowland (KY)
Rep. Joe Hoppe (MN)
Rep. Justin Hill (MO)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Asm. Andrew Garbarino (NY)
Sen. Bob Hackett (OH)
Rep. Glen Mulready (OK)
Rep. Tom Oliverson (TX)
Rep. Bill Botzow (VT)

Other legislators present were:

Rep. Paul Mosley (AZ)
Rep. Bryon Short (DE)
Rep. Darlene Taylor (GA)
Rep. Steve Riggs (KY)
Sen. Paul Wieland (MO)
Sen. Ed Buttrey (MT)
Rep. Ron Tusler (WI)

Also in attendance were:

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

MINUTES

Upon a motion made and seconded the Committee unanimously approved the minutes of its November 18, 2017 meeting in Phoenix, Arizona.

DISCUSSION ON STATE OPTIONS FOR RESPONDING TO CHANGES IN FEDERAL HEALTH POLICY

Heather Howard, Director of State Health and Value Strategies, and Lecturer in Public Affairs at Princeton University & former Commissioner of Human Services for the State of NJ, began by discussing some of the changes in Federal health policy that that are affecting the individual market, the first being the repeal of the individual mandate. The tax bill repeals the ACA's individual mandate penalty, effective January 1, 2019, by setting the amount of the penalty to zero. The CBO estimates that due to the repeal, there will be a 10% increase in premiums, and 13 million will lose coverage. Notably,

however, Massachusetts' individual mandate, started in 2007, is still in effect, and some states are considering introducing their own mandates. Cmsnr. Howard noted that state individual mandates are a good tool for states to combat the issuance of substandard plans, and stated that for states considering their own mandates, some key elements that any state legislation implementing a mandate must contain include: a definition of qualifying coverage; categories of exemptions; and a penalty amount. States must also create a mechanism for granting exemptions and create a system for providers to report coverage statistics. Notifying the uninsured about their coverage options could be an optional provision. Cmsnr. Howard also stated that reinsurance is an efficient mechanism for spreading the costs of high cost enrollees and noted that the temporary Federal reinsurance program kept premiums down for the first three years of the ACA.

Three states were approved for 1332 reinsurance waivers in 2017 (AK, MN, OR) and several others are considering submitting applications in 2018. Cmsnr. Howard stated that the elimination of the individual mandate penalties in 2019 will build pressure for premium relief, especially for unsubsidized individuals, and noted that Congress is considering a second round of Federal funding for reinsurance to help stabilize the individual market. Cmsnr. Howard also noted that reinsurance has a proven track record of reducing premiums by guaranteeing carriers don't face large losses. Reinsurance also correlates with increased insurer participation (insurer participation declined when Federal reinsurance ended) and reduced market volatility. Cmsnr. Howard then provided a brief overview of the three approved 1332 wavier applications (AK, MN, OR) and encouraged states to plan ahead on any waiver applications as early planning positions states to influence Federal policy and to respond successfully to shifts in Federal policy. Cmsnr. Howard noted that the latest state to submit a 1332 waiver application for a reinsurance program was Wisconsin, and stated that 1332 waivers have bi-partisan support.

Cmsnr. Howard then discussed the recently proposed regulations from the Departments of Health and Human Services and Treasury regarding short term limited duration health plans (STLDs). The regulations propose to allow the STLD duration limit to be extended from 3 months to up to 12 months and make it easier for consumers to renew such policies. The regulations also revise what disclosures the policies must make to consumers. Comments on the proposed regulations are due on April 23. Cmsnr. Howard stated that, if implemented, the STLD regulations' impact on the individual market could be substantial, particularly when compounded with the zeroing out of the individual mandate penalty. HHS estimates that between 100,000 and 200,000 individuals would leave the individual market for STLD plans, which would result in higher premiums for those left.

Cmsnr. Howard also noted that those who purchase STLD plans will incur increased financial liability if they get sick and/or injured, and there is a history of deceptive marketing tactics surrounding STLDs. However, nothing in the proposed regulations changes or diminishes states' authority as the primary regulators of STLDs, and therefore, states have a broad set of options to consider when dealing with them. States could: ban them outright; require STLDs to comply with some or all individual market rules; limit the duration of STLDs; require STLDs to meet a minimum medical loss ratio (MLR); and require improved consumer disclosures and education about STLDs. Depending on the state, some of those options could be implemented administratively, while some would need legislation.

Cmsnr. Howard stated that it is important to follow what Idaho is proposing by allowing the sale of plans that skirt ACA requirements. If the federal government does not step in, other states will likely follow that process. Cmsnr. Howard also stated that at the end of this month, a Federal omnibus appropriations bill is expected to pass. Some members of Congress are trying to include state individual market reforms in the bill: Senators Alexander and Murray are trying to fund the CSR payments; and Senators Collins and Nelson are trying to provide for Federal grants to help states establish reinsurance programs. The timing is critical on those issues since carriers are in the process of deciding whether to stay or enter into the ACA market.

Rep. Matt Lehman (IN), NCOIL Treasurer, asked if we are witnessing the dismantling of the ACA state-by-state. Cmsnr. Howard stated that seems to the trend and it started with efforts to repeal the ACA outright but now there is a shift to administratively provide states with flexibility to innovate and experiment. It will be very interesting going forward to compare and contrast the results of what states are now doing.

Rep. Bill Botzow (VT), NCOIL Vice President, asked if more attention should be focused on the rural-urban divide as it pertains to healthcare and the age differences between the two. Younger people seem to be migrating more to cities, and the elderly to rural areas.

Cmsnr. Howard stated that there is a particular stress on the healthcare delivery system in rural areas but to end on a hopeful note, Maryland is pioneering global budgeting which seems to provide rural areas with great hope going forward. In the other forty-nine states, hospitals are paid using fee-for-service, which results in a hospital prioritizing volume and filling beds instead of quality. Under the Global Budget Revenue system, hospitals receive a fixed sum payment for all Medicare patients for the year. Any money not spent on healthcare can be kept as profit, which reverses the incentives for hospitals. Instead of incentivizing hospitals to see as many patients as possible, hospitals are now incentivized to increase the quality of their care and reduce preventable illnesses.

PRESENTATION ON INITIATIVES TO PROMOTE SOLUTIONS ACROSS THE AUTISM SPECTRUM

Lorri Unumb of Autism Speaks began by stating that her son, Ryan, was diagnosed with autism at 22 months of age. Autism is a medical condition brought on through no apparent fault of the family – it is not yet known what causes it. Autism is diagnosed by a doctor or psychologist and often a developmental pediatrician. For reasons not yet known, autism is four times more common in boys than girls. There used to be three different “strains” – a.) autistic disorder; b.) Asperger’s syndrome; and c.) pervasive developmental disorder (a catch-all category). However, now autism is referenced on certain levels of “autism spectrum disorder.” The prevalence of autism is skyrocketing, and it is not certain why, although some is probably due to better diagnostics and an expanded definition. The Center for Disease Control (CDC) estimates that 1 in every 68 children is diagnosed somewhere on the autism spectrum.

Ms. Unumb stated that applied behavior analysis (ABA) is helpful in treating autism. It consists of a one-on-one intervention where they break down every skill that a human being needs to operate in life and train the child how to pick up any skills they are lacking through repetition, prompting, and positive reinforcement. Ms. Unumb stated

that when doctors recommended that her son undergo 40 hours per week of ABA, the cost was $71,000 per year. At that time, insurance did not cover any of that amount which is what led her to start advocating for insurance coverage of autism treatment. Some of the reasons insurers gave for not covering ABA were: it was an experimental line of treatment (it was not); it was being conducted by unlicensed providers (there were no licenses at the time); and that the schools could handle it. Motivated by that experience, Ms. Unumb wrote a piece of legislation in South Carolina in 2005 that requires insurance to cover evidence-based treatments as recommended by a physician. The bill passed in 2007 and became known as "Ryan's law."

Ryan's law requires coverage of autism treatment through age 16 with a $50,000 per year cap on ABA. Since that time, Ms. Unumb has been traveling across the country trying to get similar laws enacted. In 2001, only 1 state covered ABA (Indiana) but today, 46 states cover autism treatment. However, those 46 states vary dramatically in their levels of required coverage. Some states still lack coverage for ABA, and some states have made coverage distinctions for the individual and small group markets. Ms. Unumb stated that such coverage restrictions are a problem for families with autistic children and it often results in the family moving, or a change in employment with better coverage. Almost all states have autism insurance coverage in the state employee market, and all the 46 states have coverage in the large group market.

Rep. Paul Mosley (AZ) asked what Arizona's level of autism insurance coverage is. Ms. Unumb stated that Arizona's autism coverage mandate was one of the first to be enacted, and only applies to state employees and the large group market. However, after the ACA passed and states were given an opportunity to select a benchmark plan, Arizona selected the state employee plan as its benchmark. By virtue of that, autism coverage became part of the essential health benefit requirements and thus is available in non-grandfathered plans.

Ms. Unumb stated that some states have managed to get ABA coverage into their EHB package by including it in the "habilitative services." Also, the phrase "…including behavioral health treatment" was included in the ACA's list of EHB's specifically for ABA coverage. Ms. Unumb also noted that in states such as Ohio, Governor Kasich simply wrote to the Federal government requesting that ABA be included in their EHB and it now is. Accordingly, many families in Ohio can purchase a qualified health plan just for purposes of ABA coverage.

Ms. Unumb further stated that some states require autism coverage, but the coverage is impermissibly restricted. The Federal Mental Health Parity & Addiction Equity Act (MHPAE) prohibits financial requirements or treatment limitations on mental health benefits that are more restrictive than those on medical/surgical benefits. The term "treatment limitations" includes "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." However, many state insurance autism laws have dollar caps or age caps that are clearly quantitative treatment limitations that restrict coverage on a mental health benefit.

As an example, Arizona has a $50,000 cap on treatment for children aged 0-9, and a $25,000 cap on children aged 9-17. Notably, Arizona's law was in place before MHPAE was enacted. Ms. Unumb closed by urging the committee members to look at the materials she provided that shows each state's level of autism insurance coverage and to work to ensure there are no impermissible restrictions. Ms. Unumb noted that in

addition to improving the children's lives, autism insurance-coverage laws are important because the children can cost states a tremendous amount of money if they are not treated at an early age.

Asm. Kevin Cahill (NY), Chair of the Committee, asked if the MHPAE is broad enough to cover all autism treatment, and whether there are state mental health parity laws that have filled any gaps. Ms. Unumb stated that most states do have mental health parity laws but, in most instances, the MHPAE is broader and it aims to include autism treatment under the definition of "mental health benefit."

DISCUSSION ON REPORTING AND NOTIFICATION REQUIREMENTS FOR PRESCRIPTION DRUG MANUFACTURERS RELATED TO DRUG PRICING (SEE CALIFORNIA SB 17 (2017) AND VERMONT S.216 (2016)

Asm. Ken Cooley (CA), NCOIL Secretary, stated that California has tried a series of strategies to try to lower healthcare costs in general. In a recent survey conducted by the Journal of American Medicine, 25% of those polled stated that they did not pursue filling a prescription due to cost concerns. California SB 17 is an effort to improve transparency in the prescription drug market in order to have healthcare costs lowered. CA SB 17 requires pharmaceutical companies to notify public and private health insurers anytime the companies plan to raise the price of a drug by more than 16 percent over two years. Such notice must be provided at least 60 days prior to the planned effective date of the increase, and include a statement explaining the price increase. Additionally, CA SB 17 implements reporting requirements for certain health plans regarding: the 25 most frequently prescribed drugs; the 25 most costly drugs by total annual spending; and the 25 drugs with the highest year-over-year increase in total annual plan spending. This information is to be compiled into a report and submitted to the public and legislators demonstrating "the overall impact of drug costs on health care premiums."

Rep. Botzow stated that VT S.216 directed the Green Mountain Care Board, in collaboration with the Department of Vermont Health Access (DHVA), to identify annually up to 15 prescription drugs representing different drug classes "on which the state spends significant health care dollars and for which the wholesale acquisition cost (WAC) 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 statute also requires that the manufacturers of the identified drugs provide a justification for the increase in the WAC, including all relevant information and supporting documentation, and provide that information to the Attorney General on a confidential basis.

Rep. Botzow stated that the latest report from the Attorney General was just released and he cited one of the DHVA's main observations from the data collected: "increasing WAC does not always result in more rebates for commercial payers, as rebates are not available on all drugs. Since rebates are sometimes based on a percentage of WAC, purchasers and payers may still pay more when WAC increases. In addition, uninsured and under-insured patients, such as those with high deductible health plans or limited coverage, often bear the full burden of price increases at the pharmacy." Rep. Botzow noted that the information in Vermont has been helpful but more needs to be done to see a meaningful decrease in drug pricing and healthcare costs in general. Rep. Botzow also noted that the Vermont Senate just recently passed a bill that contains elements of the CA SB 17 and other state drug pricing transparency laws.

Ed Silverman, Senior Writer at STAT News, stated that in the absence of any movement by the Trump Administration or Congress to directly address prescription drug prices, many states are taking some form of action in the area of transparency, the idea being that transparency would get information out there that is not currently known, and it would better enable remedial action to be taken if an egregious drug price increase took place. Mr. Silverman noted that nearly two dozen states have introduced legislation that would demand transparency from drug makers and, in some cases, pharmacy benefit managers (PBMs). More than two dozen states have bills directed at PBMs specifically, some of which address incentives for mail order pharmacy and penalize pharmacists who discuss costs with consumers. Mr. Silverman noted that Nevada passed a drug pricing transparency law that focuses on diabetes medicines given the prevalence of diabetes in the country and associated health costs. Colorado, among other states, has introduced similar legislation.

Additionally, Mr. Silverman stated that a growing number of states are also introducing legislation that creates a mechanism for state residents to purchase medicines that are imported from Canada. Mr. Silverman noted that Utah has introduced such a bill that has Republican support, which is illustrative of the fact that these issues are not just associated with "blue" states such as Vermont and California. Furthermore, in May 2017, Maryland became the first State to prohibit drug manufacturers from "price gouging" in the sale of essential off-patent or generic drugs. Mr. Silverman noted that an extremely large percentage of prescriptions today are written for generic drugs. Mr. Silverman stated that many of the drug pricing transparency laws do not have a lot of "teeth" with regard to their penalty and enforcement provisions. Mr. Silverman noted that from what he has heard regarding VT S.216, the law is not moving the needle.

Emily Donaldson, Senior Director of Policy and Research at PhRMA, stated that drug pricing transparency measures have generally focused on the WAC which is generally not illustrative of the actual cost for a drug that is paid by PBMs and insurers since those entities receive substantial discounts and rebates from brand manufacturers. A recent study found that for certain medicines used to treat chronic conditions such as asthma, high cholesterol, or diabetes, rebates reduced the list price by 30% to 70%. We know that prevention and better management of chronic conditions can save states more money than what is spent on the medicines used to treat them, but PhRMA understands the pressures facing state budgets and state lawmakers and is committed to providing solutions to those challenges.

With regard to VT S.216, Ms. Donaldson stated that PhRMA appreciates why people want to know why the cost of a drug might increase, however, it is unclear that the law will have any impact on patients. We do know what does have an impact on patients: a recent report found that the number of plans with a deductible for medicines doubled between 2012 and 2015. And oftentimes, insurers are receiving rebates for those medicines while the patient is paying full price; and after meeting a deductible, some patients still have to pay coinsurance, which is based on the list price. The number of employees with no deductible for pharmacy or medical benefits continues to decrease: 49% in 2016; 44% in 2017. One-third of employers are considering more cost-sharing measures in the future, which means higher deductibles and additional formulary tiers.

Ms. Donaldson pointed out that these types of policy changes are occurring despite the fact that drug spending growth is slowing. Express Scripts, the nation's largest PBM, and CMS, announced that 2017 growth in Rx spending was between 1.3% and 1.5%,

but overall health spending increased more than 4%. In addition, almost half of all commercial plans saw a decrease in their per-enrollee drug spending last year. Ms. Donaldson stated that those statistics indicate that the focus needs to be broadened: measures that hit one industry or another are not going to make it easier for people to afford their medicines. It is imperative that anything a state does to address these issues must not result in negative unintended consequences.

With regard to CA SB 17, Ms. Donaldson stated that the law's advance price notification requirements can have severe consequences because it has happened before. Notifications based on costs and future price increases can incentivize speculative purchasing and problematic stockpiling that both the industry and the Federal government have sought to eliminate. In the past, speculative purchasing was a practice used by distributors to profit from fluctuations in medicine prices. Congress looked into that issue after drug shortages came to its attention and it found that grey-market companies were charging exorbitant prices for shortage drugs and that fake pharmacies were acquiring prescription drugs and selling them into the grey-market. As a result, in 2012, Congress passed the Grey Market Drug Reform and Transparency Act: manufacturers and primary distributors - the wholesalers who purchase medicines directly from manufacturers – enter into agreements that manage the volume of medicines that a distributor can hold. These arrangements discourage stockpiling of inventory in amounts that exceed patient need. Advance price notification creates a new incentive for some distributors, especially those without contracts with manufacturers, to profit from purchasing medicines at an old price and selling them at a new price. Such a policy will not help patients afford their medicines.

Ms. Donaldson stated that PhRMA understands the need for transparency in healthcare and it agrees that it is crucial for patients to have the ability to know what they will pay for both medical services and medicines. That is why PhRMA is supportive of measures that take a wholistic, meaningful approach to transparency – not transparency for the sake of the word. Specifically, for PBMs, transparency could mean registration requirements so that there is some accountability. Also, to increase understanding and awareness of the different prices paid by supply-chain stakeholders and consumers, PBMs could disclose, in aggregate, the rebates they receive, the rebates that are passed along to health plans and employers, and the fees that they receive. PBMs should also be prohibited from restricting pharmacists from informing consumers of lower cost prescription drug options.

For insurers, according to Ms. Donaldson, states could consider adopting the NAIC's Prescription Drug Benefit Management Model Act, and at a minimum, require that insurers provide: formulary information that is easily accessible and regularly updated, including notice of formulary changes; concise, clear reporting on a per-drug basis on prior-authorization requirements, step therapy, exceptions processes, and cost-sharing; and the rights on denials and appeals. PhRMA believes that reporting requirement for pharmaceutical manufactures should be focused on medicines with a significant impact on the state. Identification of medicines should be done by a state agency with knowledge and expertise on the issue such as the Department of Health of Department of Insurance. Information contained in manufacturing reporting should be consistent with the 10-K filing that manufacturers already file with the SEC which already requires thorough financial disclosures. State reporting requirements should also preempt any county and municipal requirements

Ms. Donaldson stated that PhRMA has been working to improve cost-sharing fairness and affordability for patients. One option is to require that health insurers disclose to current and prospective enrollees and plan sponsors that the enrollees' cost-sharing amount for prescription medicine could exceed the amount paid by the insurer[1]. One large, major insurer already does this. Another option is to require that health insurers certify in their annual filing documents that a majority of the rebates they received are passed through to consumers at the point of sale. Another option is to require that one of several specific rebate pass-through amounts is passed through to consumers at the point of sale.

Rep. Tom Oliverson (TX) stated that in every industry there are both good and bad actors, and asked Ms. Donaldson what are some of PhRMA's suggestions to reign in some of the bad actors. Ms. Donaldson stated that PhRMA has changed some of its membership rules and that it is important to remember that when talking about a research-based industry, you don't want to stifle innovation by overreaching on some in ways that could negatively affect others. Ms. Donaldson stated that it takes approximately $2.6 billion to take a drug to market and for every success, there are many failures, but those successes can be life changing and life saving. PhRMA is committed to making sure patients can afford their medicines and offered to discuss some state-specific options with Rep. Oliverson.

Rep. George Keiser (ND) stated that North Dakota was one of the first states to pass PBM "gag clause" legislation, and it has also passed specialty drug legislation – both are currently being litigated.

Rep. Deborah Ferguson (AR) stated that everyone involved in the issue of drug pricing affordability deserves some blame, not just PBMs. Some drugs, such as the EpiPen, have nothing to do with research and development (R&D) costs – they have been around for so long. PhRMA spends more money on advertising than on R&D. Ms. Donaldson stated that she believed Rep. Ferguson's R&D vs. advertising costs can be disputed and offered to discuss that issue with her later. Ms. Donaldson also stated that her earlier remarks regarding a "wholistic" approach to drug pricing transparency was meant to include PhRMA. One approach that PhRMA is looking into is value-based contracting which would help to re-align incentives across the supply-chain to lower medicine costs for patients.

Mr. Silverman closed by stating that PhRMA has filed suit in California alleging CA SB 17 is unconstitutional on several grounds; and the generic drug trade group has also filed suit over the Maryland law. Ms. Silverman also noted that Ms. Donaldson's statistic of $2.6 billion for taking a drug to market has been disputed. The drug pricing transparency laws discussed today have value, but more work needs to be done to help lowers costs for consumers.

Asm. Cahill closed by asking any interested parties to submit comments on CA SB 17, VT S.216, and other drug pricing transparency laws to NCOIL staff since the Committee will continue to look at this issue going forward.

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[1] While the witness used the word "insurer" here, it is likely that "PBM" would better reflect this scenario for instances where the PBM pays the drug manufacturer a price for a drug and collects an amount greater than that price from its member. It is not usual for a health insurer to buy & sell medications, while it is for PBMs.

DISCUSSION ON THE REGULATION OF PHARMACY BENEFIT MANAGERS (PBMs)

Sen. Jason Rapert (AR), NCOIL President, began by referring to an article written by David Smith, an owner of a community pharmacy in Arkansas, about PBMs titled: “The Monster in the Closet.” PBMs act as intermediaries on every drug prescription transaction. They were originally intended only to process claims from the pharmacy to the insurance company for payment but over the past 20 years they have grown into something entirely different. They still connect pharmacies with insurance companies, but they now have control over which medications consumers have, how many doses consumers can take each day, how many times consumers can get them filled during the course of a year, and how much consumers have to pay as a co-pay when getting them filled.

Sen. Rapert stated that there is a tremendous amount of information about PBMs that we simply do not know and that while every other industry involved in prescription drug transactions is subject to regulation, there is no “referee” for PBMs. Pharmacy owners are required to sign contracts with PBMs in order to process prescriptions through the PBM for payment which is where, as Dr. Smith states, the monster peeks out of the closet. The contracts are non-negotiable in which the pharmacy literally has no bargaining power, and pharmacies are not allowed to band together locally in a geographic area to try to negotiate a better deal – that would be considered price fixing and they would go to jail.

Sen. Rapert stated that he has heard stories in Arkansas of where Tamiflu costs the pharmacy $80 to purchase but it gets reimbursed $34 from the PBM and the PBM gets paid $100 for that transaction. As the practice of PBMs have begun to be seriously analyzed in Arkansas, pharmacists have been receiving faxes from PBMs stating that they are not permitted to discuss their contracts with any government official without prior approval from the PBM. The Arkansas Attorney General is also now investigating certain PBMs for anti-trust violations.

Sen. Rapert stated that he believes what is needed is not something that is favorable to pharmacists or PBMs, but rather favorable to the consumers and taxpayers. A referee is needed. In Arkansas, a bill was recently introduced that would require PBMs to be licensed by the Insurance Department and would give said Department the authority to enforce the State’s maximum allowable cost (MAC) law which currently is enforced by the Attorney General through deceptive trade practices. Sen. Rapert stated that the Arkansas bill provides necessary but reasonable regulation over PBMs to review pharmacy reimbursement programs for the purpose of ensuring there are an adequate number of pharmacies and pharmacy networks for consumers who are insured.

The AR bill provides reasonable licensing and financial solvency standards on PBMs and it officially brings into one state agency, the Insurance Department, the pharmacy pricing laws that are currently in place. The bill does not govern ERISA or self-funded health plans. The bill also provides for the protection of PBMs’ proprietary information. Sen. Rapert closed by stating that this issue is what NCOIL was built for: to hear from all interested parties on a certain issue; debate the issue; and come up with reasonable policy that can be considered across the country and tailored to states’ specific needs. Also, Sen. Rapert noted that a special legislation session on PBMs has been scheduled in Arkansas for later in the month.

Lauren Rowley, Vice President of State Affairs at the Pharmaceutical Care Management Association (PCMA) stated that PBMs exist to hold down the costs of prescription drugs and they are hired by highly sophisticated purchases of healthcare, including the federal government with Medicare Part D, and unions, not individual businesses. Typically, those entities will submit an RFP and the bidding process is highly competitive. PBMs hold down the costs of prescription drugs by making everyone in the prescription drug delivery system accountable. To the extent there are different drugs in a therapeutic class, PBMs negotiate rebates because rebates hold down the cost of prescription drugs. There is no correlation between rebates and list price – there are studies that show that. Ms. Rowley noted that independent pharmacies do ban together under what's called a Pharmacy Services Administrative Organization (PASO) and it negotiates with PBMs on behalf of the individual pharmacies in addition to providing the drugs to the pharmacies. The only time an independent pharmacy will directly contract with a PBM is in rural settings due to network adequacy standards.

Ms. Rowley stated that for employers, PBMs develop tiered formularies and the goal is to arrive at lowest-cost drug – generics are preferred. PBMs also implement utilization management techniques that make sure a person is not going to the directly advertised drug but to a lower-cost alternative instead. PBMs also implement drug adherence programs. With regard to "gag clauses," Ms. Rowley stated that it is the policy of PCMA and its companies that pharmacists should be able to talk to consumers about lowercost drug alternatives. Ms. Rowley closed by saying that nobody is forced to hire a PBM – they are hired because of the important services they provide in holding down prescription drug costs.

Asm. Cahill asked Ms. Rowley what PCMA's position is on proposed laws such as Arkansas' that requires licensing of PBMs. Ms. Rowley stated that 26 states currently require PBMs to register as a TPA. It is important to note that PBMs are not insurers – they do not collect premiums and they are not at risk. Rather, PBMs are administrators of a drug benefit which is designed by the plan sponsor. Accordingly, treating PBMs like insurers does not make sense. PBMs allow their clients to review rebates, but open disclosure of rebates is not a good thing, and the FTC has written many opinions saying such and would lead to tacit collusion among pharmaceutical manufacturers.

Leanne Gassaway, Senior Vice President of State Affairs at America's Health Insurance Plans (AHIP), stated that many health insurers use PBMs to administer their pharmacy benefits for two main reasons: a.) to strive towards evidence-based care; and b.) to lower healthcare costs. Ms. Gassaway stated that when entities use PBMs, they demand certain information. With regard to point-of-sale rebates, if Medicare was to change the way it operates its Part D program, it would cost the Federal government $42 billion over 10 years, to allow the point-of-sale rebate to go down to the counter instead of going back to the Federal government and back to the taxpayers.

Ms. Gassaway continued that on the health plan side, the rebate is shared with the consumer. AHIP's most recent study shows that over 22 cents of every premium dollar goes towards prescription drugs and that number is rising. She stated that the problem starts with the price of the drug, and everything that PBMs and health plans do are in an effort to lower that price. Accordingly, it is important to be cognizant that any reforms being discussed do not have unintended consequences that would raise premiums and harm consumers. Ms. Gassaway stated that it is important to not be distracted from the real issue that s hurting most consumers – the list price of drugs.

Scott Brunner, Senior Vice President of Communications & State Government Affairs at the National Community Pharmacists Association (NCPA), stated that there are 22,000 independent community pharmacies nationwide, mostly based on main streets in small towns who provide civic leadership. 80% are located in areas with populations less than 50,000 and they serve as essential healthcare providers in underserved areas. 91% of prescriptions are covered by insurance, and in those instances, the patient's price is set by the PBM, not the pharmacy. For cash transactions, the pharmacy sets the price. Mr. Brunner stated that what community pharmacies charge patients and are reimbursed is often determined by a competitor because PBMs own or are affiliated with competing retail and/or mail-order and/or specialty pharmacies and PBMs often require or incentivize patients to use the PBM-owned pharmacy. Everyone involved in the prescription drug supply chain is highly regulated except for PBMs. Usually, PBMs have no fiduciary duty to anyone but their shareholders, unless health plans and plan sponsors write it into their contracts. Also, in most states the state Medicaid agency does not write into the contract a fiduciary responsibility.

The lack of oversight and regulation on PBMs means that PBMs steer patients to PBM-owned retail, mail order, or specialty pharmacies (with whom the patient has no relationship or which may not be geographically convenient). There are also network access hurdles, particularly in preferred networks, that limit patient access to pharmacies. Mr. Brunner stated that the lack of oversight and regulation of PBMs results in take-it-or-leave-it contacts between PBMs and pharmacies – contracts that would not be permissible in any other industry. There is also a lack of transparency in reimbursement pricing, and underwater reimbursements without recourse, in addition to retaliatory audits and network exclusion for any reason they want. Prior authorization requests are also problematic, and there is not a process for appeals or a remedy for unfair practices. Oftentimes PBMs impose retroactive fees, particularly in the Part D space, that lead to a culture of unpredictability.

Mr. Brunner stated that PBMs make money through: administrative fees paid by plan sponsors and pharmacies; rebates (discounts the manufacturers gives to PBMs for formulary placement); and spread-pricing (profit-taking that results from the difference between what the PBM reimburses the pharmacy for a medication and what it bills the health plan for that medication cost). The main point is that PBMs make money from almost every player in the prescription supply chain, including the patient, yet they never touch a medication. They have tremendous market power – the three largest PBMs cover 89% the market. Insurance Commissioners are the logical referee best suited to oversee PBM practices.

Scott Pace, Executive Vice President & CEO of the Arkansas Pharmacists Association, stated that starting in January of this year, they saw that the largest insurer operating in the Arkansas exchange moved from a transparent relationship with its PBM, to a spread-pricing relationship, which means instead of the pharmacy being paid what the insurance plan was charged by the PBM, that became hidden behind a curtain of secrecy. As a result, reimbursements to pharmacies plummeted, charges to the plans stayed at a very high level, and patient access began to diminish because the spread in the middle became greater than the total payment to the pharmacies for buying the drug and providing the service. Mr. Pace said that pharmacists were able to see this data from patient's EOBs and it was discovered that during the first three weeks of this year, the spread was more than the total amount paid to the pharmacies. That was consistent with a December 2017 report to the Virginia General Assembly that showed an average

spread of $22.72 per prescription for a total spread of almost $14 million in just one quarter. And in Kentucky, it was found that last year, $1.68 billion was paid out for pharmacy benefits last year in the Medicaid program, but only $1 billion went to pharmacies.

Mr. Pace stated that the spread statistics matter because they affect the medical loss ratio (MLR) numbers that are being reported by plans to CMS to determine if premium increases are justified and if certain rebate amounts are due back to the consumers. Additionally, there are anticompetitive practices which PBMs operate under such as termination without cause and gag clause provisions in contracts. Additionally, data shows that major PBMs paid themselves $63.51 per prescription more than locally owned pharmacies. This is a case of the fox guarding the henhouse. Mr. Pace closed by stating that he disagreed with Ms. Gassaway's assertion that the list price should be the focus – it is the rebates that are driving the list price so the pharmaceutical industry can maintain their margins. Insurance commissioner oversight of PBMs would solve many of these problems.

On behalf of the NAIC, Russ Galbraith, Chief Deputy Commissioner at the Arkansas Department of Insurance, stated that the NAIC Health Carrier Prescription Drug Benefit Model Act was adopted in 2003 and sets out standards for the establishment, maintenance and management of prescription drug formularies and other PBM procedures. The Model also establishes a medical exceptions process to permit consumers to request a non-formulary prescription drug or to request an exception to a PBM procedure requirement. During the drafting process, the NAIC held a public hearing concerning the role of PBMs in the development and management of prescription drug formularies. At the hearing, testimony was given stating that PBMs were already regulated as TPA's or utilization review organizations depending on what activity they were performing. After reviewing the testimony, the NAIC decided to develop a Model that would provide standards for the development and maintenance of formularies and not develop a Model that would directly regulate PBMs. Consistent with other NAIC Models, the NAIC decided to regulate the health carrier who contracts with an entity, such as a PBM. During recent discussions concerning whether to revise the Model to include provisions that would regulate PBMs, the NAIC decided to leave it the state's discretion.

Rep. Botzow requested that this topic continue to be on the agenda and that he supports Sen. Rapert's goal of developing an NCOIL Model law to regulate PBMs.

Rep. Darlene Taylor (GA) stated that she is a TPA and has watched over the last 25 years the costs of prescription drugs continually to rise to currently about 25/30% of a healthcare plan. That is not sustainable, and, in some cases, she has seen clients drop their PBMs and their costs went down. The process surrounding rebates is deceptive, and they often are not returned until several months later, making auditing extremely difficult. Rep. Taylor stated that something needs to be done, and that the states will need to be the ones to be proactive.

Rep. Oliverson asked why there can't be more transparency on MAC. As a physician, he knows his contracted rates when he signs the contracts, and that he understands that formulary prices change but in the internet age, it is shocking that a pharmacist finds himself in a situation where they are not sure what they will be reimbursed until they process the claim. Further, Rep. Oliverson asked Ms. Gassaway if future business

models include independent pharmacists because it seems that there are strategies in place to run them out of business.

As to Rep. Oliverson's first question, Ms. Rowley stated that "MAC" began in Medicaid and has been used by the industry for many years because there are sometimes thousands of generic drugs in the marketplace and each manufacturer sells them at a different price. PBMs, and Medicaid, find what the median price is for those drugs and sets a reimbursement rate. If the PSAO, as purchasers of the prescription drug, does a good job then the pharmacy will make extra money on a specific drug. However, if PSAO's don't purchase at a good price, the pharmacy won't make as much money, but you have to look at the basket of drugs and it evens out. Ms. Rowley stated that marketplace solutions work and that it is in the best interest of PBMs to keep as many pharmacies in its network as it can. In many states, including Arkansas, there are "any willing provider" laws which basically means if you agree to certain conditions you can participate in any PBM's pharmacy network. MAC works despite there being some outlier situations of the pharmacy being underwater.

Rep. Oliverson asked why we can't know what the MAC is at the point of service with certainty – why is there secrecy over what the price actually is. Ms. Rowley stated that it is not secret – the list price can change week to week. PBMs update their MAC lists according to what's happening the marketplace with those drugs.

As to Rep. Oliverson's second question, Ms. Gassaway stated that business practices are constantly evolving, and she sees community pharmacists embracing technology. She does not agree that community pharmacists are being pushed out of the market and stated that is best for everyone to stop competing and start working together. Community pharmacies have actually increased nationwide in the past 8 years, including in Arkansas.

Rep. Ferguson asked Mr. Brunner what his recommendations are for solving problems associated with mail order prescriptions. Mr. Brunner stated that no patient should be forced to use mail-order; there should be legislation in states to prevent PBMs from steering patients to pharmacies in which they have an ownership interest, at least without full disclosure. Community pharmacies should also be permitted to do 90-day fills. Frequently, when community pharmacies are chosen over mail-order, the patient can only get a 30-day fill. Rep. Ferguson asked if there are cost savings associated with mail-order. Mr. Brunner stated that it depends on what outcome you want as he believes regular interaction with a pharmacist goes a long way in getting the patient better.

Sen. Bob Hackett (OH) asked if there is a formula for determining rebates. Ms. Rowley stated that there is no formula. Some insurers want 100% pass-back to the consumer whereas some want to use some of it to lower their administrative fee. The client of course gets to see that information and can audit the PBM to make sure the rebates are being dealt with as agreed upon. There is good transparency between the contracted parties, but the FTC has opined that public disclosure will raise prices. Sen. Hackett stated that it is important to note that everybody's plans have gotten much weaker. Costs are trying to be controlled and one way is to reduce benefits – the consumer is being harmed. Ms. Gassaway agreed and stated that if you look at the average launch price of a drug today versus what it was 10 years ago, it is baffling.

Sen. Rapert thanked all of the panelists for coming and stated that by November, he hopes that a Model law will be ready for the Committee to consider.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
ATLANTA, GA
MARCH 4, 2018

The National Council of Insurance Legislators (NCOIL) Business Planning and Executive Committee met at the Whitley Buckhead on Sunday, March 4 at 11:06 a.m. NCOIL President, Sen. Jason Rapert, AR, Chair of the Committee presided.

MEMBERS OF THE COMMITTEE PRESENT:

Rep. Bill Botzow, VT, Vice-Chair
Rep. Sam Kito, AK
Rep. Deborah Ferrguson, AR
Asm. Ken Cooley, CA
Rep. Richard Smith, GA
Rep. Matt Lehman, IN
Rep. Steve Riggs, KY
Rep. Bart Rowland, KY
Sen. Jerry Klein, ND
Asm. Kevin Cahill, NY
Asm. Andrew Garbarino, NY
Sen. Bob Hackett, OH
Rep. Glen Mulready, OK

OTHER LEGISLATORS PRESENT:

Rep. Bryon Short, DE
Re. Darlene Taylor, GA
Sen. Paul Weiland, MO
Sen. Valerie Foushee, NC
Rep. Tom Oliverson, TX
Rep. Ron Tusler, WI

ALSO PRESENT:

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

MINUTES

A motion was made and seconded to approve the minutes of the November 19th meeting. The motion carried on a voice vote.

FUTURE LOCATIONS

As a follow up to the conversation in Phoenix, Commissioner Considine announced that because both Florida and North Carolina have become NCOIL contributing states, the 2020 Spring Meeting will be in Charlotte, NC from March 1 – 3 at the Marriott and the Annual Meeting will be at the Tampa Marriott from December 8 – 12. The Summer location and dates have not been chosen because the dates for the national political conventions have yet to be announced.

RECRUITMENT OF NEW MEMBER STATES

Sen. Rapert discussed how NCOIL legislators were working with IEC members to recruit legislators from member states to participate more fully.

Commissioner Considine reminded the audience that Florida and North Carolina have

become contributing states, bring the total number to 34. In addition, NCOIL contributing states comprise 81% of the population of the United States and for the first time ever the top 10 states by population are NCOIL contributing states. There were 5 Commissioners or equivalent and 11 Insurance Departments represented.

ADMINISTRATION

Commissioner Considine noted that there were 268 registrants for the Spring Meeting, 51 legislators and participants from 32 states. This is more than a Spring Meeting has had in at least a decade, if not longer. 8 legislators participated via ILF scholarship. Paul Penna gave the 2017 unaudited financial report that showed $998,661.76 in revenue and $858,881.09 in expenses for a net operating revenue of $139,780.67. Commissioner Considine suggested that the committee retain Collins & Co. as auditor, noting they charged the same rate as last year and provided a good product. A motion was made by Sen. Hackett and seconded by Sen. Klein and carried on a voice vote.

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

Asm. Cooley stated that the purpose of the model has been revised to ensure that legislators have more opportunities to be engaged and understand insurance policy.

Sen. Rapert asked if he would like the model considered today or deferred so members can digest it further.

Asm. Cooley said he would like to defer to consider comments and observations from members. It can strengthen policymaking and appropriate to keep in comments.
Rep. Lehman stated that Sen. Holdman has been a strong advocate for this type of IBR legislation and it passed the IN House and Senate. There were changes that require department to provide a public record synopsis of what they adopted and transmit it to the Chair of House and Senate Insurance Committees to ensure that it has not strayed beyond their authority.

Commissioner Considine stated that this bill dovetails nicely with an initiative the NAIC has begun to address concerns and IBR issues. NAIC has really reached out in last two years and encouraged more legislators to come to NAIC meetings. This formalizes it in a systemic way.

Secondly, continued Considine, the IBR issue did not originate with NCOIL. Legislators learned about it from industry. However, quite recently, in Indiana, industry moved off its IBR position and suggested that Sen. Holdman could not address it legislatively because it will create a regulatory and financial patchwork. NAIC had said “it’s not our issue, it’s a state-by-state issue.” This model from Asm. Cooley takes care of much of the remaining issues it seems.

Rep. Riggs stated this is much bigger than IBR but about informed decision making and we should look for similar parallel in business, military and other industries.

Asm. Cooley stated that although the Commissioner in California is elected, the state provision has been unchanged since 1923 and charges the Commissioner with implementing statutes. This model is a good way to educate legislators and encourages

them to invite lawmakers to meetings, which is good for national system of insurance. With all the global challenges it strengthens the process.

Sen. Rapert stated that he has been invited to the NAIC Insurance Summit and asked Chara Bradstreet to thanks all commissioners for being here. He also stated the NAIC asked him to speak during the Commissioners Roundtable at NAIC meeting.

Commissioner Considine stated that Commissioner Chaney has been a strong NCOIL advocate and encouraged his colleagues to participate with NCOIL.

Rep. Mulready stated that the NAIC encourages state participation and Commissioner Doak has invited him once a year to attend NAIC meetings.

CONSENT CALENDAR

Sen. Rapert noted there was no action taken at the committee level that requires Executive Committee consideration during the consent calendar.

The Property & Casualty Committee tabled Amendments to Model State Building Codes Act and tabled consideration of the Consumer Protection Model Towing Act.

OTHER SESSIONS

Sen Rapert noted the Griffith Foundation Legislator Luncheon, “A Primer on Captive Insurance” by Prof. Harold Weston at Georgia State University was informative.
He also noted we had high-level speakers at the Spring Meeting including Georgia Gov. Deal, Florida CFO Jimmy Patronis, Randy Pate, Director CCIIO, Randy Maurstad, FEMA Assistant Administrator, and Heather Howard, Center for Health and Wellbeing & Woodrow Wilson School of Public and International Affairs

GENERAL SESSIONS

Sen. Rapert noted the general sessions were timely including the “Health Insurance Exchanges in the Trump Administration – Are Waivers the Solution?” and “Principles Based Regulation – Who Needs Legislation Anyway?”

ATLANTA

Sen Rapert called on Rep. Smith and thanked him and the Georgia delegation, including Rep. Taylor for being such wonder hosts. Rep. Smith thanked NCOIL for being here. Sen. Rapert said he looks forward to seeing everyone in Salt Lake City in July and encouraged legislators to have their colleagues participate.

OTHER BUSINESS

Rep. Riggs made a motion that the Executive Committee extend membership to Texas Rep. Tom Oliverson. Asm. Garbarino seconded and the motion carried on a voice vote.

ADJOURNMENT

There being no further business, the committee adjourned at 12:11 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
INTERIM COMMITTEE CALL
MAY 2, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee held an interim meeting via conference call on May 2, 2018 at 3:00 P.M. (EDT).

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

Other members of the Committees present were:

Rep. Sam Kito, AK
Rep. Deborah Ferguson, AR
Asm. Ken Cooley, CA
Rep. Richard Smith, GA
Rep. Joe Fischer, KY
Rep. George Keiser, ND
Sen. Bob Hackett, OH
Rep. Marguerite Quinn, PA
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

DISCUSSION OF PROPOSED FINAL DRAFT NO.2 OF 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 ALI's Proposed Restatement of the Law of Liability Insurance (Proposed Restatement), NCOIL has been heavily involved due to the concern that several provisions of the Proposed Restatement go beyond established law, and either chart new territory, present a minority perspective, or address matters properly within the legislative prerogative. Sen. Rapert stated that it is important to note that just because legislatures may not have passed laws in an area doesn't mean the legislatures haven't considered the issue. The decision not to pass something, such as bad-faith legislation, is an exercise of the legislative prerogative.

Sen. Rapert stated that the purpose of our meeting today is to discuss Proposed Final Draft No. 2 of the Proposed Restatement before the ALI's Annual Meeting (May 21-23), during which the ALI will consider a final vote on the Proposed Restatement. Sen. Rapert then introduced the invited participants for the meeting:

- Stephanie Middleton - Deputy Director – ALI
- Lorie Masters, Partner - Hunton & Williams
- Victor Schwartz, Chair, Public Policy Group - Shook, Hardy & Bacon, LLP
- Peter Kochenburger - Associate Clinical Professor of Law and Executive Director of the Insurance LLM Program and Deputy Director of the Insurance Law Center - University of Connecticut School of Law
- Laura Foggan, Partner - Crowell & Moring, LLP

Sen. Rapert noted that the ALI has made changes to the Proposed Restatement, and that he looks forward to hearing everyone's perspective as to whether those changes alleviate NCOIL's concerns.

Commissioner Tom Considine, NCOIL CEO, stated that at the NCOIL Spring Meeting in March, it was determined that the nature of the changes made in Proposed Final Draft No.2 would dictate NCOIL's next steps. Accordingly, this is a great opportunity to hear directly from the ALI and others about the changes made to said draft, and to determine how NCOIL should proceed before and after the ALI's Annual Meeting later this month. Cmsr. Considine stated that after discussing the changes to the draft, the Executive Committee will discuss some actions he believes it needs to consider in light of the ALI's changes and if the ALI proceeds with final adoption at its Annual Meeting.

If the Committee embraces the changes, it could endorse the Proposed Restatement. If the Committee does not embrace the changes and remains opposed, NCOIL could: send a follow-up letter to State Judicial Presiding Judges informing them of the Restatement's adoption by the ALI, urging them to not afford it recognition as an authoritative reference; send a letter to state legislators across the country, informing them of the Restatement's adoption by the ALI, urging them to adopt Resolutions declaring that the Restatement should not be afforded recognition by courts as an authoritative reference; develop model legislation intended to accurately state what the settled law is in certain areas of liability insurance. On behalf of NCOIL, Cmsr. Considine thanked the ALI for the changes made thus far to the Proposed Restatement.

Ms. Middleton thanked the Committee for inviting her to participate in the meeting, and thanked NCOIL for following the Proposed Restatement and providing input. The ALI wants to "get it right" with regard to the Proposed Restatement as the ALI does not have an agenda. Ms. Middleton stated that the ALI tries to stay in its lane and respect the legislative prerogative as the ALI knows that statutes trump common law. Ms. Middleton stated that she believes almost everyone can agree that most of the Proposed Restatement is helpful and that both policyholder and insurer representatives have stated that a Restatement of liability insurance law would be helpful and would cut down on litigation.

Ms. Middleton stated that from the beginning of the project the plain-meaning rule has been heavily discussed, and this past January at the ALI Council meeting changes were made to that section (§ 3). Ms. Middleton acknowledged that there still have been concerns voiced about comment (c) to § 3 which deals with when custom, practice, and usage can be considered when deciding whether a term has a plain meaning and, if so, what that plain meaning is. Changes have also been made to § 12 regarding an insurer being liable for the negligence of outside independent counsel representing the policyholder.

Ms. Middleton noted that there is still some controversy regarding § 12, but that she thinks generally, most agree that if the insurer overrides the independent judgment of the independent counsel then it could be liable in circumstances for the bad results of overriding the independent judgment. Ms. Middleton noted the concern that § 12 still states that the insurer could be liable for breach of a duty of care in selecting an independent counsel. The thought there is that if the insurer decides to recommend a son-in-law of someone at the company who does not have any relevant experience, then there should be liability.

Ms. Middleton then noted that key changes have been made to § 19 regarding the consequences for an insurer if it breaches the duty to defend a legal action. The prior draft stated that there were forfeiture of coverage defenses if there is a breach of the duty to defend – that has now been moved to the bad-faith remedies section. Ms. Middleton noted that this is an example of when states have conflicting case law on an issue, the ALI must choose a rule when drafting a Restatement and it has to be clear in the comments why that rule was chosen so courts are clear on the ALI's reasoning. Another substantial change made in the current draft was the elimination of fee-shifting as a remedy.

Ms. Middleton acknowledged that concerns still exist regarding terminating the duty to defend and that she believes there is a drafting issue as she does not believe the Reporters intended to say that you always must go to court to get approval to terminate the duty to defend. Lastly, Ms. Middleton stated that the Reporters may need to clarify that for the remedies available for a breach of contract, whether mitigation is relevant.

Ms. Masters stated that she does not consider herself a "proponent" of the Proposed Restatement – she is a proponent of the process and of the ALI. The point of the ALI's process in drafting Restatements is to reach the best possible result which means that not all interested parties will get everything they want included in the Restatement. Ms. Masters stated that as a policyholder attorney, there are many provisions of the Proposed Restatement that she does not agree with. Ms. Masters stated that she supports the current draft's revised plain-meaning rule section, specifically its provisions dealing with extrinsic evidence and custom and practice.

Ms. Masters stated that with regard to § 27 dealing with damages for breach of the duty to make reasonable settlement decisions, it should be re-examined as it causes confusion. The point of the section is to discuss what kind of damages can be assessed when an insurance company breaches the duty to make reasonable settlement decisions but the discussion in the draft talks about two different issues: it starts with talking about damages that can be assessed but then it gets into the law on insurability of punitive damages. Lastly, Ms. Masters stated that she believes § 24 needs clarification as she does not support its provision that whether claimants are willing to settle can be used in defense in coverage actions.

Professor Schwartz discussed three sections of the Proposed Restatement that do not seem to align with the goal of reducing litigation. Section 8 of the Proposed Restatement deals with rescission and the law in all of the states is if a misrepresentation to an insurer is material, the insurer can modify the policy. However, in the Proposed Restatement the Reporters added a "substantiality" requirement for the misrepresentation to be material. Prof. Schwartz stated that "substantiality" is widely known as a "weasel" word in the legal community and it is a litigation-driver.

Additionally, in § 12, an insurer is under a duty to select good counsel, and to ensure that said counsel has "adequate" malpractice insurance – that is another litigation-driver. Lastly, § 27 is problematic because if there is a breach of a duty to settle, the carrier will be liable for an excess compensatory verdict, but under the provisions of the Proposed Restatement, the insurer is also liable for punitive damages. It is the policy of many states to not insure punitive damages – the bad actor is supposed to "feel the sting" of punitive damages to prevent recidivism.

Professor Kochenburger began by stating that he agrees with Sen. Rapert's statement made earlier that just because legislatures may not have passed laws in an area doesn't mean the legislatures haven't considered the issue. The decision not to pass something, such as bad-faith legislation, is an exercise of the legislative prerogative. Prof. Kochenburger stated that is where common law serves its role – filling in those gaps not addressed by legislatures. When there is significant difference among states on a specific topic, the ALI exists to step in and recommend what they think is the best statement of the law. At any time, legislatures can step in and enact a statute.

Prof. Kochenburger stated that insurance law and contract law blend together in many instances since insurance itself is a contract. There are instances with the Proposed Restatement where the insurance industry wants it both ways as the industry has argued that some provisions are inconsistent with common law contract principles while arguing that other provisions, when consistent with common law contract principles, represent a minority opinion of a specific liability insurance issue. An example is that the Proposed Restatement states that if there is an excess verdict and there was a reasonable opportunity to settle, the insurer is liable for that excess verdict. That is the law in some states and is also a basic element of contract law: consequential damages.

Laura Foggan stated that she agreed with Ms. Masters' statement that the goal of a Restatement is to get it right – it is not to draft something that is beneficial to one industry/group. However, there are some sections in the Proposed Restatement that go too far in one direction and that carry some troubling consequences. There have been important changes made in the current draft but there remain several problematic provisions. Ms. Foggan agreed with Prof. Schwartz's concerns regarding § 8 dealing with rescission. The "substantiality" requirement is a litigation driver and is problematic because it is at odds with existing statutory and common law governing misrepresentation and rescission.

Ms. Foggan stated that § 36 dealing with late notice under a claims made and reported policy is also problematic. That section creates a question of whether late notice under a claims made and reported policy will still be recognized as late if it comes close to the end of the policy and the policy does not contain an extended reporting period. That overrides insurance contract terms and makes a judgment about when a late notice defense should be permitted. Ms. Foggan also shared Prof. Schwartz's concerns about § 12 dealing with adequacy of malpractice insurance. This is a precise example of where the Proposed Restatement goes too far since it takes on what is obviously a very substantial public policy judgment about whether professional liability insurance should be required for attorneys. There are only two (2) jurisdictions that mandate attorney malpractice insurance: Idaho and Oregon. Interestingly, Oregon's attorney malpractice insurance statute derived from a goal of making insurance affordable to attorneys, not consumer protectionism.

Prof. Kochenburger stated that by definition, the Proposed Restatement cannot "go too far" since statutes will always trump any of its provisions. Also, the "substantiality" requirement referenced in § 8 is the law in many states. Prof. Schwartz stated that he agrees with the goal of § 8 but including the word "substantially" is nothing but a litigation-driver.

Asm. Ken Cooley (CA), NCOIL Secretary, stated that it is concerning that some of the characterizations of the issues in the Proposed Restatement will affect how judges evaluate fact patterns. In California, some insurance laws have been decided by voters and it is a very complex task to try and set forth state liability insurance law. Sen. Rapert stated that a proposal to cap damages in certain instances is on the ballot this year in Arkansas.

Rep. George Keiser (ND) stated that he believes there are two alternatives on how to proceed: put together policy statements/best practices on certain liability insurance issues and send them to courts; or, preferably, have courts request that legislatures take up some of the issues mentioned in the Proposed Restatement and enact statutes - that is what happened several years ago with transportation network company (TNC) legislation. It is discouraging that the ALI has considered itself so important that it would draft the Proposed Restatement without consulting legislators, and the result will end up being that legislatures will step in and enact statutes that address certain issues in the Proposed Restatement.

Rep. Matt Lehman (IN), NCOIL Treasurer, stated that he does not believe that the changes made to the current draft are enough to make the Committee comfortable. Rep. Lehman agreed that there are some instances where the insurance industry has wanted it both ways, but he feels that some of the Proposed Restatement's provisions will make it harder on insurance agents and questioned what the next step should be for the Committee to take.

Sen. Rapert stated that the Committee has put its voice behind the Resolution adopted in January encouraging the ALI to make material changes to the Proposed Restatement and asked Cmsr. Considine if the changes made in the current draft are in fact material and enough to alleviate the Committee's concerns.

Cmsr. Considine stated that some of the changes made are substantive and meaningful but there remain many problematic provisions. Cmsr. Considine offered the following course of action for the Committee to consider: if the ALI adopts the Proposed Restatement without any further changes, the Committee could pass an omnibus Model Liability Insurance Law that clarifies what NCOIL believes is the law in specific areas; or pass a series of more specific liability insurance Model Laws that deal with one issue per-Model.

Rep. Lehman stated that one concern is what to do in states that have addressed some of these issues through the ballot as Sen. Rapert and Asm. Cooley mentioned. Rep. Lehman stated that he believes the Committee needs to continue discussing the Proposed Restatement and it can react accordingly after the ALI's Annual Meeting.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE, AND HEALTH RETIREMENT ISSUES COMMITTEE
INTERIM COMMITTEE CONFERENCE CALL
JUNE 8, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health, Long Term Care and Health Retirement Issues Committee held an interim meeting via conference call on Friday, June 8, 2018 at 12:00 P.M.

Assemblyman Kevin Cahill (NY), Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Tom Oliverson, M.D. (TX), Committee Vice-Chair

Sen. Jason Rapert (AR), NCOIL Pres.
Asm. Ken Cooley (CA), NCOIL Sec.
Rep. Richard Smith (GA)
Rep. Matt Lehman (IN), NCOIL Treas.
Rep. Peggy Mayfield (IN)
Rep. Willie Dove (KS)
Rep. Joseph Fischer (KY)
Rep. Justin Hill (MO)
Sen. Valerie Foushee (NC)
Asw. Maggie Carlton (NV)
Asm. Andrew Garbarino (NY)
Sen. Bob Hackett (OH)
Rep. Lewis Moore (OK)
Rep. Glen Mulready (OK)

Other legislators present were:

Rep. Sean Scanlon (CT)

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 FROM CHAIRMAN CAHILL

Assemblyman Kevin Cahill (NY), Chair of the Committee, began by stating that the Committee had an initial, in-depth, discussion on the licensure and regulation of pharmacy benefit managers (PBMs) at the NCOIL Spring Meeting in Atlanta a few months ago. One of the directions of the body was to continue the discussion. In the interim, many events have evolved and developed. Many states have introduced legislation regarding PBMs, some comprehensive in nature, some very specific. Asm. Cahill noted that the federal government is also considering the potential merger of CVS and Aetna. With that mind, this issue is ripe for discussion. Asm. Cahill thanked Senator Jason Rapert (AR) – NCOIL President – for sponsoring the draft PBM Licensure and Regulation Model Act (Model).

REMARKS FROM SENATOR JASON RAPERT (AR) – NCOIL PRESIDENT

Sen. Rapert first welcomed Rep. Sean Scanlon (CT) and acknowledged that CT has recently taken action on gag-clause and rebate legislation. Sen. Rapert thanked everyone for participating on the call and thanked those who submitted comments on the discussion draft of the Model. Sen. Rapert encouraged more comments on the Model to be submitted as they are very helpful. The goal of this entire process is to draft a Model that is manageable as there is a tremendous amount of chaos surrounding this issue. Sen. Rapert hopes to establish a framework that will begin to address the many issues being discussed about PBMs across the country and will ensure that the marketplace is fair for all those involved.

Sen. Rapert noted that the Committee had a great initial discussion on the many issues surrounding PBM's at the NCOIL Spring Meeting this past March. Soon after that meeting, Arkansas Governor Asa Hutchinson signed into law the "Arkansas Pharmacy Benefits Manager Licensure Act" which had garnered bipartisan support. Sen. Rapert noted that he has used that law as the starting point for the development of an NCOIL Model, and that he looks forward to everyone's input moving forward.

Sen. Rapert stated that throughout the past several months he has learned a great deal about PBMs and their business practices, but there remains a lot to learn. PBMs have long played a significant role in our healthcare system, but their role has grown far beyond all original intent and cries out for regulation. PBMs were originally intended only to process claims from the pharmacy to the insurance company for payment but over the past 20 years they have grown into something entirely different. Sen. Rapert stated that when working on the Arkansas PBM law, he and his colleagues learned that it was not just Arkansas that was seeing problems arise with PBMs - many states across the country are having similar problems. Sen. Rapert encouraged everyone on the call to visit the NCOIL website which contains information on state legislative activity relating to PBMs.

Sen. Rapert further stated that many of the problems surrounding PBMs are due to the tremendous amount of information that we simply do not know about them since they are not regulated like all the other industries involved in the prescription drug supply chain. Sen. Rapert stressed that he firmly believes that providing State Insurance Departments with licensure and regulatory authority over PBMs is the best way to proceed to protect consumers. Insurers are regulated by insurance departments, doctors are regulated by medical boards, pharmacists answer to pharmacy boards, but PBMs have no one regulating them and each time someone calls for them to be regulated, PBMs reply that they should not. To bring stability, and to lessen the chaos surrounding these issues, Sen. Rapert stated that he and many others across the country believe that the simplest way to proceed is to empower each state insurance department to have the authority to regulate and monitor the actions of PBMs. State insurance departments can do so without interfering in private contracts and without interfering in PBMs' ability to run their businesses and perform the services they were originally intended to provide.

Sen. Rapert stated that he hopes that after further discussion during the NCOIL Summer Meeting in July, the Model will be ready for consideration and vote at the NCOIL Annual Meeting in early December. It may take another interim telephone meeting of this Committee to make that happen, but it is important that NCOIL have something to offer the State Legislatures around the country when they come into session beginning in January. Sen. Rapert stated that in no way is he trying to tell people or companies that

they cannot do business. Rather, he is saying that it is time for a referee to play a role with PBMs. Sen. Rapert also stated that the first draft of the Arkansas regulations that stem from the Arkansas PBM Licensure and Regulation law have just been released. Sen. Rapert encouraged everyone on the call to review those regulations, and stated that he believes that when interested parties review said regulations, particularly representatives of the Pharmaceutical Care Management Association (PCMA), they will see that many of their concerns with the draft Model are not valid.

DISCUSSION/REVIEW OF DRAFT NCOIL PBM LICENSURE AND REGULATION MODEL ACT

Legislator Comments

Beginning with Section 3 – Definitions - Chairman Cahill noted that many of the comments submitted focused on the definition of "independent pharmacy" with one comment noting that every pharmacy is affiliated with a PBM because they enter into a contract. Tightening that definition may be something that the Committee should give serious consideration to. Sen. Rapert agreed and stated that the intent was to acknowledge that some pharmacies do not have a direct connection. Commissioner Tom Considine, NCOIL CEO, stated that staff will amend the definition to include some type of language acknowledging a corporate relationship as opposed to a contractual relationship. Sen. Rapert agreed and stated that he will discuss the definition with staff.

Rep. Tom Oliverson, M.D. (TX), Vice Chair of the Committee, stated that one of the comments submitted stated that Section 3(b)(2)(viii) – which excludes "health benefit plans that are self-funded and specifically exempted from regulation by this State by ERISA" - from the definition of "health benefit plan" – is overly broad, and that "the model act's protections would not apply to a significant number of beneficiaries who receive health benefits through self-funded employer plans. Under Supreme Court precedent, the model act's provisions, which apply to PBMs, not health benefit plans, are not of the type that run afoul of ERISA." Rep. Oliverson requested comments on that issue. Sen. Rapert stated that said comment sounded like one of the hollow arguments previously submitted by PCMA in Arkansas and that there are no legal issues regarding the Arkansas law which is the basis for the draft NCOIL Model.

Rep. Oliverson stated that the comment he mentioned was submitted by the National Community Pharmacists Association (NCPA). Sen. Rapert stated that he will have to review the draft Model again to ensure that it mirrors the Arkansas law but that he has been told by several attorneys that even mentioning ERISA in legislation is an immediate problem. Sen. Rapert stated that he will work with staff to look at the provision of the Model.

Leeanne Gassaway of America's Health Insurance Plans (AHIP) stated that she believes that provision of the Model is correct and consistent with prevailing law. Sen. Rapert reiterated some attorneys stated to him and his colleagues in Arkansas that mentioning anything about ERISA in legislation is a problem and the legislation can be a point of litigation, which is why ERISA is not mentioned in the Arkansas law, but it is clear that the Arkansas law does not deal with self-funded plans.

In Section 5 – PBM Network Adequacy – Rep. Glen Mulready (OK) asked whether "reasonable distance" – as mentioned in Section 5(a)(1) – was defined in the Arkansas

law. Sen. Rapert stated that is an example of how in the Arkansas law, they intentionally tried to give as much room as possible for the Insurance Department to promulgate proper and necessary rules. Being very specific in legislation with certain terms can be problematic and can have unintended consequences, and by giving the Insurance Department the authority to promulgate rules, said Department can quickly resolve any issues through the rulemaking process rather than through the legislative process.

Rep. Willie Dove (KS) asked why the Model excludes mail-order pharmacies when determining a PBM's network adequacy (section 5(a)(2)). In Kansas, many citizens do not have pharmacies that are a reasonable distance from their homes. Asm. Cahill noted that said provision does not mention anything about prohibiting mail-order pharmacies, rather, the provisions prohibits them from being included in the calculations determining a PBM's network adequacy. Asm. Cahill stated that he believes the fear was that mail-order pharmacies may be used as a substitute for a brick and mortar network. Sen. Rapert agreed and stated that Arkansas is similar to Kansas in that it has many rural areas, and that if mail-order pharmacies were permitted to be included in PBM network adequacy calculations, it would be argued that all networks are adequate since everyone can receive mail.

Cmsr. Considine stated that as someone who used to have to determine network adequacy for a state, although one not quite as rural as Arkansas or Kansas, insurance departments need to make these types of decisions for radiology groups and in rural states there are very few such groups. Accordingly, the Model leaves those decisions to the insurance department since there are fewer of everything in rural parts of the state. It may be that in rural parts of the state the Kansas Insurance Department uses a far greater geography to determine reasonableness for network adequacy than would be used in downtown Manhattan. Accordingly, the Model certainly allows for mail-order pharmacies but just not when calculating PBM network adequacy, and goes back to the individual state insurance departments to allow for calculation of geographic adequacy.

Asm. Ken Cooley, NCOIL Secretary, stated that the face-to-face contact at brick and mortar pharmacies includes the conversations that occur and delivery of medical care to individuals comes through a lot of channels. If someone has access to a pharmacist whom they know or maintain regular contact with, that probably translates into them feeling comfortable enough to ask questions and get advice. Accordingly, there is an element that brick and mortar pharmacies provide that is important to the total system and that the provision in the Model being discussed upholds that value.

Sen. Bob Hackett (OH) asked if the provision being discussed takes away some flexibility from state insurance departments. Sen. Rapert stated that Section 5(b) states that a PBM "network adequacy report describing the pharmacy benefit manager network and the pharmacy benefits manager network accessibility in this state *in the time and manner required by rule issued by the State Insurance Department*." (emphasis added). Accordingly, the Model allows for the state insurance department to tailor its rules to meet the needs and concerns of that state. Sen. Hackett asked what if a conflict emerges where state insurance departments determine that mail-order pharmacies should be used when calculating PBM network adequacy. Sen. Rapert stated that is up to each state insurance department.

Rep. Dove asked for clarification if it was correct that despite the provision stating that mail-order pharmacies shall not be included in the calculations determining PBM

network adequacy, it is up to individual states to calculate what needs to be done to generate the services needed in that state. Sen. Rapert stated yes. Asw. Maggie Carlton (NV) stated that telemedicine is very prevalent in Nevada and asked how Section 5 of the Model addresses that. Sen. Rapert stated that is an example of another issue that would be dealt with in the state insurance department. Rep. Peggy Mayfield (IN) noted that Indiana has urban areas where the crime rate is so high that pharmacies have closed leaving only one (1) in an entire metropolitan area.

In Section 6 – Compensation – Prohibited Practices – Rep. Dove stated that said section appears to be a guaranteed profit for local pharmacies at the expense of consumers and employees and that he does not know of any other business that has such a guaranteed protection. Sen. Rapert stated that the questions Rep. Dove is asking are similar to those asked in Arkansas and the bottom line is that there has not been a problem with pharmacies making a guaranteed profit. The problem has been with something as simple as Tamiflu, pharmacies may need to pay $136 to fill that prescription but then are only reimbursed $36. The problem has been that some PBMs have been reimbursing independent pharmacies at levels that didn't even reimburse them at the cost of the drug. Sen. Rapert stated that in Arkansas, data was presented to him and his colleagues that showed such practices. Outside the discussion of the NCOIL draft Model, there are other issues that Attorneys General and law enforcement are addressing relating to PBM practices. Accordingly, Sen. Rapert stated that Section 6 is meant to reiterate some things that should be stated, but he does not believe he has heard anyone appear before the Arkansas legislature stating that pharmacists are being guaranteed a profit.

Rep. Mulready stated that during negotiations surrounding the Oklahoma PBM law, he heard from legislators that were pharmacists similar complaints about low reimbursements so he asked if they were willing to put a cap on the reimbursement amount. Losing money in parts of businesses is a part of every business, not just the pharmacy business. Rep. Mulready stated that he is uncomfortable guaranteeing a profit on a per-item basis versus a global markup. Pharmacists are not contracting for each individual item that they sell, no different than what a retail store might do. Sen. Rapert asked for the specific section that Rep. Dove and Rep. Mulready are referring to. Rep. Dove replied Section 6(a)(1). Sen. Rapert stated that the operating language in that provision is … "under the standards issued by rule of the State Insurance Department." Accordingly, the department can promulgate rules if it sees clear instances of PBMs trying to drive out independent pharmacists. Asm. Cahill noted that Section 6 is a controversial section that will need further discussion and asked if it was agreeable to discuss that section further at the NCOIL Summer Meeting. Sen. Rapert, Rep. Dove and Rep. Mulready agreed.

In Section 7 – Gag Clauses Prohibited – Asm. Cahill stated that gag clauses are the subject of significant legislative activity across the country and noted that the summary of such activity that is on the NCOIL website. Sen. Rapert stated that when some pharmacies faced the potential of closing and reached out to public officials to state the problems they were having, pharmacies experienced retribution tactics for speaking up. Sen. Rapert stated that he hopes this section remains in the Model.

In Section 8 – Enforcement – Sen. Rapert stated that said section was a point of contention in Arkansas and noted that Section 8(b)(2) stated that "the information or data acquired during an examination under subdivision (b)(1) of this section is: (A) considered

proprietary and confidential; and (B) not subject to the [Freedom of Information Act] of this State."[2] Sen. Rapert noted that it was never the intent in Arkansas, nor his intent in this Model, to do away with the ability of companies to protect their proprietary information. Much like state insurance departments receive and protect confidential and proprietary information from insurance companies, they are in the best position to receive and protect such information from PBMs.

Sen. Hackett asked if that Section means that a company would not, under any circumstances, have to disclose the amount of rebates they are receiving under their contracts. Sen. Rapert stated that they will have to disclose such information, but as the Model states, the information will be considered proprietary, confidential, and not subject to state freedom of information laws.

In Section 12 – Maximum Allowable Cost (MAC) Lists – Sen. Rapert stated that an issue in Arkansas that may be going on in other states is that the Attorney General had the lead on enforcing the MAC, but the Model empowers the the state Insurance Department with the lead on managing the MAC. Asm. Cahill asked if the language in Section 12 mirrors what was adopted in Arkansas. Sen. Rapert stated that the Model should mirror what was adopted in Arkansas. Cmsr. Considine stated that the only changes made to Section 12 were removal of specific references to Arkansas law.

Sen. Hackett asked Sen. Rapert what costs the Arkansas Insurance Department is looking at regarding dealing with administrative appeals under Section 12(b)(4). Sen. Rapert stated that Arkansas Insurance Commissioner Alan Kerr was not concerned about his Department's ability to manage what is called for in Section 12. Sen. Rapert acknowledged that states obviously differ in terms of management practices and budgets, but the Arkansas Insurance Department has managed its budget very well and it has the ability to make adjustments. Sen. Rapert further stated that the Arkansas Insurance Department was very involved and supportive of the Arkansas PBM law, and there is nothing in said law that the Arkansas Insurance Department objected to. Sen. Rapert stated that he had heard from one state that adopted PBM legislation that it did struggle with managing it. Accordingly, Sen. Rapert stated that each state needs to be mindful and listen to their insurance departments saying what they can and cannot handle.

Rep. Mulready asked Sen. Rapert to comment on Section 12(e)(2) which stated that the section "shall not apply to the pharmacy benefit manager employed by the State Medicaid Program or the Employee Benefits Division if, at any time, the State Medicaid Program or the Employee Benefits Division engages the services of a pharmacy benefits manager to maintain a Maximum Allowable Cost List." Sen. Rapert stated that said section is splitting a hair in that it only applies if the State Medicaid Program or the Employee Benefits Division engages the services of a PBM to maintain a MAC.

Rep. Dove stated that it is his understanding that the provisions in Section 12 have been ruled unconstitutional by the 8th Circuit Court of Appeals, and questioned why the Model would contain language ruled as unconstitutional as the Committee should not lead any

[2] Section 8(b)(2)(B) of the Model contains a Drafting Note stating "State FOIAs have different names in different states, often called Open Public Record Acts, Public Records Act, Public Records Law, etc. and thus the specific title used in this subsection needs to be tailored accordingly."

states to a lawsuit. Sen. Rapert stated that is one of the arguments that was made in Arkansas simply made to slow down the process of enacting the law.

In Section 14 – Effective Date – Asm. Cahill stated that an immediate effective date is probably not practical in view of that fact that the regulatory agency will need to have a period of time to make the rules and there would be a need for compliance. Asm. Cahill stated that he is not asking for an amendment at this time but noted that it should be looked at going forward. Sen. Rapert stated that the reason why the Model provides for an immediate effective date is that in Arkansas, they wanted to give the Insurance Department immediate authority to start its rulemaking process, but, subsection (a) of Section 10 – Applicability – states that the "Act is applicable to a contract or health benefit plan issued, renewed, recredentialed, amended, or extended on and after_____." Accordingly, the Department can immediately start the rulemaking process but Section 10(a) provides each state flexibility with when the Act will apply to health benefit plans.

Interested Party Comments

Melodie Shrader of PCMA stated that in Section 3 – Definitions – PCMA agrees with the concerns raised earlier regarding the definition of "independent pharmacy" and concerns also exist with the definition of "Maximum Allowable Cost List." The latter definition could include both brand and generic drugs which Ms. Shrader does not believe is the intent of the Model. PCMA also has concerns with the definition of "Pharmacy acquisition cost" because it fails to take into account for off-invoice adjustments, such as rebates, volume discounts, prompt-pay discounts, etc. PCMA has heard from other insurance departments that those discounts could be as much as 30%, and since this this definition is used in Section 12, it is concerning that profits can be guaranteed to pharmacies.

PCMA also has concerns with the definition of "pharmacy services administrative organization." PSAO's work on behalf of independent pharmacies, not PBMs, so there appears to be a technical error in that definition.

Ms. Gassaway stated that, as noted in AHIP's written comments, although there is a general understanding of the fact that a PBM is not a health plan, a health plan is not a PBM, the Model's definition of PBM needs to be tightened to avoid including licensed health plans that conduct pharmacy benefits internally.

In Section 5 – PBM Network Adequacy – Ms. Gassaway stated that AHIP is concerned that there could be a duplication and/or overlap of standards for PBMs that are providing prescription drug management for a health plan because health plans are already required to provide an adequate network and prove that to the regulators. Having a separate set of requirements for PBMs provide confusion and the section should be tightened to say that if its for a health plan business, the health plan is responsible for providing an adequate network, and it should be regulated at the health plan level, not at PBM level. PBM contracted network providers may be utilized by the health plan but they may not be the sole source – the health plan may have direct contracts of their own. Confusing whose network is whose is a concern.

Ms. Gassaway further stated that AHIP is concerned that Section 5 removes flexibility from state insurance departments by stating that mail-order pharmacies shall not be utilized when calculating PBM network adequacy. There are many parts of the country

where there is no pharmacy and if you hold a health plan or PBM under requirements like Section 5, it could lead to health plans and/or PBMs removing themselves from that service area because it cannot meet the network adequacy requirements.

Asm. Cahill then requested that comments from interested parties on the call be limited to those that differ from any written comments submitted prior to the call. Asm. Cahill also noted that Section 5(a)(2) does not say that mail-order pharmacies cannot be used as part of a network – it says that they cannot be included in the calculations determining PBM network adequacy – those are two very different concepts. Ms. Gassaway stated that if one does not have an adequate network, they cannot serve that part of the state. Asm. Cahill then echoed the comments made earlier regarding Section 5 being subject to insurance departments determining what is the proper way to calculate network adequacy based on its state's specific needs.

John Covello of the Independent Pharmacy Cooperative (IPC) stated that IPC will be submitting written comments and noted that the Model should consider time as well as distance in Section 5, and it should also consider what some states have adopted regarding anti-mail-order mandatory provisions. Those provisions ensure that contracts don't either provide a mandated use or an incentive that is not at parity with retail pharmacies. IPC's written comments will also contain language regarding parity in networks regarding giving the patient the freedom of choice of their pharmacy.

In Section 6 – Compensation – Prohibited Practices - Ms. Shrader stated that PCMA is concerned that the standards for reviewing reimbursement are "fair and reasonable." It is a misconception that independent pharmacies are negotiating with a very large PBM. It is important to note that most often it is a PSAO that is negotiating on behalf of independent pharmacies. According to the U.S. GAO, over 80% of the independent pharmacies use a PSAO. Ms. Shrader stated that the franchise names involved in PSAO's are names everyone is familiar with such as Cardinal Health – they are the ones PBMs most frequently negotiate with on behalf of independent pharmacies.

Ms. Gassaway stated that AHIP believes the broadness of Section 6, when in the hands of an Insurance Commissioner, could lead to price setting in the pharmaceutical arena in terms of how much PBMs should be paying and since there is also an affiliate equalizer in Section 6(b)(4)(A) – that would essentially price-set a cost across an entire set of pharmacies that would be at the complete discretion of the insurance department. AHIP does not believe that the insurance department or any other state agency has been enabled to set prices for any healthcare provider on what they deem is fair and reasonable.

In Section 7 – Gag Clauses prohibited – Mr. Covello stated that language should be added to ensure that when communicating with legislators about legislation or regulation, there be a safe harbor provision. Pharmacists are often reluctant to talk, especially in formal government settings, for fear of retaliation including termination of contracts.

In Section 9 – Rules – Michael O'Neill from Pharmacy Benefit Dimensions (PBD) asked whether under Section 9(a)(2)(k) which permits the Insurance Commissioner to adopt rules relating to "lists of health benefit plans administered by a pharmacy benefit manager in this state", a PBM would be required to submit a list of health benefit plans administered by a PBM in that state or required to submit a list of every health plan

administered by the organization. Sen. Rapert stated that the said sub-section states "in this state."

Ms. Gassaway stated that sub-sections (h) and (j) could lead to price setting by insurance departments since Section 9(a)(2) states that the insurance commissioner may adopt rules…. "without limitation."

In Section 12 – MAC Lists – Ms. Shrader stated that said Section mirrors the Arkansas MAC law that was ruled by the 8th Circuit to be preempted by ERISA and therefore unconstitutional. Lauren Rowley of PCMA stated that the 8th Circuit's opinion stated that the Arkansas MAC law was also preempted by Medicare Part D in addition to ERISA.

Mr. Covello stated that IPC will submit comments regarding the "generic effective rate" which is a methodology PBMs used in totality as to how they pay for generic prices, and it should be included in the Model.

Sen. Rapert noted that the PCMA arguments regarding preemption relate to ERISA and the Arkansas law only applies to the private market. Accordingly, PCMA's arguments are moot.

Hearing no comments on the remaining Sections, Asm. Cahill asked if any interested parties had any summary comments.

Mr. Covello stated that IPC applauds the Model but will be submitting written comments with provisions relating to PBMs that have been moving through state legislatures, particularly those dealing with audit protections.

Sen. Rapert closed by stating that he and the Committee will consider all of submitted and additional comments, and that all are welcome to reach out to him individually. Sen. Rapert stated that he is open to anything that would handle a real problem as far as the Model goes. As far as the necessity for NCOIL to address this problem, it is clear to everybody and it is just a matter of how NCOIL reacts. Sen. Rapert stated that he does not believe that any stakeholders want the Federal government to handle this, and that the regulators that are already regulating the health insurance plans should be the ones to step in to make sure that this particular component of the healthcare industry, namely the PBMs, have some level of oversight.

Sen. Rapert stated that it is much easier for the health plans and all concerned to deal with the insurance regulator in the individual states based upon the needs of that individual market than it is to deal with a one size fits all situation that does not give departments rulemaking authority. The Model is not meant to be a statement that says "everyone must follow Arkansas" – it is drafted in such a way that there are important provisions included that ultimately give the insurance departments the leeway they need to promulgate rules effective for their community and states.

Sen. Rapert further stated that the statements on the call reiterate what were in the written comments and as the Committee moves forward towards Salt Lake City, he hopes everyone will come prepared with ways that they can make the Model better. However, Sen. Rapert cautioned interested parties from coming forward to say that they simply don't want PBMs regulated, because while other legislators may be sympathetic

towards such statements, he will not be. Sen. Rapert stated that we've seen the fallout in this country and we all know PBMs are included among those that have made money during the opioid crisis. Sen. Rapert thanked everyone for their time, thanked Chairman Cahill, and stated that he will save his other comments for later.

ADJOURNMENT

There being no further business, the Committee adjourned at 2:00 p.m.

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

Model Act on Workers' Compensation Repackaged Pharmaceutical Reimbursement Rates

Model expanded and adopted by the NCOIL Executive Committee on July 14, 2013, and by the Workers' Compensation Insurance Committee on July 12, 2013. Originally adopted by the committees on March 10, 2013, and March 9, 2013, respectively. Co-sponsored for discussion by Rep. Bill Botzow (VT) and Rep. Charles Curtiss (TN)

Drafting Note: This model language is intended for inclusion in state insurance code or regulation related to workers' compensation medical fee schedules.

Re-adoption is pending discussion and review of proposed Amendments to the Model that are sponsored by Rep. Marguerite Quinn (PA) and are to be discussed during the NCOIL Workers' Compensation Insurance Committee at the NCOIL Annual Meeting in December 2018

Section 1. Purpose

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

Section 2. Short Title

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

Section 3. Definitions

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

Section 4. Reimbursement for Repackaged Pharmaceutical Products*

A. All pharmaceutical bills submitted for repackaged products must include the National Drug Code (NDC) Number of the original manufacturer registered with the U.S. Food &

Drug Administration (FDA) or its authorized distributor's stock package used in the repackaging process.

B. The reimbursement allowed shall be based on the current published manufacturer's Average Wholesale Price (AWP) of the product, calculated on a per unit basis, as of the date of dispensing.

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. A repackaged NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. If 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.

D. The maximum period during which a provider may dispense a repackaged drug or over-the-counter (OTC) drug is seven days from the date of the employee's initial treatment.

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.

Section 5. Enforcement

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

Section 6. Effective Date

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

* 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)

Pharmacy Benefits Manager Licensure and Regulation Model Act

Sponsored by Sen. Jason Rapert (AR)
Discussion Draft as of May 8, 2018

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Section 1. Title

This Act shall be known as and may be cited as the "[State] Pharmacy Benefits Manager Licensure and Regulation Act."

Section 2. Purpose

(a) This Act establishes the standards and criteria for the regulation and licensure of pharmacy benefits managers providing claims processing services or other prescription drug or device services for health benefit plans.

(b) The purpose of this Act is to:

(1) Promote, preserve, and protect the public health, safety, and welfare through effective regulation and licensure of pharmacy benefits managers;

(2) Provide for powers and duties of the Insurance Commissioner, the State Insurance Department; and

(3) Prescribe penalties and fines for violations of this Act.

Section 3. Definitions

For purposes of this Act:

(a) "Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

(1) Receiving payments for pharmacist services;

(2) Making payments to pharmacists or pharmacies for pharmacist services; or

(3) Both subdivisions (a)(1) and (2) of this section.

(b) (1) "Health benefit plan" means any individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by a healthcare insurer in this state.

(2) “Health benefit plan” does not include:

(i) Accidental-only plans;

(ii) Specified disease plans;

(iii) Disability income plans;

(iv) Plans that provide only for indemnity for hospital confinement;

(v) Long-term care only plans that do not include pharmacy benefits;

(vi) Other limited-benefit health insurance policies or plans; or

(vii) Health benefit plans provided under the Workers’ Compensation Laws of this State

(viii) Health benefit plans that are self-funded and specifically exempted from regulation by this State by The Employee Retirement Income Security Act of 1974 (ERISA)

(c) "Healthcare insurer" means an insurance company, a health maintenance organization, or a hospital and medical service corporation.

(d) “Independent pharmacy” means a pharmacy that is not in any way affiliated with a pharmacy benefits manager.

(e) “Maximum Allowable Cost List” means a listing of drugs used by a pharmacy benefits manager setting the maximum allowable cost on which reimbursement to a pharmacy or pharmacist may be used.

(f) "Other prescription drug or device services" means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including without limitation:

(1) Negotiating rebates, discounts, or other financial incentives and arrangements with drug companies;

(2) Disbursing or distributing rebates;

(3) Managing or participating in incentive programs or arrangements for pharmacist services;

(4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;

(5) Developing formularies;

(6) Designing prescription benefit programs; or

(7) Advertising or promoting services.

(g) “Pharmaceutical wholesaler” means a person or entity that sells and distributes prescription pharmaceutical products, including without limitation a full line of brand-name, generic, and over-the-counter pharmaceuticals, and that offers regular and private delivery to a pharmacy

(h) "Pharmacist" means an individual licensed as a pharmacist by the State Board of Pharmacy.

(i) "Pharmacist services" means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy.

(j) "Pharmacy" means the place licensed by the State Board of Pharmacy in which drugs, chemicals, medicines, prescriptions, and poisons are compounded, dispensed, or sold at retail.

(k) “Pharmacy acquisition cost” means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy’s invoice.

(l) (1) "Pharmacy benefits manager" means a person, business, or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefits manager, that provides claims processing services or other prescription drug or device services, or both, for health benefit plans.

(2) "Pharmacy benefits manager" does not include any:

(i) Healthcare facility licensed in [this State];

(ii) Healthcare professional licensed in [this State];

(iii) Consultant who only provides advice as to the selection or performance of a pharmacy benefits manager; or

(iv) Entity that provides claims processing services or other prescription drug or device services for the fee-for-service [State]Medicaid Program only in that capacity.

(m) "Pharmacy benefits manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one (1) or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefits manager.

(n) “Pharmacy benefits manager network” means a network of pharmacists or pharmacies that are offered by an agreement or insurance contract to provide pharmacist services for health benefit plans.

(o) "Pharmacy benefits plan or program" means a plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmacist services under a health benefit plan.

(p) "Pharmacy services administrative organization" means an organization that helps independent pharmacies and pharmacy benefits managers, or third-party payers achieve administrative efficiencies, including contracting and payment efficiencies.

(q) (1) "Rebate" means a discount or other price concession based on utilization of a prescription drug that is paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefits manager, pharmacy services administrative organization, or pharmacy after a claim has been processed and paid at a pharmacy.

(2) "Rebate" includes without limitation incentives, disbursements, and reasonable estimates of a volume-based discount.

(r) "Third party" means a person, business, or entity other than a pharmacy benefits manager that is not an enrollee or insured in a health benefit plan.

Section 4. License to do business – Annual statement – Assessment

(a) (1) A person or organization shall not establish or operate as a pharmacy benefits manager in this State for health benefit plans without obtaining a license from the Insurance Commissioner under this Act.

(2) The commissioner shall prescribe the application for a license to operate in this State as a pharmacy benefits manager and may charge application fees and renewal fees as established by rule.

(b) (1) The commissioner shall issue rules establishing the licensing, fees, application, financial standards, and reporting requirements of pharmacy benefits managers under this Act and not inconsistent herewith.

Section 5. Pharmacy Benefit Manager Network Adequacy

A pharmacy benefits manager shall provide:

(a) (1) A reasonably adequate and accessible pharmacy benefits manager network for the provision of prescription drugs for a health benefit plan that shall provide for convenient patient access to pharmacies within a reasonable distance from a patient's residence.

(2) A mail-order pharmacy shall not be included in the calculations determining pharmacy benefits manager network adequacy; and

(b) A pharmacy benefits manager network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility in this state in the time and manner required by rule issued by the State Insurance Department.

Section 6. Compensation – Prohibited Practices

(a) (1) The Insurance Commissioner may review and approve the compensation program of a pharmacy benefits manager with a health benefit plan to ensure that the reimbursement for pharmacist services paid to a pharmacist or pharmacy is fair and reasonable to provide an adequate pharmacy benefits manager network for a health benefit plan under the standards issued by rule of the State Insurance Department.

(2) All information and data acquired during the review under subdivision (a)(1) of this section is:

(A) Considered proprietary and confidential; and

(B) Not subject to the [Freedom of Information Act][3] of this State.

(b) A pharmacy benefits manager or representative of a pharmacy benefits manager shall not:

(1) Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading;

(2) Unless reviewed and approved by the commissioner, charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including without limitation a fee for:

(A) The receipt and processing of a pharmacy claim;

(B) The development or management of claims processing services in a pharmacy benefits manager network; or

(C) Participation in a pharmacy benefits manager network;

(3) Unless reviewed and approved by the commissioner in coordination with the State Board of Pharmacy, require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the board;

(4) (A) Reimburse an independent pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services.

(B) The amount shall be calculated on a per-unit basis using the same generic product identifier or generic code number; or

(5) Do any combination of the actions listed in subdivisions (b)(1)-(4) of this section.

(c) A claim for pharmacist services shall not be retroactively denied or reduced after adjudication of the claim, unless:

(1) The original claim was submitted fraudulently;

(2) The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services; or

(3) The pharmacist services were not properly rendered by the pharmacy or pharmacist.

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[3] DRAFTING NOTE: State FOIAs have different names in different states, often called Open Records Acts, Public Records Act, Public Records Law, etc. and thus the specific title used in this subsection needs to be tailored accordingly.

(d) Termination of a pharmacy or pharmacist from a pharmacy benefits manager network shall not release the pharmacy benefits manager from the obligation to make any payment due to the pharmacy or pharmacist for pharmacist services properly rendered.

(e) The commissioner may issue a rule establishing prohibited practices of pharmacy benefits managers providing claims processing services or other prescription drug or device services for health benefit plans.

Section 7. Gag clauses prohibited

(a) In any participation contracts between pharmacy benefits managers and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted, or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers or similar persons to authorize or deny services, the process that is used to authorize or deny healthcare services or benefits, or information on financial incentives and structures used by the insurer.

(b) A pharmacy or pharmacist may provide to an insured information regarding the insured's total cost for pharmacist services for a prescription drug.

(c) A pharmacy or pharmacist shall not be proscribed by a pharmacy benefits manager from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured if a more affordable alternative is available.

(d) A pharmacy benefits manager contract with a participating pharmacist or pharmacy shall not prohibit, restrict, or limit disclosure of information to the Insurance Commissioner, law enforcement, or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefits manager's compliance with the requirements under this Act.

Section 8. Enforcement

(a) The Insurance Commissioner shall enforce this Act.

(b) (1) The commissioner may examine or audit the books and records of a pharmacy benefits manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine if the pharmacy benefits manager is in compliance with this Act.

(2) The information or data acquired during an examination under subdivision (b)(1) of this section is:

(A) Considered proprietary and confidential; and

(B) Not subject to the [Freedom of Information Act][4] of this State

Section 9. Rules

(a) (1) The Insurance Commissioner may adopt rules regulating pharmacy benefits managers that are not inconsistent with this Act.

(2) Rules that the commissioner may adopt under this Act include without limitation rules relating to:

(A) Licensing;

(B) Application fees;

(C) Financial solvency requirements;

(D) Pharmacy benefits manager network adequacy;

(E) Prohibited market conduct practices;

(F) Data reporting requirements under State price-gouging laws

(G) Compliance and enforcement requirements under State laws concerning Maximum Allowable Cost Lists;

(H) Rebates;

(I) Prohibitions and limitations on the corporate practice of medicine (CPOM)[5];

(J) Compensation; and

(K) Lists of health benefit plans administered by a pharmacy benefits manager in this state.

(b) Rules adopted under this Act shall set penalties or fines, including without limitation monetary fines, suspension of licensure, and revocation of licensure for violations of this

[4] DRAFTING NOTE: State FOIAs have different names in different states, often called Open Records Acts, Public Records Act, Public Records Law, etc. and thus the specific title used in this subsection needs to be tailored accordingly.

[5] DRAFTING NOTE: Commissioners may wish to evaluate whether PBMs disregarding of physicians' prescribing practices and substituting their (PBMs') own judgment through the use of mandated step therapy constitutes the practice of medicine.

Act and rules adopted under this Act.

Section 10. Applicability

(a) This Act is applicable to a contract or health benefit plan issued, renewed, recredentialed, amended, or extended on and after _____.

(b) A contract existing on the date of licensure of the pharmacy benefits manager shall comply with the requirements of this Act as a condition of licensure for the pharmacy benefits manager.

(c) This Act is not applicable to health benefit plans that are self-funded and specifically exempted from regulation by this State by The Employee Retirement Income Security Act of 1974 (ERISA).

Section 11. Annual Report

(a)(1) Unless otherwise required more frequently by the Insurance Commissioner, a pharmacy benefits manager shall file an annual report with the commissioner pursuant to the timing, format, and requirements issued by rule of the State Insurance Department.

(2) The annual report shall contain information regarding:

(i) when seeking payment or reimbursement for pharmacist services provided in connection with a pharmacy benefits plan or program or reporting expenditures for pharmacist services provided in connection with a pharmacy benefits plan or program, a pharmacy benefits manager shall itemize by individual claim:

(1) The amount actually paid or to be paid to the pharmacy or pharmacist for the pharmacist services;

(2) The identity of the pharmacy or pharmacist actually paid or to be paid; and

(3) The prescription number or other identifier of the pharmacist services.

(b) The annual report shall be considered proprietary and confidential and not subject to the [Freedom of Information Act][6] of this State.

Section 12. Maximum Allowable Cost Lists

(a) Before a pharmacy benefits manager places or continues a particular drug on a Maximum Allowable Cost List, the drug:

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[6] DRAFTING NOTE: State FOIAs have different names in different states, often called Open Records Acts, Public Records Act, Public Records Law, etc. and thus the specific title used in this subsection needs to be tailored accordingly.

(1) Shall be listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or "Green Book" or has an NR or NA rating by Medi-span, Gold Standard, or a similar rating by a nationally recognized reference;

(2) Shall be available for purchase by each pharmacy in the state from national or regional wholesalers operating in this State; and

(3) Shall not be obsolete.

(b) A pharmacy benefits manager shall:

(1) Provide access to its Maximum Allowable Cost List to each pharmacy subject to the Maximum Allowable Cost List;

(2) Update its Maximum Allowable Cost List on a timely basis, but in no event longer than seven (7) calendar days from an increase of ten percent (10%) or more in the pharmacy acquisition cost from sixty percent (60%) or more of the pharmaceutical wholesalers doing business in the state or a change in the methodology on which the Maximum Allowable Cost List is based or in the value of a variable involved in the methodology;

(3) Provide a process for each pharmacy subject to the Maximum Allowable Cost List to receive prompt notification of an update to the Maximum Allowable Cost List; and

(4) (A) (i) Provide a reasonable administrative appeal procedure to allow pharmacies to challenge maximum allowable costs and reimbursements made under a maximum allowable cost for a specific drug or drugs as:

(a) Not meeting the requirements of this section; or

(b) Being below the pharmacy acquisition cost.

(ii) The reasonable administrative appeal procedure shall include the following:

(a) A dedicated telephone number and email address or website for the purpose of submitting administrative appeals;

(b) The ability to submit an administrative appeal directly to the pharmacy benefits manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization; and

(c) No less than seven (7) business days to file an administrative appeal.

(B) The pharmacy benefits manager shall respond to the challenge under subdivision (c)(4)(A) of this section within seven (7) business days after receipt of the challenge.

(C) If a challenge is under subdivision (c)(4)(A) of this section, the pharmacy benefits manager shall within seven (7) business days after receipt of the challenge either:

(i) If the appeal is upheld:

(a) Make the change in the maximum allowable cost;

(b) Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question;

(c) Provide the National Drug Code number that the increase or change is based on to the pharmacy or pharmacist; and

(d) Make the change under subdivision (c)(4)(C)(i)(a) of this section effective for each similarly situated pharmacy as defined by the payor subject to the Maximum Allowable Cost List;

(ii) If the appeal is denied, provide the challenging pharmacy or pharmacist the National Drug Code number and the name of the national or regional pharmaceutical wholesalers operating in this State that have the drug currently in stock at a price below the Maximum Allowable Cost List; or

(iii) If the National Drug Code number provided by the pharmacy benefits manager is not available below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale, then the pharmacy benefits manager shall adjust the Maximum Allowable Cost List above the challenging pharmacy's pharmacy acquisition cost and permit the pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged maximum allowable cost.

(c) (1) A pharmacy benefits manager shall not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services.

(2) The amount shall be calculated on a per unit basis based on the same generic product identifier or generic code number.

(d) A pharmacy or pharmacist may decline to provide the pharmacist services to a patient or pharmacy benefits manager if, as a result of a Maximum Allowable Cost List, a pharmacy or pharmacist is to be paid less than the pharmacy acquisition cost of the pharmacy providing pharmacist services.

(e) (1) This section does not apply to a Maximum Allowable Cost List maintained by the State Medicaid Program or the Employee Benefits Division.

(2) This section shall apply to the pharmacy benefits manager employed by the State Medicaid Program or the Employee Benefits Division if, at any time, the State Medicaid Program or the Employee Benefits Division engages the services of a pharmacy benefits manager to maintain a Maximum Allowable Cost List.

(f) A violation of this section is a deceptive and unconscionable trade practice under the [State] Deceptive Trade Practices Act, a prohibited practice under this Act, and the [State] Trade Practices Act.

Section 13. Severability Clause

If any provision of this act or the application of this act to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are declared severable.

Section 14. Effective Date

This Act is effective immediately.

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)
Model Act Regarding Auto Airbag Fraud

Adopted by the NCOIL Executive Committee on November 22, 2009.

To be considered for re-adoption by the NCOIL Property & Casualty Insurance Committee on July 12, 2018

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Section 1. Purpose

Airbag system fraud is a public safety concern for consumers and the automobile insurance system. Efforts to combat this problem—one that could place innocent consumers at risk of serious bodily injuries—have been piecemeal. This model is intended to address the issue in a coordinated way. It is through this collective effort that consumers will be protected and the integrity of the restraint system assured.

Section 2. Summary

The Act establishes criminal penalties for fraudulent installation or reinstallation of an airbag, with more severe penalties for persons whose airbag fraud results in serious injury or death; requires that any person engaged in the business of purchasing, selling, or installing an airbag maintain detailed records of airbags they purchase, sell, or install; mandates that any person engaged in the business of installing an airbag submit an affidavit to a vehicle owner saying that an airbag was installed properly; requires a person repairing a vehicle to affix a permanent dashboard label disclosing that a salvaged airbag had been used; establishes that police accident reports must note whether an airbag deployed; and provides that a person trading or selling a motor vehicle must disclose whether an airbag is inoperable.

Section 3. Definitions

A. “Airbag” means any component of an inflatable occupant restraint system that is designed in accordance with federal safety regulations for the make, model, and year of the vehicle to be installed and to operate in a motor vehicle to activate, as specified by the vehicle manufacturer, in the event of a crash. Airbag components include but are not limited to sensors, controllers, wiring, and the airbag itself.

B. “Light manipulating system” means anything that would mask or cause the inaccurate indication of the airbag system status, condition, or operability.

C. “Person” means any natural person, corporation, partnership, unincorporated association, or other entity.

D. “Salvaged airbag” means an OEM non-deployed airbag that has been removed from a motor vehicle for use in another vehicle.

Section 4. Installation or reinstallation of any false airbag; deceptive trade practices; criminal liability

A. It is a deceptive trade practice when:

1. a person installs or reinstalls, as part of a vehicle inflatable occupant restraint system, any object in lieu of an airbag, including any light manipulating system

2. a person sells or offers for sale any device with the intent that such device will replace an airbag in any motor vehicle if such person knows or reasonably should know that such device does not meet federal safety requirements

3. a person sells or offers for sale any device that when installed in any motor vehicle gives the impression that a viable airbag is installed in that vehicle, including any light manipulating system

4. any person intentionally misrepresents the presence of an airbag when one does not exist

B. Any person who violates this section is guilty of a felony and, upon conviction thereof, shall be punished by a fine of not less than $ ____ and not more than $ ____ per violation, or imprisonment in [insert facility] for up to ____ year(s), or both.

C. A person whose violation of subsection A(1) of this section results in serious bodily injury or death shall be imprisoned for not more than _____ years or fined not more than $_____, or both.

Section 5. Airbag antitheft

A. Purchase, sale, or installation of new or salvaged airbag; records

1. Any person engaged in the business of purchasing, selling, or installing salvaged airbags shall maintain a manual or electronic record of the purchase, sale, or installation, which must include the identification number of the airbag;

the vehicle identification number of the vehicle from which the salvaged airbag was removed; the name, address, and driver's license number or other means of identification of the person from whom the salvaged airbag was purchased; and, in the event that the salvaged airbag is installed, the vehicle identification number of the vehicle into which the airbag is installed. No new or salvaged airbag shall be sold or installed which is or has been subject to a specific manufacturer's or appropriate authority's notice of recall.

2. In the case of a new replacement airbag, any person engaged in installing any airbag shall maintain the name and tax identification number of the supplier of the airbag and record the vehicle identification number of the vehicle into which the airbag is installed, as well as the identification number of the airbag being installed. Additionally, the airbag identification of the previously deployed airbag being replaced shall be recorded. Upon request of any law enforcement officer of this state or other authorized representative of the agency charged with administration of this section, the installer shall produce such records and permit said agent or police officer to examine them.

3. Any person who installs a salvaged airbag in a vehicle shall apply a permanent, durable label that clearly states that the vehicle contains a salvaged airbag. Such label must be permanently installed on the dashboard of the vehicle. Any person who removes such a label shall be guilty of a criminal offense.

4. Any person who sells a salvaged airbag or who installs a salvaged airbag must disclose to the purchaser and vehicle owner that the airbag is salvaged.

5. The person who installs a new or salvaged airbag shall submit an affidavit to the vehicle owner or their representative stating that the replacement airbag had been properly installed.

6. All records must be maintained for not less than five years following the transaction and may be inspected during normal business hours by any law enforcement officer of this state or other authorized representative of the agency charged with administration of this section.

7. Upon request, information within a portion of such record pertaining to a specific transaction must be provided to the insurer and the vehicle owner.

8. Persons engaged in the business of selling salvage airbags shall comply with regulations developed by the [insert appropriate state agency].

9. State rules regarding the sale of salvaged airbags shall include but not be limited to the following standards:

a. identification of the supplier of the unit

b. identification of the recipient vehicle, including VIN, year, make, and model

c. identification of the airbag module cover color (and color code if available)

d. identification of the donor vehicle, including VIN, year, make, and model

e. supplier's internal stock number or locator number

f. indication of source of interchange information (i.e. interchange manual/part number, OEM info, etc.)

g. a supplier certificate indicating that all the requirements of the inspection protocol have been successfully achieved and identifying the person who completed the inspection

h. a document containing the vehicle description including the year, make, and model for which the airbag system component is required when being sold to the end-user

10. Salvage airbags conforming to such standards shall be accompanied by a Certificate of Conformance which shall be retained by the installer.

Drafting Note: Each state should consider allowing the regulator to adopt a protocol to insure that only salvaged airbags that have met specific criteria are used.

B. *Prohibition; penalties*

1. It is unlawful for any person to knowingly possess, sell, or install a stolen airbag; an airbag from which the manufacturer's part number labeling and/or VIN has been removed, altered, or defaced; or an airbag taken from a stolen motor vehicle. Any person who violates this paragraph commits a felony of the [insert degree].

2. Any person who fails to maintain complete and accurate records, to prepare complete and accurate documents, to provide information from such record upon request, or to properly disclose that an airbag is salvaged, as required by this Act, commits a misdemeanor.

Section 6. Accidents; police authorities report

Any automobile vehicle accident report that is filed by the appropriate law enforcement agency shall clearly contain a notation as to whether the automobile's airbag or inflatable restraint system had been deployed in the accident.

Drafting Note: Airbag systems often contain seatbelt pretensioners that, once deployed, must be replaced in order to restore the integrity of the airbag system. In some crashes, the pretensioners will deploy in conjunction with the airbags and in other crashes the pretensioners will deploy even if the airbag does not. Because law enforcement officers may miss the pretensioner deployment if it is not accompanied by release of an airbag,

officers should be educated to recognize and report that a pretensioner has deployed and must be replaced.

Section 7. Sale or trade of motor vehicle with an inoperable airbag

A. Any person selling or trading a motor vehicle who has actual knowledge that the motor vehicle's airbag is inoperable shall notify the buyer or the person acquiring the trade, in writing, that the airbag is inoperable.

B. A person who violates subsection A of this section is subject to civil and/or criminal prosecution at the selection of the state.

Section 8. Severability

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

Section 9. Effective Date

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

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

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding Disclosure of Rental Vehicle Damage Waivers

Adopted by the NCOIL Executive Committee on March 1, 2008.
Sponsored by Sen. Alan Sanborn, MI

To be considered for re-adoption by the NCOIL Property & Casualty Insurance Committee on July 12, 2018*

Section 1. Purpose
The purpose of this Act is to amend a state's general business/consumer protection law to require that rental vehicle companies make certain disclosures to consumers prior to offering optional rental vehicle damage waivers.

Section 2. Definitions
For the purposes of this Act, the following terms mean:

A. Damage waiver—a provision in an agreement in which a rental vehicle company agrees, for a fee, to waive any claims against a renter of a motor vehicle for any damage to (including loss of use), or theft of, the motor vehicle that occurs during the term of the rental agreement, provided the rental motor vehicle is being operated in accordance with the terms and conditions of the rental agreement.

B. Rental agreement—a written agreement that contains the terms and conditions governing the use of a rented motor vehicle by a consumer for a period of not more than 60 days. The term includes any additional or supplemental agreements executed as part of the rental agreement.

C. Rental vehicle company—any person or organization, or any subsidiary or affiliate, including a franchisee, in the business of providing rental vehicles to the public from locations in this state

Section 3. Disclosure Requirements
The general business/consumer protection act of the State of [insert state] is hereby amended to include the following:

A. A rental vehicle company shall not offer a damage waiver to a consumer as an optional provision in a rental agreement for a motor vehicle unless the rental agreement contains all of the following statements:

1. the purchase of a damage waiver is optional

2. the purchase of a damage waiver is not required to rent a motor vehicle
3. the renter may wish to contact his or her insurance representative or credit card company to obtain some or all of the following information:

a. his or her coverage or protection, if any, for damage to or theft of a rented motor vehicle

b. the amount of his or her insurance deductible or out-of-pocket risk for filing a claim for damage to, or theft of, a rented motor vehicle

B. At each place of business in this state at which the rental vehicle company rents motor vehicles to consumers, the rental vehicle company must have written materials or brochures readily available that contain all of the statements described in Paragraph A.

Section 4. Effective Date
This part shall take effect [60 days] after enactment.

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

State Flood Disaster Mitigation and Relief Model Act

Amended by the NCOIL Property-Casualty Insurance Committee on July 11, 2008, and Executive Committee on July 13, 2008.
Originally adopted by the NCOIL Property-Casualty Insurance and Executive Committees on November 21, 2003.

To be considered for re-adoption by the NCOIL Property & Casualty Insurance Committee on July 12, 2018

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Part IV. Miscellaneous Provisions Regarding Participation

Section 1. Purpose

The legislature finds that unforeseen periodic flood disasters cause personal hardship and economic distress, requiring substantial disaster relief that strains limited state resources. In order to provide a sustainable system to provide disaster relief, the U.S. Congress has established the National Flood Insurance Program (NFIP), which provides flood insurance in conjunction with the private insurance industry. The legislature further finds the viability of this essential program requires the participation of state and local governments to mitigate the hazard and lower the magnitude of the potential disasters.

This Act develops a multifaceted state program of insurance producer and realtor education; local floodplain zoning; mandatory purchase of flood insurance by, and notification by lenders to, property owners in a floodplain; property owner self-certification of compliance; and other measures to improve floodplain management and hazard mitigation.

Section 2. Short Title

This act may be called the State Flood Disaster Mitigation and Relief Model Act.

PART I. FLOOD INSURANCE COVERAGE AND NOTICE

Sec. 1. Flood insurance purchase and compliance requirements and escrow accounts

(a) Requirement of State officers/agencies. After 60 days following the passage of this Act, no state officer or agency shall approve any financial assistance for acquisition or construction purposes for use in any area that has been identified by the Director of the Federal Emergency Management Agency (FEMA) or designee as an area having special flood hazards and in which the sale of flood insurance has been made available under the National Flood Insurance Act, 42 U.S.C. Chapter 50, unless the building or mobile home and any personal property to which such financial assistance relates is covered by flood insurance in an amount at least equal to its development or project cost (less estimated land cost) or to the maximum limit of coverage made available with respect to the particular type of property under the National Flood Insurance Act, 42

U.S.C. Chapter 50, whichever is less. If the financial assistance provided is in the form of a loan or an insurance or guaranty of a loan, the amount of flood insurance required need not exceed the outstanding principal balance of the loan and need not be required beyond the term of the loan. The requirement of maintaining flood insurance shall apply during the life of the property, regardless of transfer of ownership of such property.

(b) Requirement for mortgage loans.

(1) Regulated lending institutions. Each [State entity for lending regulation] shall by regulation direct regulated lending institutions not to make, increase, extend, or renew any loan secured by improved real estate or a mobile home located or to be located in an area that has been identified by the Director as an area having special flood hazards and in which flood insurance has been made available under the National Flood Insurance Act, 42 U.S.C. Chapter 50, unless the building or mobile home and any personal property securing such loan is covered for the term of the loan by flood insurance in an amount at least equal to the outstanding principal balance of the loan or the maximum limit of coverage made available under the Act with respect to the particular type of property, whichever is less.

(2) Applicability

(A) Existing coverage. Except as provided in subdivision (b)(1), this subsection shall apply [three months] after the effective date of this Act.

(B) New coverage. This subsection shall apply only with respect to any loan made, increased, extended, or renewed after the expiration of the one-year period beginning [three months] after the effective date of this Act.

(3) Small loans. Notwithstanding any other provision of this Sec. 1, subsections (a) and (b) of this section shall not apply to any loan having

(A) an original outstanding principal balance of $5,000 or less; and

(B) a repayment term of one year or less.

(c) Escrow of flood insurance payments.

(1) Regulated lending institutions. Each [State entity for lending regulation] shall by regulation require that, if a regulated lending institution requires the escrowing of taxes, insurance premiums, fees, or any other charges for a loan secured by residential improved real estate or a mobile home, then all premiums and fees for flood insurance under the National Flood Insurance Act, 42 U.S.C. Chapter 50 for the real estate or mobile home shall be paid to the regulated lending institution or other servicer for the loan in a manner sufficient to make payments as due for the duration of the loan. Upon receipt of the premiums, the regulated lending institution or servicer of the loan shall deposit the premiums in an escrow account on behalf of the borrower. Upon receipt of a notice from the [State entity for lending regulation] or the provider of the insurance that insurance premiums are due, the regulated lending institution or servicer shall pay from the escrow account to the provider of the insurance the amount of insurance premiums owed.

(2) “Residential improved real estate” defined. For purposes of this subsection, the term “residential improved real estate” means improved real estate for which the improvement is a residential building.

(3) Applicability. This subsection shall apply only with respect to any loan made, increased, extended, or renewed after [one year following the passage of this Act].

(d) Placement of flood insurance by lender.

(1) Notification to borrower of lack of coverage. If, at the time of origination or at any time during the term of a loan secured by improved real estate or by a mobile home located in an area that has been identified by the Director (at the time of the origination of the loan or at any time during the term of the loan) as an area having special flood hazards and in which flood insurance is available under the National Flood Insurance Act, 42 U.S.C. Chapter 50, the lender or servicer for the loan determines that the building or mobile home and any personal property securing the loan is not covered by flood insurance or is covered by such insurance in an amount less than the amount required for the property pursuant to subdivision (b)(1), (2), or (3) of this Sec. 1, the lender or servicer shall notify the borrower under the loan that the borrower should obtain, at the borrower's expense, an amount of flood insurance for the building or mobile home and such personal property that is not less than the amount under subdivision (b)(1) of this Sec.1, for the term of the loan.

(2) Purchase of coverage on behalf of borrower. If the borrower fails to purchase such flood insurance within 45 days after notification under subdivision (d)(1), the lender or servicer for the loan shall purchase the insurance on behalf of the borrower and may charge the borrower for the cost of premiums and fees incurred by the lender or servicer for the loan in purchasing the insurance.

(3) Review of determination regarding required purchase.

(A) In general. The borrower and lender for a loan secured by improved real estate or a mobile home may jointly request the Director to review a determination of whether the building or mobile home is located in an area having special flood hazards. Such request shall be supported by technical information relating to the improved real estate or mobile home. Not later than 45 days after the Director receives the request, the Director shall review the determination and provide to the borrower and the lender a letter stating whether or not the building or mobile home is in an area having special flood hazards. The determination of the Director shall be final.

(B) Effect of determination. Any person to whom a borrower provides a letter issued by the Director pursuant to subdivision (d)(3)(A), stating that the building or mobile home securing the loan of the borrower is not in an area having special flood hazards, shall have no obligation under this title to require the purchase of flood insurance for such building or mobile home during the period determined by the Director, which shall be specified in the letter and shall begin on the date on which such letter is provided.

(C) Effect of failure to respond. If a request under subdivision (d)(3)(A) is made in connection with the origination of a loan and the Director fails to provide a letter under subdivision (d)(3)(A) before the later of either (i) the expiration of the 45-day period under such subdivision, or (ii) the closing of the loan, no person shall have an obligation under this title to require the purchase of flood insurance for the building or mobile home securing the loan until such letter is provided.

(4) Applicability. This subsection (d) shall apply to all loans outstanding on or after [three months following the passage of this Act].

(e) Civil monetary penalties for failure to require flood insurance or to notify.

(1) Civil monetary penalties against regulated lenders. Any regulated lending institution that is found to have a pattern or practice of committing violations under subdivision (e)(2) (below) shall be assessed a civil penalty by the [appropriate State entity for lending regulation] in the amount provided under subdivision (e)(4) (below).

(2) Lender violations. The violations referred to in subdivision (e)(1) shall include:

(A) making, increasing, extending, or renewing loans in violation of:

(i) the regulations issued pursuant to subsection (b) of this Sec. 1;

(ii) the escrow requirements under subsection (c) of this Sec. 1; or

(iii) the notice requirements under Sec. 2 of this Part (below); or

(B) failure to provide notice or purchase flood insurance coverage in violation of subsection (e) of this section.

(3) Notice and hearing. A penalty under this subsection (e) may be issued only after notice and an opportunity for a hearing on the record.

(4) Amount. A civil monetary penalty under this subsection may not exceed $350 for each violation cited under subdivision (e)(2). The total amount of penalties assessed under this subsection against any single regulated lending institution or enterprise during any calendar year may not exceed $100,000.

(5) Lender compliance. Notwithstanding any State or local law, for purposes of this subsection (e), any regulated lending institution that purchases flood insurance or renews a contract for flood insurance on behalf of or as an agent of a borrower of a loan for which flood insurance is required shall be considered to have complied with the regulations issued under subsection (b) of this Sec. 1.

(6) Effect of transfer on liability. Any sale or other transfer of a loan by a regulated lending institution that has committed a violation under subdivision (e)(1), which occurs subsequent to the violation, shall not affect the liability of the transferring lender with respect to any penalty under this subsection. A lender shall not be liable for any violations relating to a loan committed by another regulated lending institution that previously held the loan.

(7) Deposit of penalties. Any penalties collected under this subsection shall be paid into the Hazard Mitigation and Floodplain Management Account established in Sec. 4 of Part III of this Act. [Drafting note: This money could be targeted for floodplain mapping.]

(8) Additional penalties. Any penalty under this subsection shall be in addition to any civil remedy or criminal penalty otherwise available.

(9) Statute of limitations. No penalty may be imposed under this subsection after the expiration of the [four-year period] beginning on the date of the occurrence of the violation for which the penalty is authorized under this subsection.

(f) Other actions to remedy pattern of noncompliance.

(1) Authority of State entities for lending regulation. A [State entity for lending] regulation may require a regulated lending institution to take such remedial actions as are necessary to ensure that the regulated lending institution complies with the requirements of the National Flood Insurance Program if the State agency for lending regulation makes a determination under subdivision (f)(2) (below) regarding the regulated lending institution.

(2) Determination of violations. A determination under this subdivision shall be a finding that:

(A) the regulated lending institution has engaged in a pattern and practice of noncompliance in violation of the regulations issued pursuant to

subsection (b), (c), or (d) of this Sec. 1 or the notice requirements under Sec. 2 of this Part; and

(B) the regulated lending institution has not demonstrated measurable improvement in compliance despite the assessment of civil monetary penalties under subsection (e) of this Sec. 1.

(g) Fee for determining location. Notwithstanding any other Federal or State law, any person who makes a loan secured by improved real estate or a mobile home or any servicer for such a loan may charge a reasonable fee for the costs of determining whether the building or mobile home securing the loan is located in an area having special flood hazards, but only in accordance with the following requirements:

(1) Borrower fee. The borrower under such a loan may be charged the fee, but only if the determination:

(A) is made pursuant to the making, increasing, extending, or renewing of the loan that is initiated by the borrower;

(B) is made pursuant to a revision or updating under 42 U.S.C. 4101(f) of the floodplain areas and flood-risk zones or publication of a notice or compendia under subsection (h) or (i) of 42 U.S.C. 4101(h) or (i) that affects the area in which the improved real estate or mobile home securing the loan is located or that, in the determination of the Director, may reasonably be considered to require a determination under this subsection; or

(C) results in the purchase of flood insurance coverage pursuant to the requirement under subdivision (d)(2) of this Sec. 1.

(2) Purchaser or transferee fee. The purchaser or transferee of such a loan may be charged the fee in the case of sale or transfer of the loan.

Sec. 2. Notice requirements

(a) Notification of special flood hazards.

(1) Regulated lending institutions. Each [State entity for lending regulation] shall by regulation require regulated lending institutions, as a condition of making, increasing, extending, or renewing any loan secured by improved real estate or a mobile home that the regulated lending institution determines is located or is to be located in an area that has been identified by the Director under 42 U.S.C. Chapter 50 as an area having special flood hazards, to notify the purchaser or lessee (or to obtain satisfactory assurances that the seller or lessor has notified the purchaser or lessee) and the servicer of the loan of such special flood hazards, in writing, a reasonable period in advance of the signing of the purchase agreement, lease, or other documents involved in the transaction. The regulations also shall require that the regulated lending institution retain a record of the receipt of the notices by the purchaser or lessee and the servicer.

(2) Contents of notice. Written notification required under this subsection (a) shall include:

(A) a warning, in a form to be established by the [State entity for lending regulation], stating that the building on the improved real estate securing the loan is located, or the mobile home securing the loan is or is to be located, in an area having special flood hazards;

(B) a description of the flood insurance purchase requirements under section 102(b) of the Flood Disaster Protection Act, 42 U.S.C. Chapter 50;

(C) a statement that flood insurance coverage may be purchased under the National Flood Insurance Program and also is available from private insurers; and
(D) any other information that the [State entity for lending regulation] considers necessary to carry out the purposes of the National Flood Insurance Program.

(b) Notification of change of servicer.

(1) Lending institutions. Each [State entity for lending regulation] shall by regulation require regulated lending institutions, in connection with the making, increasing, extending, renewing, selling, or transferring any loan described in subdivision (b)(1) of this Sec. 1, to notify, in writing, the [State entity for lending regulation] of the servicer of the loan during the term of the loan. Such institutions shall also notify the [State entity for lending regulation] of any change in the servicer of the loan, not later than 60 days after the effective date of such change. The regulations under this subsection shall provide that, upon any change in the servicing of a loan, the duty to provide notification under this subsection shall transfer to the transferee servicer of the loan.

(c) Notification of expiration of insurance. The [State entity for lending regulation] shall, not less than 45 days before the expiration of any contract for flood insurance under this chapter, issue notice of such expiration by first-class mail to the owner of the property covered by the contract, the servicer of any loan secured by the property covered by the contract, and (if known to the [State entity for lending regulation]) the owner of the loan.

Sec. 3. Rules; report

(a) The [State entity for lending regulation] is authorized to adopt rules to implement this Part I.
(b) The [State entity for lending regulation] shall submit a report to the legislature on the implementation of this Part I and on compliance with the rules one year after passage.

PART II. FLOODPLAIN REGULATION

Sec. 1. Purposes

The purposes of this Part are to:

(1) Minimize the extent of floods by preventing obstructions that inhibit water flow and increase flood height and damage.

(2) Prevent and minimize loss of life, injuries, property damage, and other losses in flood hazard areas.

(3) Promote the public health, safety, and welfare of citizens of the State in flood hazard areas.

Sec. 2. Definitions

(a) As used in this Part:

(1) “Agency” means the state agency in charge of floodplain regulation

(2) “Artificial obstruction” means any obstruction to the flow of water in a stream that is not a natural obstruction, including any that, while not a significant obstruction in itself, is capable of accumulating debris and thereby reducing the flood-carrying capacity of the stream.
(3) “Base flood” or “100-year flood” means a flood that has a one percent (1%) chance of being equaled or exceeded in any given year. The term “base flood” is used in the National Flood Insurance Program to indicate the minimum level of flooding to be addressed by a community in its floodplain management regulations.
(4) “Base floodplain” or “100-year floodplain” means that area subject to a one percent (1%) or greater chance of flooding in any given year, as shown on the current floodplain maps prepared pursuant to the National Flood Insurance Program or approved by the Agency.
(5) “Flood hazard area” means the area designated by a local government, pursuant to this Part, as an area where development must be regulated to prevent damage from flooding. The flood hazard area must include and may exceed the base floodplain.
(6) “Local government” means any county or city.
(7) “Lowest floor,” when used in reference to a structure, means the lowest enclosed area, including a basement, of the structure. An unfinished or flood-resistant enclosed area, other than a basement, that is usable solely for parking vehicles, building access, or storage is not a lowest floor.
(8) “Natural obstruction” includes any rock, tree, gravel, or other natural matter that is an obstruction and has been located within the 100-year floodplain by a nonhuman cause.
(9) “Secretary” means the Secretary of the Agency.
(10) “Stream” means a watercourse that collects surface runoff from an area of one square mile or greater.
(11) “Structure” means a walled or roofed building, including a mobile home and a gas or liquid storage tank.

(b) As used in this Part, the terms “artificial obstruction” and “structure” do not include any of the following:

(1) An electric generation, distribution, or transmission facility.
(2) A gas pipeline or gas transmission or distribution facility, including a compressor station or related facility.
(3) A water treatment or distribution facility, including a pump station.
(4) A wastewater collection or treatment facility, including a lift station.
(5) Processing equipment used in connection with a mining operation.

Sec. 3. Regulation of flood hazard areas; prohibited uses

(a) Powers of local government. A local government may adopt ordinances to regulate uses in flood hazard areas and may grant permits for the use of flood hazard areas that are consistent with the requirements of this Part II.

(b) Allowable uses. The following uses may be made of flood hazard areas without a permit issued under this Part, provided that these uses comply with local land-use ordinances and any other applicable laws or regulations:

(1) General farming, pasture, outdoor plant nurseries, horticulture, forestry, mining, wildlife sanctuary, game farm, and other similar agricultural, wildlife, and related uses;
(2) Ground-level loading areas, parking areas, rotary aircraft ports and other similar ground-level area uses;
(3) Lawns, gardens, play areas and other similar uses;
(4) Golf courses, tennis courts, driving ranges, archery ranges, picnic grounds, parks, hiking or horseback riding trails, open space, and other similar private and public recreational uses.
(5) Land application of waste at agronomic rates consistent with an approved animal waste–management plan.
(6) Land application of septage consistent with a permit issued by the State permit authority.

(c) Prohibited uses. New solid waste disposal facilities, hazardous waste management facilities, salvage yards, and chemical storage facilities are prohibited in the 100-year floodplain except at authorized under Sec. 4(b) (below).

Sec. 4. Minimum standards for ordinances; variances for prohibited uses

(a) A flood-hazard prevention ordinance adopted by a county or city pursuant to this Part shall, at a minimum:

(1) Meet the requirements for participation in the National Flood Insurance Program and of this Sec. 4.
(2) Prohibit new solid waste disposal facilities, hazardous waste management facilities, salvage yards, and chemical storage facilities in the 100-year floodplain except as authorized under subsection (b) of this Sec. 4.
(3) Provide that a structure or tank for chemical or fuel storage incidental to a use that is allowed under this Sec. 4 or to the operation of a water treatment plant or wastewater treatment facility may be located in a 100-year floodplain only if the structure or tank is either elevated above base-flood elevation or designed to be watertight with walls substantially impermeable to the passage of water and with structural components capable of resisting hydrostatic and hydrodynamic loads and the effects of buoyancy.

(b) Variances. A flood-hazard prevention ordinance may include a procedure for granting variances for uses prohibited under Sec. 3(c). A county or city shall notify the Secretary of its intention to grant a variance at least 30 days prior to granting the variance. A county or city may grant a variance upon finding that all of the following apply:

(1) The use serves a critical need in the community.
(2) No feasible location exists for the location of the use outside the 100-year floodplain.
(3) The lowest floor of any structure is elevated above the base-flood elevation or is designed to be watertight with walls substantially impermeable to the passage of water and with structural components capable of resisting hydrostatic and hydrodynamic loads and the effects of buoyancy.
(4) The use complies with all other applicable laws and regulations.

Sec. 5. Acquisition of existing structures

A local government may acquire, by purchase, exchange, or condemnation an existing

structure located in a flood hazard area in the area regulated by the local government if the local government determines that the acquisition is necessary to prevent damage from flooding. The procedure in all condemnation proceedings pursuant to this Sec. 5 shall conform as nearly as possible to the procedure provided in [State statute reference].

Sec. 6. Delineation of flood hazard areas and 100-year floodplains; powers of the Agency; powers of local governments and of the Agency

(a) Use of additional resources. For the purpose of delineating a flood hazard area and evaluating the possibility of flood damages, a local government may:

(1) Request technical assistance from the competent State and federal agencies, including the Army Corps. of Engineers, the Natural Resources Conservation Service, the Federal Emergency Management Agency (FEMA), the Department of Public Safety, and the U.S. Geological Survey, or successor agencies.

(2) Utilize the reports and data supplied by federal and state agencies as the basis for the exercise by local ordinance or resolution of the powers and responsibilities conferred on responsible local governments by this Part II.

(b) Powers of the Agency. The Agency shall provide advice and assistance to any local government having responsibilities under this Part. In exercising this function, the Agency may furnish manuals, suggested standards, plans, and other technical data; conduct training programs; give advice and assistance with respect to delineation of flood hazard areas and the development of appropriate ordinances; and provide any other advice and assistance that the Agency deems appropriate. The Agency shall send a copy of every rule adopted to implement this Part to the governing body of each local government in the State.

(c) Delineation using maps and descriptions. A local government may delineate any flood hazard area subject to its regulation by showing it on a map or drawing, by a written description, or any combination thereof, to be designated appropriately and filed permanently with the clerk of superior court and with the register of deeds in the county where the land lies. A local government also may delineate a flood hazard area by reference to a map prepared pursuant to the National Flood Insurance Program. Alterations in the lines delineated shall be indicated by appropriate entries upon or addition to the appropriate map, drawing, or description. Entries or additions shall be made by or under the direction of the clerk of superior court. Photographic, typed, or other copies of the map, drawing, or description, certified by the clerk of superior court, shall be admitted in evidence in all courts and shall have the same force and effect as would the original map or description. A local government may provide for the redrawing of any map. A redrawn map shall supersede for all purposes the earlier map or maps that it is designated to replace upon the filing and approval thereof as designated and provided above.

(d) Preparation of maps. The Agency may prepare a floodplain map that identifies the 100- year floodplain and base-flood elevations for an area for the purposes of this Part II if all of the following conditions apply:

(1) The 100-year floodplain and base-flood elevations for the area are not identified on a floodplain map prepared pursuant to the National Flood Insurance Program within the previous five years.

(2) The Agency determines that the 100-year floodplain and the base-flood elevations for the area need to be identified and the use of the area regulated in accordance with the requirements of this Part II in order to prevent damage from flooding.
(3) The Agency prepares the floodplain map in accordance with the federal standards required for maps to be accepted for use in administering the National Flood Insurance Program.

(e) Notice. Prior to preparing a floodplain map pursuant to subsection (d) of this Sec. 6, the Agency shall advise each local government whose jurisdiction includes a portion of the area to be mapped.

(f) Upon completing a floodplain map pursuant to subsection (d) of this Sec. 6, the Agency shall both:
(1) Provide copies of the floodplain map to every local government whose jurisdiction includes a portion of the 100-year floodplain identified on the floodplain map.
(2) Submit the floodplain map to the Federal Emergency Management Agency for approval for use in administering the National Flood Insurance Program.

(g) Responsibility upon approval of map. Upon approval by the Federal Emergency Management Agency of a floodplain map prepared pursuant to subsection (d) of this Sec. 6 for use in administering the National Flood Insurance Program, it shall be the responsibility of each local government whose jurisdiction includes a portion of the 100-year floodplain identified in the floodplain map to incorporate the revised map into its floodplain ordinance.

Sec. 7. Procedures in issuing permits

(a) Considerations. A local government may establish application forms and require maps, plans, and other information necessary for the issuance of permits in a manner consonant with the objectives of this Part II. For this purpose a local government may take into account anticipated development in the foreseeable future that may be adversely affected by the obstruction, as well as existing development. A local government shall consider the danger that a proposed artificial obstruction in a stream may pose to life and property by:
(1) Water that may be backed up or diverted by the obstruction.
(2) The danger that the obstruction will be swept downstream to the injury of others.
(3) The injury or damage at the site of the obstruction itself.

(b) Ordinances. In prescribing standards and requirements for the issuance of permits under this Part II and in issuing permits, local governments shall enact ordinances.

(c) Issuance of permits. The local governing body is hereby empowered to adopt regulations it may deem necessary concerning the form, time, and manner of submission of applications for permits under this Part II. These regulations may provide for the issuance of permits under this Part by the local [governing body], as prescribed by the governing body. Every final decision granting or denying a permit under this Part shall be subject to review by the superior court of the county, with the right of jury trial at the election of the party seeking review. Pending the final disposition of an appeal, no

action shall be taken that would be unlawful in the absence of a permit issued under this Part.

Sec. 8. Violations and penalties

(a) Violations. Any willful violation of this Part II or of any ordinance adopted (or of the provisions of any permit issued) under the authority of this Part shall constitute a [indicate level of crime] misdemeanor.

(1) A local government may use all of the remedies available for the enforcement of ordinances to enforce an ordinance adopted pursuant to this Part II.

(b) Failure to remedy. Failure to remove any artificial obstruction or enlargement or replacement thereof, that violates this Part or any ordinance adopted (or the provision of any permit issued) under the authority of this Part, shall constitute a separate violation of this Part for each day that the failure continues after written notice from the county board of commissioners or governing body of a city.

(c) Other proceedings. In addition to or in lieu of other remedies, the local governing body may institute any appropriate action or proceeding to restrain or prevent any violation of this Part II or of any ordinance adopted (or of the provisions of any permit issued) under the authority of this Part, or to require any person, firm, or corporation that has committed a violation to remove a violating obstruction or restore the conditions existing before the placement of the obstruction.

Sec. 9. Other approvals required

(a) Approvals required under separate statutes. The granting of a permit under the provisions of this Part II shall in no way affect any other type of approval required by any other statute or ordinance of the State or any political subdivision of the State, or of the United States, but shall be construed as an added requirement.

(b) Permits for construction. No permit for the construction of any structure to be located within a flood-hazard area shall be granted by a political subdivision unless the applicant has first obtained the permit required by any local ordinance adopted pursuant to this Part.

Sec. 10. Floodplain management

The provisions of this Part II shall not preclude the imposition by responsible local governments of land-use controls and other regulations in the interest of floodplain management for the 100-year floodplain.

PART III. FLOODPLAIN MANAGEMENT AND HAZARD MITIGATION

Sec. 1. Zoning restrictions in floodplain

(a) Definition. As used in this Sec. 1, “floodplain” means that area of a municipality located within the real or theoretical limits of the base flood or base flood for a critical activity, as determined by the Federal Emergency Management Agency in its flood insurance study or flood insurance–rate map for the municipality, prepared pursuant to the National Flood Insurance Program (44 C.F.R. Part 59 et seq.).

(b) Restrictions upon revising zoning requirements. Whenever a municipality, pursuant to the National Flood Insurance Program (44 C.F.R. Part 59 et seq.), is required to revise its zoning regulation or any other ordinance regulating a proposed building, structure, development, or use located in a floodplain, the revision shall provide for restrictions for flood storage and conveyance of water for floodplains that are not tidally influenced as follows:

(1) Within a designated floodplain, all encroachments (including fill, new construction, substantial improvements to existing structures, and any other development) are prohibited unless the applicant provides certification to the commission by a registered professional engineer that such encroachment shall not result in any increase in base-flood elevation;

(2) The water-holding capacity of the floodplain shall (A) not be reduced by any form of development unless such reduction is compensated for by deepening or widening the floodplain, (B) be on-site, unless adjacent property owners grant easements, (C) be within the same hydraulic reach and a volume not previously used for flood storage, (D) be hydraulically comparable and incrementally equal to the theoretical volume of flood water at each elevation, up to and including the 100-year flood elevation, which would be displaced by the proposed project, and (E) have an unrestricted hydraulic connection to the same waterway or water body; and

(3) Any work within adjacent land subject to flooding, including work to provide compensatory storage, shall not restrict flows resulting in increased flood stage or velocity.

(c) Additional restrictions. Notwithstanding the provisions of subsection (b) of this Sec. 1, a municipality may adopt more stringent restrictions for flood storage and conveyance of water for floodplains that are not tidally influenced.

Sec. 2. Creation of plan by Secretary

The Secretary of the [State agency in charge of flood regulations], after consultation with all appropriate State, regional and local agencies and other appropriate persons shall, prior to [set date], (1) complete a revision of the existing plan and enlarge it to include policies relating to risks associated with natural hazards, including, but not limited to, flooding, high winds, and wildfires; (2) identify the potential impacts of natural hazards on infrastructure and property; and (3) make recommendations for the siting of future infrastructure and property development to minimize the use of areas prone to natural hazards, including, but not limited to, flooding, high winds, and wildfires.

Sec. 3. Plan of conservation and development

At least once every ten years, the [local entity in charge of planning] shall prepare or amend and shall adopt a plan of conservation and development for the municipality. Following adoption, the [local entity in charge of planning] shall regularly review and maintain such plan. The [local entity in charge of planning] may adopt such geographical, functional, or other amendments to the plan or parts of the plan, in accordance with the provisions of this Sec. 3, as it deems necessary. The [local entity in charge of planning] may, at any time, prepare, amend, and adopt plans for the redevelopment and improvement of districts or neighborhoods that, in its judgment, contain special problems or opportunities or show a trend toward lower land values. The

[local entity in charge of planning] shall identify the potential impacts of natural hazards on infrastructure and property and shall prepare, adopt, and amend plans for the siting of future infrastructure and property development to minimize the use of areas prone to natural hazards, including, but not limited to, flooding, high winds, and wildfires.

Sec. 4. Hazard mitigation and floodplain management account

(a) General. There is established an account to be known as the "Hazard Mitigation and Floodplain Management Account." Any balance remaining in the account at the end of any fiscal year shall be carried forward in the account for the fiscal year next succeeding. The account shall be available to the [State entity in charge of environmental protection] for the purposes of Sec.s 3 to 7, inclusive, of this Part III.

(b) Funding. The State shall increase the fee for land use permits [or similar fee] and dedicate proceeds of the increase to the Hazard Mitigation and Floodplain Management Account.

Sec. 5. Definitions

As used in Sec.s 6 to 9, inclusive, of this Part III:
(a) "Hazard mitigation" means activities that include, but are not limited to, actions taken to reduce or eliminate long-term risk to human life, infrastructure, and property resulting from natural hazards including, but not limited to, flooding, high winds, and wildfires; and

(b) "Floodplain management" means activities that include, but are not limited to, actions taken to retain the existing capacity of designated floodplain areas to store and convey flood waters.

Sec. 6. Hazard mitigation and floodplain management grant program

(a) Purposes and applications. The [State entity in charge of environmental protection] shall establish and administer a hazard mitigation and floodplain management grant program to reimburse municipalities for costs incurred in the reduction or elimination of long-term risks to human life, infrastructure and property from natural hazards, including, but not limited to, flooding, high winds and wildfires, and in the retention of present capacity of designated floodplain areas to store and convey flood waters. Application for a grant shall be made in writing to the commissioner in such form as the [State entity] may prescribe and shall include a description of the purpose, objectives, and budget of the activities to be funded by the grant. The chief executive officer of the municipality applying for the grant may designate the town planner, director of public works, police chief, fire chief, or emergency management director as the agent to make the application.

(b) Awarding of grants; notice of program. The [State entity in charge of environmental protection] shall establish, by rules, relative priorities for the approval of grants under this Sec. 6. Such priorities may take into account the differing needs of municipalities, the need for consistency and equity in the distribution of grant awards, and the extent to which particular projects may advance the purposes of this section. The [State entity] may establish further criteria for the approval of grants under this Sec. 6 and shall develop and disseminate a pamphlet that describes the evaluation process for grant

applications. In awarding grants under this section, the [State entity] shall consult with any person the commissioner deems necessary.

(c) Allocation of moneys. The [State entity] shall allocate not less than 60 percent of the moneys in the Hazard Mitigation and Floodplain Management Account in any fiscal year for grants under this section.

Sec. 7. Grants to municipalities for planning

(a) Effective date. On and after [insert date], the [State entity in charge of environmental protection] shall make grants to municipalities from the Hazard Mitigation and Floodplain Management Account, established under Sec. 4 of Part III of this Act, for hazard mitigation and floodplain management.

(b) Conditions of repayment. If the [State entity] finds that any grant awarded pursuant to this section is being used for other purposes or to supplant a previous source of funds, the commissioner may require repayment.

(c) Specific purposes. The [State entity] shall allocate moneys in the Hazard Mitigation and Floodplain Management Account, established under Sec. 4 of Part III of this Act, for (1) the preparation or revision of hazard mitigation plans by municipalities; (2) the preparation or revision of municipal plans of conservation and development that include the identification of the potential impacts of natural hazards, including, but not limited to, flooding, high winds, and wildfires; (3) reimbursement of costs associated with participation in the community rating system of the National Flood Insurance Program; (4) the execution of hazard mitigation projects by municipalities in accordance with approved hazard mitigation plans; and (5) costs for administering and providing financial assistance for the hazard mitigation and floodplain management grant program established under Sec. 6 of Part III of this Act.

(d) Submission of report. Annually, the [State entity] shall submit a report describing the activities performed with the allocated moneys for the preceding fiscal year to the joint standing committees of the General Assembly having cognizance of matters relating to planning and development and the environment.

Sec. 8. Municipal report

(a) Each municipality that receives a grant from the Hazard Mitigation and Floodplain Management Account, established under Sec. 4 of Part III of this Act, shall submit a report to the [State entity in charge of environmental protection], in such form as the [State entity] prescribes, not later than September first of the fiscal year following the year such grant was received. Such report shall contain a description of activities paid for with financial assistance under the grant. The chief executive officer of a municipality that receives a grant from the Hazard Mitigation and Floodplain Management Account may designate the town planner, director of public works, police chief, fire chief, or emergency management director of that municipality as the agent to make such report.

(b) Report of [State entity in charge of environmental protection]. On or before [insert date], and annually thereafter, the [State entity in charge of environmental protection] shall submit a report on grants made under Sec.s 6 and 7 of Part III of this Act for the preceding fiscal year to the joint standing committees of the General Assembly having

cognizance of matters relating to planning and development and the environment. Each such report shall include: (1) a description of the grants made, including the amount, purposes, and the municipalities to which they were made; (2) a summary of the activities for which the Department of Environmental Protection used the moneys allocated to it under Sec. 6 of Part III of this Act; and (3) any findings or recommendations concerning the operation and effectiveness of the grant program.

Sec. 9. Model ordinance

The [State entity in charge of environmental protection] shall develop guidelines to be used by municipalities in revising ordinances restricting flood storage and conveyance of water for floodplains that are not tidally influenced. Such guidelines shall include, but not be limited to, a model ordinance that may be used by municipalities to comply with the provisions of Sec. 1 of this Part III. The commissioner shall make the guidelines available to the public.

Sec. 10. Regulations

The [State entity in charge of environmental protection] shall adopt regulations to implement the provisions of this Part III.

PART IV. MISCELLANEOUS PROVISIONS REGARDING PARTICIPATION

Sec. 1. Insurance producer qualification; continuing education

The [State entity for regulating insurance] shall require:

(1) Pre-licensing requirement. The [State entity for regulating insurance] shall require all resident insurance producer applicants to demonstrate satisfactory knowledge and understanding of flood insurance and the National Flood Insurance Program, as determined by the [State entity for regulating insurance] in order to qualify for licensure.

(2) Continuing education requirement for existing licensees. The [State entity for regulating insurance] shall require resident insurance producers licensed on [the bill's effective date] to complete a basic or advanced continuing education course related to flood insurance and the National Flood Insurance Program before [a date certain at least two years from the bill's effective date]. The course may be online or instructor-led and shall be approved by the [State entity for regulating insurance]. Completion of the course will provide the licensee with continuing education credits as determined by the [State entity for regulating insurance].

Sec. 2. Insurance adjuster qualification; education

The [State entity for regulating insurance] shall require:

(1) Insurance-adjuster license applicants to demonstrate satisfactory knowledge and understanding of flood insurance, as determined by the [State entity for regulating insurance], in order to qualify; and
(2) An applicant for an insurance-adjuster license renewal to complete at least two hours of continuing educational programs in flood insurance every two years.

Sec. 3. Real estate broker and salesperson qualification; education

The [State entity for regulating the licensing of real estate brokers and salespersons] shall require:

(1) applicants for real-estate broker or salesperson licensing to demonstrate satisfactory knowledge and understanding of flood insurance, as determined by the [State entity for regulating the licensing of real estate brokers and salespersons], in order to qualify; and (2) an applicant for real-estate broker or salesperson license renewal to complete at least two hours of continuing educational programs in flood insurance every two years.

Sec. 4. Disclosure of real estate flood propensity

The [State entity in charge of consumer protection or the State Real Estate Commission, as the case may be] shall, by regulations, require a written residential disclosure report to be provided to a real estate buyer that is to include information concerning flood propensity. [If a state already has a required form for disclosure, this provision could be added to it.]

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)

Model Anti-Runners Fraud Bill

Adopted by the NCOIL Executive Committees on July 11, 2003. Readopted on July 8, 2005, and November 20, 2010.

To be considered for re-adoption by the NCOIL Property & Casualty Insurance Committee on July 12, 2018

Section 1: Definitions

As used in this section, the following terms have the meanings given:
(a) "Provider" means an attorney, health care professional, an owner of a health care practice or facility, or any person employed or acting on behalf of any of the aforementioned persons.

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

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

Section 2: Penalties

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

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
PROPERTY/CASUALTY INSURANCE MODERNIZATION ACT

Adopted by the NCOIL Executive Committee on July 13, 2001.
Amended by the NCOIL Executive Committee on November 16, 2001, and March 1, 2002.
Reviewed and amended by the NCOIL Executive Committee on November 21, 2003.
Readopted by the NCOIL Executive Committee on July 22, 2006.

To be considered for re-adoption by the NCOIL Property & Casualty Insurance Committee on July 12, 2018

Summary
This model bill establishes a use-and-file rate regulatory system for personal lines of insurance, a no-file system for commercial lines, and allows policies sold to large, sophisticated commercial insurance providers to be exempt from rate and regulatory requirements. This creates a more competitive and less onerous regulatory industry. This model is intended for consideration in insurance regulatory jurisdictions with a more restrictive rate filing and review system than outlined in the bill.

Section 1. {Short Title}

This act shall be known as the Property/Casualty Insurance Modernization Act.

Section 2. {Legislative Declaration}

This legislature finds and declares that a modernized and competitive procedure be employed

A. To recognize and enhance the role well-informed consumers play in the competitive marketplace

B. To promote price competition among insurers

C. To protect policyholders and the public against adverse effects of excessive, inadequate, or unfairly discriminatory rates

D. To prohibit unlawful price fixing agreements by or among insurers

E. To authorize essential cooperative activities among insurers in the ratemaking process and to regulate such activities to prohibit practices that tend to substantially lessen competition or create monopolies

F. To provide necessary regulatory authority in the absence of a competitive marketplace

Drafting Note: This model is intended for consideration in insurance regulatory jurisdictions with a more restrictive rate filing and review system than outlined in this bill. States may also wish to consider implementing a competitive rating law that eliminates the regulatory rate filing process for all lines of insurance that are competitive.

Section 3. {Definitions}

A. For the purpose of this Act, “Advisory organization” means any person or organization, which has five (5) unrelated members and which assists insurers as authorized by Section 11. It does not include joint underwriting organizations, actuarial or legal consultants, single insurers, any employees of an insurer, or insurers under common control or management of their employees or managers.

B. For the purpose of this Act, “Classification system” or “classification” means the process of grouping risks with similar risk characteristics so that differences in costs may be recognized.

C. For the purpose of this Act, “Commercial risk” means any kind of risk, which is not a personal risk.

D. For the purpose of this Act, “Commissioner” means the Commissioner or Director or Superintendent of Insurance of this state.

E. For the purpose of this Act, “Competitive market” means any market except those which have been found to be non-competitive pursuant to Section 5.

F. For the purpose of this Act, “Developed losses” means losses (including loss adjustment expenses) adjusted, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those which are anticipated to provide actual ultimate loss (including loss adjustment expense) payments.

G. For the purpose of this Act, “Expenses” means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses, and fees.

H. For the purpose of this Act, “Experience rating” means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder’s loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit, or unity modification.

I. For the purpose of this Act, “Joint underwriting” means an arrangement established to provide insurance coverage for a risk, pursuant to which two or more insurers contract with the insured for a price and policy terms agreed upon between or among the insurers.

J. For the purpose of this Act, “Large Commercial Policyholder” is a commercial policyholder with the size, sophistication, and insurance-buying expertise to negotiate with insurers in a largely unregulated environment and which meets at least two of the following criteria: (1) aggregate premium on commercial policies held by the insured, including workers’ compensation, (2) number of employees, (3) annual net revenues or sales, (4) net worth, (5) annual budgeted expenditures for not-for profit organizations or a public body or agencies, or (6) population for municipalities.

Drafting Note: Specific criteria may require a large commercial policyholder to generate annual net revenues or sales in excess of $50,000,000; employ more than 50 employees; procure insurance through a full-time risk manager or retained qualified insurance consultant; possess net worth in excess of $25,000,000; or, if a nonprofit organization or public body/agency, generate annual budgeted expenditures of at least $25,000,000.

K. For the purpose of this Act, “Loss adjustment expense” means the expenses incurred by the insurer in the course of settling claims.

L. For the purpose of this Act, “Market” is the statewide interaction between buyers and sellers in the procurement of a line of insurance coverage pursuant to the provisions of this Act.

Drafting Note: A state may wish to consider a geographic area smaller than the statewide market to be tested, keeping in mind the state’s particular insurance market environment.

M. For the purpose of this Act, “Non-competitive market” means a market, which is subject to a ruling pursuant to Section 5 that a reasonable degree of competition does not exist, and, for the purposes of this Act, residual markets, and pools are non-competitive markets.

N. For the purpose of this Act, “Personal risk” means homeowners, tenants, nonfleet private passenger automobiles, mobile homes, and other property and casualty insurance for person, family, or household needs. This includes any property and casualty insurance that is otherwise intended for non-commercial coverage.

O. For the purpose of this Act, “Pool” means an arrangement pursuant to which two or more insurers participate in the sharing of risks on a predetermined basis. A pool may operate as an association, syndicate, or in any other generally recognized manner.

P. For the purpose of this Act, “Prospective loss cost” means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

Q. For the purpose of this Act, “Rate” means that cost of insurance per exposure unit whether expressed as a single number or as a prospective loss cost with

an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

R. For the purpose of this Act, “Residual market mechanism” means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment of risks among insurers for insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods.

S. For the purpose of this Act, “Special assessments” means guaranty fund assessments, Special Indemnity Fund assessments, Vocational Rehabilitation Fund assessments, and other similar assessments. Special assessments shall not be considered as either expenses or losses.

T. For the purpose of this Act, “Supplementary rate information” means any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, and any other similar information needed to determine an applicable rate in effect or to be in effect.

U. For the purpose of this Act, “Supporting information” means (1) the experience and judgment of the filer and the experience or data of other insurers or organizations relied upon by the filer, (2) the interpretation of any statistical data relied upon by the filer, (3) a description of methods used in making the rates, and (4) other similar information relied upon by the filer.

V. For the purpose of this Act, “Trending” means any procedure for projecting losses to the average date of loss, or premiums or exposures to the average date of writing, for the period during which the policies are to be effective.

Section 4. {Scope}

A. This Act applies to all kinds of insurance written on risks in this state by any insurer authorized to do business in this state except:

1. Life insurance
2. Annuities
3. Accident and health insurance
4. Ocean marine insurance
5. Aircraft liability and aircraft hull insurance
6. Reinsurance
7. Surplus Lines
8. Workers Compensation Insurance

Section 5. {Competitive Market}

A. A competitive market for a line of insurance is presumed to exist unless the commissioner, after notice and hearing, determines that a reasonable degree of competition does not exist within a market and issues a ruling to that effect. The burden of proof in any hearing shall be placed on the party or parties advocating the position

that competition does not exist. Any ruling that a market is not competitive shall identify the factors causing the market not to be competitive. Such ruling shall expire one year after issue unless rescinded earlier by the commissioner or unless the commissioner renews the ruling after a hearing and a finding as to the continued lack of a reasonable degree of competition. Any ruling that renews the finding that competition does not exist shall also identify the factors that cause the market to continue not to be competitive.

B. The following factors shall be considered by the commissioner for purposes of determining if a reasonable degree of competition does not exist in a particular line of insurance:

1. The number of insurers or groups of affiliated insurers providing coverage in the market
2. Measures of market concentration and changes of market concentration over time
3. Ease of entry and the existence of financial or economic barriers that could prevent new firms from entering the market
4. The extent to which any insurer or group of affiliated insurers controls all or a portion of the market
5. Whether the total number of companies writing the line of insurance in this state is sufficient to provide multiple options
6. The availability of insurance coverage to consumers in the markets
7. The opportunities available to consumers in the market to acquire pricing and other consumer information

C. The commissioner shall monitor the degree and continued existence of competition in this State on an on-going basis. In doing so, the commissioner may utilize existing relevant information, analytical systems, and other sources; or rely on some combination thereof. Such activities may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors, and/or in any other appropriate manner.

Section 6. {Rating Standards and Methods}

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

1. For the purpose of this Act, “Excessive” means a rate that is likely to produce a long-term profit that is unreasonably high for the insurance provided. No rate in a competitive market shall be considered excessive.

Drafting Note: Reflecting the well-accepted economic principle that costs and prices are driven downward by competition, insurance laws in seventeen (17) states do not allow a finding of excessiveness in a competitive market. Those seventeen (17) states are: Arkansas, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Kentucky, Michigan, Missouri, Montana, Nevada, Oklahoma, Oregon, Vermont, Virginia, and Wyoming. Insurance laws in five (5) other states say that rates are “presumed” not to be excessive if there is a reasonable degree of competition. Those five (5) states are: Arizona, Kansas, Minnesota, New Mexico, and Wisconsin.

2. For the purpose of this Act, “Inadequate” means a rate which is unreasonably low for the insurance provided and

a. the continued use of which endangers the solvency of the insurers using it, or

b. will have the effect of substantially lessening competition or creating a monopoly in any market

3. a. For the purpose of this Act, “Unfairly discriminatory” refers to rates that cannot be actuarially justified. It does not refer to rates that produce differences in premiums for policyholders with like loss exposures, so long as the rate reflects such differences with reasonable accuracy. A rate is not unfairly discriminatory if it averages broadly among persons insured under a group, franchise or blanket policy, or a mass marketing plan.

b. No rate in a competitive market shall be considered unfairly discriminatory unless it violates the provisions of section 6(B) in that it classifies risk, on the basis of race, color creed, or national origin. Risks may be classified in any way except that no risk may be classified on the basis of race, color, creed, or national origin.

B. In determining whether rates in a non-competitive market are excessive, inadequate, or unfairly discriminatory, consideration may be given to the following elements:

1. Basic Rate Factors. Due consideration shall be given to past and prospective loss and expense experience within and outside of this state; to catastrophe hazards and contingencies; to events or trends within and outside of this state; to dividends or savings to policyholders, members, or subscribers; and to all other factors and judgments deemed relevant by the insurer.

2. Classification. Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified for individual risks in accordance with rating plans or schedules which establish standards for measuring probable variations in hazards or expenses, or both.

3. Expenses. The expense provision shall reflect the operating methods of the insurer and its own past expense experience and anticipated future expenses.

4. Contingencies and Profits. The rates shall contain a provision for contingencies and a provision for a reasonable underwriting profit, and reflect investment income directly attributable to unearned premium and loss reserves.

5. Other relevant factors. Any other factors available at the time of hearing.

Section 7. {Rate Regulation in a Market Determined to be Non-Competitive}

A. If the commissioner determines that competition does not exist in a market and issues a ruling to that effect pursuant to Section 5, the rates applicable to insurance sold in that

market shall be regulated in accordance with the provisions of Section 6 through 9 applicable to non-competitive markets.

B. Any rate filing in effect at the time the commissioner determines that competition does not exist pursuant to Section 5 shall be deemed to be in compliance with the laws of this state unless disapproved pursuant to the procedures and rating standards contained in Section 6 through 9 applicable to non-competitive markets.

C. Any insurer having a rate filing in effect at the time the commissioner determines that competition does not exist pursuant to Section 5 may be required to furnish supporting information within 30 days of a written request by the commissioner.

Section 8. {Filing of Rates, Supplementary Rate Information, and Supporting Information}

A. Filings in Competitive Markets. For personal lines, every insurer shall file with the commissioner all rates and supplementary rate information to be used in this state no later than 30 days after the effective date; provided, that such rates and supplementary rate information need not be filed for inland marine risks, which by general custom are not written according to manual rules or rating plans. Rates in a competitive market for commercial insurance need not be filed.

B. Filings in Non-Competitive Markets.

1. Every insurer shall file with the commissioner all rates, supplementary rate information, and supporting information for non-competitive markets at least 30 days before the proposed effective date. The commissioner may give written notice, within 30 days of the receipt of the filing, that the commissioner needs additional time, not to exceed 30 days from the date of such notice to consider the filing. Upon written application of the insurer, the commissioner may authorize rates to be effective before the expiration of the waiting period or an extension thereof. A filing shall be deemed to meet the requirements of this Act and to become effective unless disapproved pursuant to Section 9 by the commissioner before the expiration of the waiting period or an extension thereof. Residual market mechanisms or advisory organizations may file residual market rates.

2. The filing shall be deemed in compliance with the filing provisions of this section unless the commissioner informs the insurer within 10 days after receipt of the filing as to what supplementary rate information or supporting information is required to complete the filing.

C. Reference Filings. An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by Section 11.

D. Filings Open to Inspection. All rates, supplementary rate information, and any supporting information filed under this Act shall be open to public inspection once they have been filed, except information marked confidential, Trade Secret, or proprietary by

the insurer or filer. Copies may be obtained from the commissioner upon request and upon payment of a reasonable fee.

E. Consent to Rate. Notwithstanding any other provisions of this section, upon written application of the insured, stating the reason therefore, a rate in excess of or below that otherwise applicable may be used on any specific risk.

Section 9. (Disapproval of Rates)

A. Bases for Disapproval

1. The commissioner shall disapprove a rate in a competitive market only if the commissioner finds pursuant to subsection (B) of this section that the rate is inadequate under Section (6)(A)(2) or unfairly discriminatory under Section 6(A)(3)(b).

2. The commissioner may disapprove a rate for use in a non-competitive market only if the commissioner finds pursuant to subsection (B) of this section that the rate is excessive, inadequate, or unfairly discriminatory under Section 6A.

B. Procedures for Disapproval

1. Prior to the expiration of the waiting period or an extension thereof of a filing made pursuant to Section 8, subsection (B), the commissioner may disapprove by written order rates filed pursuant to Section 8, subsection (B), without a hearing. The order shall specify in what respects such filing fails to meet the requirements of this Act. Any insurer whose rates are disapproved under this section shall be given a hearing upon written request made within 30 days of disapproval.

2. If, at any time, the commissioner finds that a rate applicable to insurance sold in a non-competitive market does not comply with the standards set forth in Section 6, the commissioner may, after a hearing held upon not less than 20 days written notice, issue an order pursuant to subsection 9(C) disapproving such rate. The Hearing notice shall be sent to every insurer and advisory organization that adopted the rate and shall specify the matters to be considered at the hearing. The disapproval order shall not affect any contract or policy made or issued prior to the effective date set forth in said order.

3. If, at any time, the commissioner finds that a rate applicable to insurance sold in a competitive market is inadequate under Section 6(A)(3)(a) or unfairly discriminatory under Section 6(A)(3)(b), the commissioner may issue an order pursuant to subsection 9(C) disapproving the rate. Said order shall not affect any contract or policy made or issued prior to the effective date set forth in said order.

C. Order of Disapproval. If the commissioner disapproves a rate pursuant to subsection (B) of this section, the commissioner shall issue an order within 30 days of the close of the hearing specifying in what respects such rate fails to meet the requirements of this Act. The order shall state an effective date no sooner than 30 business days after the date of the order when the use of such rate shall be discontinued. This order shall not affect any policy made before the effective date of the order.

D. Appeal of Orders; Establishment of Reserves. If an order of disapproval is appealed pursuant to Section 20 the insurer may implement the disapproved rate upon notification to the court, in which case any excess of the disapproved rate over a rate previously in effect shall be placed in a reserve established by the insurer. The court shall have control over the disbursement of funds from such reserve. Such funds shall be distributed as determined by the court in its final order except that de minimus refunds to policyholders shall not be required.

Section 10. {Large Commercial Policyholder}

A. A policy of insurance sold to a "Large Commercial Policyholder," as defined in Section 3(J), shall not be subject to the requirements of this chapter, including but not limited to, Sections 5, 6, 7, 8, and 9. The forms and endorsements for any policy sold to a "Large Commercial Policyholder" shall not be subject to filing and approval requirements of (reference form filing and approval provisions plus other applicable provisions).

B. All policies issued pursuant to the provisions of this section shall contain a conspicuous disclaimer printed in at least ten-point, bold-faced type that states that the policy applied for (including the rates, rating plans, resulting premiums, and the policy forms) is not subject to the rate and form requirements of this state and other provisions of the insurance law that apply to other commercial products and may contain significant differences from a policy that is subject to all provisions of the insurance law. Such notice shall set forth possible differences in policy conditions, forms, and endorsements, as compared to a policy that is subject to all of the provisions of the insurance law. The format and provisions of such notice shall be prescribed by the commissioner. The disclosure notice will also include a policyholder's acknowledgment statement, to be signed and dated prior to the effective date of the coverage, and shall remain on file with the insurer.

C. In procuring insurance, a "Large Commercial Policyholder" shall certify on a form approved by the department of insurance that it meets the eligibility requirements set out in Section 10(A) and specify the requirements that the policyholder has met. This certification is to be completed annually and remain on file with the insurer.

D. A surplus lines broker seeking to obtain or provide insurance for a "Large Commercial Policyholder" is authorized to purchase insurance from any eligible unauthorized insurer without making a diligent search of authorized insurers as required by (applicable surplus lines law).

Section 11. {Records and Reports: Exchange of Information}

A. In only those markets found to be non-competitive pursuant to Section 5, insurers and advisory organizations shall file with the commissioner, and the commissioner shall review, reasonable rules and plans for recording and reporting of loss and expense experience. The commissioner may designate one or more advisory organizations to assist in gathering such experience and making compilations thereof. No insurer shall be required to record or report its experience in a manner inconsistent with its own rating system.

B. The commissioner and every insurer and advisory organization may exchange rates and rate information and experience data with insurance regulatory officials, insurers, and advisory organizations in this and other states and may consult with them with respect to the collection of statistical data and the application of rating systems.

Section 12. {Joint Underwriting, Pools, and Residual Market Activities}

A. Acting in Concert. Notwithstanding the provisions of Section 13, insurers participating in joint underwriting, pools, or residual market mechanisms may act in cooperation with each other in the making of rates, rating systems, supplementary rate information, policy or bond forms, underwriting rules, surveys, inspections and investigations; in the furnishing of loss and expense statistics or other information; and in conducting research. Joint underwriting, pools, and residual market mechanisms shall not be deemed advisory organizations.

B. Regulation

1. If, after notice and hearing, the commissioner finds that any activity or practice of an insurer participating in a joint underwriting or pooling mechanism is unfair, unreasonable, will tend to substantially lessen competition in any market, or is otherwise inconsistent with the provisions or purposes of this Act and all other applicable statutes, the commissioner may issue a written order specifying in what respects such activity or practice is unfair, unreasonable, anti-competitive, or otherwise inconsistent with the provisions of this Act and all other applicable statutes, and require the discontinuance of such activity or practice.

2. Every pool shall file with the commissioner a copy of its constitution, articles of incorporation, agreement, or association bylaws; rules and regulations governing activities; its members; the name and address of a resident of this state upon whom notices, process, and orders of the commissioner may be served; and any changes or modifications thereof.

3. Any residual market mechanism, plan, or agreement to implement such a mechanism, and any changes or amendments thereto, shall be submitted in writing to the commissioner for approval, together with such information as may be reasonably required. The commissioner shall approve such agreements if they foster (i) the use of rates which meet the standards prescribed by this Act and all other applicable statutes and (ii) activities and practices not inconsistent with the provisions of this Act and all other applicable statutes.

4. The commissioner may review the operations of all residual market mechanisms to determine compliance with the provisions of this Act and all other applicable statutes. If after a notice of hearing, the commissioner finds that such mechanisms are violating the provisions of this Act and all other applicable statutes, the commissioner may issue a written order to the parties involved specifying in what respects such operations violate the provisions of this Act and all other applicable statutes. The commissioner may further order the discontinuance or elimination of any such operation.

Section 13. {Assigned Risks}

A. Agreements may be made among insurers with respect to the equitable apportionment among them of insurance that may be afforded applicants who are in good faith entitled to, but who are unable to, procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements, and rate modifications to be subject to the approval of the commissioner.

Drafting Note: This section is to be included if the current provision authorizing agreements for the assigned risk or other residual market is repealed as part of the current rating law. You may wish to pick up current state provisions.

Section 14. {Examinations}

A. The commissioner may examine any insurer, pool, advisory organization, or residual market mechanism to ascertain compliance with this Act.

B. Every insurer, pool, advisory organization, and residual market mechanism shall maintain adequate records from which commissioner may determine compliance with the provisions of this Act. Such records shall contain the experience, data, statistics, and other information collected or used and shall be available to the commissioner for examination or inspection upon reasonable notice.

C. The reasonable cost of an examination made pursuant to this section shall be paid by the examined party upon presentation to it of a detailed account of such costs.

D. The commissioner may accept the report of an examination made by the insurance supervisory official of another state in lieu of an examination under this section.

Section 15. {Exemptions}

The commissioner may, after public notice and hearing, exempt any line of insurance from any or all of the provisions of this Act for the purpose of relieving such line of insurance from filing or any otherwise applicable provisions of this Act.

Section 16. {Consumer Information}

The Commissioner shall utilize, develop, or cause to be developed a consumer information system(s) which will provide and disseminate price and other relevant information on a readily available basis to purchasers of homeowners, private passenger non-fleet automobile, or property insurance for personal, family, or household needs. The commissioner may utilize, develop, or cause to be developed a consumer information system(s) which will provide and disseminate price and other relevant information on a readily available basis to purchasers of insurance for commercial risks and personal risks not otherwise specified herein. Such activity may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors, and/or in any other appropriate manner. To the extent deemed necessary and appropriate by the commissioner, insurers, advisory organizations, statistical agents, and other persons or organizations involved in conducting the business of insurance in this State, to which this section applies, shall cooperate in the development and utilization of a consumer information system(s).

Drafting Note: For jurisdictions that need a separate and distinct means of funding a consumer information system the following provision may be added to Section 16:

The cost of complying with this section shall be assessed against insurers subject to this Act and authorized to write types of business subject to a consumer information system. The assessments shall be made on an equitable and practicable basis established, after hearing, in a rule promulgated by the commissioner. This activity shall be conducted in a reasonably economical manner consistent with the purposes of this Act.

Section 17. {Dividends}

Nothing in this Act shall be construed to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers. A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers shall not be deemed a rating plan or system.

Section 18. {Penalties}

A. The commissioner may impose after notice and hearing a penalty determined in accordance with (refer to appropriate penalties provision).

B. Technical violations arising from systems or computer errors of the same type shall be treated as a single violation. In the event of an overcharge, if the insurer makes restitution including payment of interest, no penalty shall be imposed.

C. The commissioner may suspend or revoke the license of any insurer, advisory organization, or statistical agent which fails to comply with an order of the commissioner within the time prescribed by such order, or any extension thereof which the commissioner may grant.

D. The commissioner may determine when a suspension of license shall become effective and the period of such suspension, which the commissioner may modify or rescind in any reasonable manner.

E. No penalty shall be imposed and no license shall be suspended or revoked except upon a written order of the commissioner stating his or her findings, made after notice and hearing.

Section 19. {Judicial Review}

A. Any order, ruling, finding, decision, or other act of the commissioner made pursuant to this Act shall be subject to judicial review in accordance with (cite applicable provisions of state civil practice act).

Section 20. {Notice and Hearing}

A. Notice Requirements. All notices rendered pursuant to the provisions of this Act shall be in writing and shall state clearly the nature and purpose of the hearing. All relevant

facts, statutes, and rules shall be specified so that respondent(s) are fully informed of the scope of the hearing, including specific allegations, if any. If a hearing is required, all notices shall designate a hearing date at least 14 days from the date of the notice, unless such minimum notice period is waived by respondents.
B. Hearings. All hearings pursuant to the provisions of this Act shall be conducted in accordance with (cite applicable provisions of Administrative Procedures Act) to the extent such provisions are consistent with the procedural requirements contained in this Act.

Section 21. {Severability}

If any provision or item of this Act, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the Act that can be given effect without the invalid provision, item, or application.

Section 22. {Effective Date}

The provisions of this Act become effective _____ months after the enactment.

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

Property/Casualty Insurance Domestic Violence Model Act

Adopted by the Property-Casualty Insurance and Executive Committees on March 1, 1998; readopted on July 13, 2005; July 11, 2003; July 8, 2005; and November 20, 2010.

To be considered for re-adoption by the NCOIL Property & Casualty Insurance Committee on July 12, 2018

Table of Contents

Section 1. Legislative Intent

The purpose of this Act is to prohibit unfair discrimination by property-casualty insurers on the basis of domestic violence.

Section 2. Scope.

This Act shall apply to all insurers issuing or renewing a policy of property-casualty insurance in this state.

Section 3. Definitions

A. “Abuse” means bodily injury as a result of battery.

B. “Innocent co-insured” means an individual who did not cooperate in or contribute to the creation of the loss.

C. “Insured” [insert state definition].

D. “Insurer” [insert state definition].

E. “Policy” [insert state definition].

Section 4. Prohibited Discriminatory Acts Relating to Property-Casualty Insurance

A. No insurer shall use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him or her by a spouse or a person in the same household as the sole reason for rating or underwriting decisions.

B. Where a policy excludes property coverage for intentional acts, the insurer shall not deny payment to an innocent co-insured who did not cooperate or contribute to the creation of the loss if the loss arose out of a pattern of criminal domestic violence and the perpetrator of the loss is criminally prosecuted for the act causing the loss. Payment to the innocent co-insured may be limited to his or her ownership interests in the property as reduced by any payments to a mortgage or other secured interest.

Section 5. Effective Date

This Act is effective [insert date], and applies to all action taken on or after the effective date, except where otherwise explicitly stated.

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

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)
Model Act on Workers' Compensation Coverage for Volunteer Firefighters (with Drafting Note)

Adopted by the NCOIL Executive Committee on November 24, 2013, and by the Workers' Compensation Insurance Committee on November 21, 2013. Sponsored for discussion by Rep. Bill Botzow (VT)

To be considered for re-adoption by the NCOIL Workers' Compensation Insurance Committee on July 13, 2018

Section 1. Purpose

The purpose of this Act is to establish a state definition of "public employment" that affords eligibility for workers' compensation insurance benefits when a volunteer firefighter performs firefighter-related duties that are not directly emergency response; mandates reporting of rosters and hours; and requires use of updated minimums for annual payroll.

Section 2. Short Title

This Act shall be known as the "Model Act on Workers' Compensation Coverage for Volunteer Firefighters."

Section 3. Definition of Public Employment*

"Public employment" includes the following:

A. municipal workers, including volunteer firefighters while acting in any capacity under the direction and control of the fire department

B. members of any regularly organized private volunteer fire department while acting in any capacity under the direction and control of the fire department

Drafting Note: The placement of the definition of "volunteer firefighter" will differ depending on the state law.

Section 4. Reporting of Rosters/Hours

A. The State Fire Marshal shall create a process to receive a roster of volunteer firefighter personnel on an annual basis. The roster must be submitted by the designated time, from each volunteer fire district in the state.

B. The roster shall include individual names and corresponding individual "total hours worked" for each volunteer firefighter.

C. "Total hours worked" means the total number of hours of each volunteer firefighter while acting in any capacity under the direction and control of the fire department.

D. Rosters collected by the State Fire Marshal shall be certified upon receipt and shall be made available to insurance carriers licensed to write workers compensation programs in this state or their designees upon request.

Section 5. Review of Minimum Payroll Basis

Notwithstanding any other provision of law, after review of losses and premium for volunteer firefighters in the state, every five years the Commissioner of Insurance shall prepare a regulation that will establish the minimum annual payroll per volunteer firefighter for the purpose of setting workers' compensation rates for the departments.

Section 6. Enforcement

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

Section 7. Effective Date

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

* Based on Vermont S. 106, signed by Governor Peter Shumlin on May 16, 2012.

DRAFTING NOTE & APPENDICES

DRAFTING NOTE:

A state may wish to identify a funding source for volunteer firefighter workers' compensation insurance. Approaches that states have employed or considered include:

A. Private market mechanisms

1. Private insurers participate in an assigned risk pool that provides volunteer firefighter workers' compensation coverage. (Vermont)

B. State-based mechanisms

1. Volunteer fire departments may obtain workers' compensation insurance for volunteer firefighters through a group insurance pool administered by a state's non-profit workers' compensation insurance provider, and the state contributes $55 per firefighter per year to help defray premium costs, up to an annual state maximum for such expenditures. (Oklahoma: see Appendix 1, pages 1 to 2)

C. Subsidies

1. A $5 million premium subsidy fund, housed within a state auditor‘s office, helps to defray expected increases in premium costs for volunteer fire departments. (West Virginia: see Appendix 2, pages 3 to 4)

D. Surcharges

1. Coverage is purchased with a fee that each political subdivision pays based on a fixed-dollar value per ____ number of people served in a district. (North Dakota)

2. A state imposes a two percent tax on fire insurance premiums, which the state fire marshal uses to buy a single policy that covers all volunteer firefighters in the state, among other purposes. (Louisiana: see Appendix 3, pages 5 to 7)

E. Tax levies

1. Each county governing body would establish a special revenue fund, financed with a new county tax levy, to reimburse volunteer firefighter departments for their workers' compensation insurance premium costs. (Montana SB 54: see Appendix 4, pages 8 to 9)

APPENDIX 1 – STATE-BASED MECHANISM

Oklahoma

§85-132a. Workers' compensation insurance – Volunteer firefighters.

A. 1. Volunteer fire departments organized pursuant to state law may obtain workers' compensation insurance for volunteer firefighters through the Volunteer Firefighter Group Insurance Pool pursuant to requirements established by CompSource Oklahoma which shall administer the Pool. For the premium set by CompSource Oklahoma, the state shall provide Fifty-five Dollars ($55.00) per firefighter per year. Except as otherwise provided by subsection D of this section, the total amount paid by the state shall not exceed Three Hundred Twenty Thousand Three Hundred Thirty-eight Dollars ($320,338.00) per year or so much thereof as may be necessary to fund the Volunteer Firefighter Group Insurance Pool.

2. CompSource Oklahoma shall collect the premium from state agencies, public trusts and other instrumentalities of the state. Any funds received by CompSource Oklahoma from any state agency, public trust, or other instrumentality for purposes of workers‘ compensation insurance pursuant to this section shall be deposited to the credit of the Volunteer Firefighter Group Insurance Pool. CompSource Oklahoma shall collect premiums, pay claims, and provide for excess insurance as needed.

B. CompSource Oklahoma shall report, annually, to the Governor, the Speaker of the Oklahoma House of Representatives, and the President Pro Tempore of the State Senate the number of enrollees in the Volunteer Firefighter Group Insurance Pool, and the amount of any anticipated surplus or deficiency of the Pool; and shall also provide to the Governor, the Speaker of the Oklahoma House of Representatives and the President Pro Tempore of the State Senate sixty (60) days advance notice of any proposed change in rates for the Volunteer Firefighter Group Insurance Pool.

C. The amount of claims paid, claim expenses, underwriting losses, loss ratio, or any other financial aspect of the Volunteer Firefighter Group Insurance Pool shall not be

considered when determining or considering bids for the amount of any premiums, rates, or expenses owed by, or any discounts, rebates, dividends, or other financial benefits owed to any other policyholder of CompSource Oklahoma.

D. Except as otherwise provided by law, any increase in the state payment rate for volunteer firefighters under the Volunteer Firefighter Group Insurance Pool shall not exceed five percent (5%) per annum. Any proposed change in rates for the Volunteer Firefighter Group Insurance Pool must be approved by the Board of Managers of CompSource Oklahoma with notice provided pursuant to subsection B of this section. CompSource Oklahoma shall not increase premiums for the Volunteer Firefighter Group Insurance Pool more than once per annum.

E. For purposes of this section, the term —volunteer fire departments includes those volunteer fire departments which have authorized voluntary or uncompensated workers rendering services as firefighters and are created by statute pursuant to Section 592 of Title 18 of the Oklahoma Statutes, Sections 29-201 through 29-205 of Title 11 of the Oklahoma Statutes, and those defined by Section 351 of Title 19 of the Oklahoma Statutes.

APPENDIX 2 – SUBSIDIES

West Virginia
§12-4-14a. Workers' Compensation Subsidy for Volunteer Fire Departments; creation of program;
Auditor to administer.

(a) For the purposes of this section:

(1) "Fiscal year" means the fiscal year of the state.

(2) "Individual base year premium" means the workers' compensation insurance premium that became due and payable by a volunteer fire department after June 30, 2010 but before July 1, 2011.

(3) "Individual premium" means the workers' compensation premium due and payable by a volunteer fire department in each twelve month period beginning on or after July 1, 2011.

(4) "Total base year premium" means the aggregate workers' compensation insurance premium due and payable by all volunteer fire departments as determined by the Insurance Commissioner after June 30, 2010 but before July 1, 2011.

(5) "Total premium" means the aggregate workers' compensation insurance premium due and payable by all volunteer fire departments in each twelve month period beginning on or after July 1, 2011.

(b) In recognition of the burden of increasing workers' compensation insurance premiums on volunteer fire departments, the Legislature has determined that additional funding assistance should be made available to eligible departments to pay a portion of

those premium increases beginning with invoices due and payable on or after July 1, 2011.

(c) There is hereby established a special program which shall be known as the "Volunteer Fire Department Workers' Compensation Subsidy Program." The program shall be administered by the State Auditor from moneys that may be appropriated and designated for the program by the Legislature.

(d) The State Auditor shall administer the distribution of moneys appropriated for Volunteer Fire Department Workers' Compensation Subsidy Program to volunteer fire departments to help defray workers' compensation insurance premium increases.

(1) Volunteer fire departments shall request supplemental funds by submitting to the Auditor the following information:

(A) The previous fiscal year's workers' compensation premium invoices with paid receipts;

(B) The current fiscal year's workers' compensation premium invoices showing the amount due and due date and any applicable paid receipts; and

(C) Any other information the Auditor deems necessary for administering the subsidy on forms and schedules as the Auditor directs. The Auditor is authorized to set up an electronic filing system at his or her discretion for filing of the aforementioned information.

(2) After determining that there is a premium increase and the amount of the premium increase for the volunteer fire department requesting the subsidy, the Auditor shall make disbursements in the manner set forth in subsection (e) of this section subject to the following requirements:

(A) The volunteer fire department must be in good standing with the State Fire Marshal;

(B) The volunteer fire department must be registered with the Auditor's Office in a form and manner prescribed by the Auditor prior to being eligible for consideration of any subsidy, which registration must be completed no fewer than thirty days prior to the due date of the workers' compensation premium;

(C) The volunteer fire department must agree that the subsidy for its workers' compensation insurance premium increase will be paid directly to its insurance carrier by the Auditor and that it will timely pay the balance of the premium due; and

(D) Should a volunteer fire department fail to pay the balance of its workers' compensation insurance premium after a disbursement by the auditor and that insurance policy is subsequently cancelled, the premium paid by the Auditor shall be returned directly to him or her. If the Auditor does not receive a reimbursement for a cancelled policy, he or she shall

seek reimbursement for the subsidy portion of the insurance premium from the State Treasurer when the treasurer makes the next quarterly payment to the volunteer fire department pursuant to sections thirty-three and fourteen-d, article three, chapter thirty-three of this code.

(e) Beginning with the fiscal year that starts July 1, 2011, and continuing in each fiscal year thereafter, after the Auditor has verified that a volunteer fire department is eligible for a subsidy pursuant to this section, he or she shall pay on behalf of a volunteer fire department its subsidy, which is calculated by:

(1) Dividing the total amount of premium subsidy allocated by the Legislature to the Volunteer Fire Department Workers' Compensation Subsidy Program by the total premium minus the total base year premium, which calculation produces the "total shortfall multiplier"; and

(2) Multiplying the total shortfall multiplier determined in subdivision (1) of this subsection by the individual premium less the individual base year premium.

(3) In no event shall a volunteer fire department receive a workers' compensation premium subsidy greater than one hundred percent of its premium increase.

(f) For fiscal years after July 1, 2011, the Auditor shall consult with the Insurance Commissioner to determine the total amount of workers' compensation premium due by volunteer fire departments for any subsequent fiscal year. The Auditor may determine payment dates based upon information reasonably available for such a determination.

(g) The Auditor may promulgate emergency rules and may propose for promulgation legislative rules, in accordance with the provisions of article three, chapter twenty-nine-a of this code, as are necessary to provide for implementation and enforcement of the provisions of this section.

(h) The volunteer fire departments' workers' compensation premium subsidy program shall undergo a review to assess its effectiveness after three years of operation. The Auditor shall submit a report to the Joint Committee on Government and Finance not later than February 1, 2015, and provide details of the program operation including funds distributed and departments taking advantage of the subsidy.

APPENDIX 3 – SURCHARGES

Louisiana
§347. Disposition of tax money

A. Monies collected under R.S. 22:342 through 349, after being first credited to the Bond Security and Redemption Fund in accordance with Article VII, Section 9(B) of the Constitution of Louisiana, shall be credited to a special fund hereby established in the state treasury and known as the "Two Percent Fire Insurance Fund" hereinafter the "fund". Monies in the fund shall be available in amounts appropriated annually by the legislature for the following purposes in the following order of priority:

(1) (a) For the state fire marshal, an amount necessary to satisfy the requirements of R.S. 40:1593, relative to the purchase of group insurance for volunteer firefighters.

(b) For the state fire marshal, an amount necessary to satisfy the requirements of R.S. 23:1036, relative to the purchase of workers' compensation insurance for volunteer firefighters.

(2) (a) For the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge for allocation to the Pine Country Education Center in the parish of Webster, the sum of seventy thousand dollars per year, which shall be transferred without imposition of administrative fee or cost, to be used to develop and operate a firefighter training center operated in accordance with the standards and requirements of the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge.

(b) For the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge for allocation to Delgado Community College, the sum of seventy thousand dollars per year, which shall be transferred without imposition of administrative fee or cost, to be used to develop and operate a firefighter training center operated in accordance with the standards and requirements of the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge.

(3) For the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge, the sum of seventy thousand dollars per year for support of the firefighter training program.

(4) For distribution to each parish governing authority in accordance with rules and regulations established by the state treasurer based upon the formula provided for herein:

(a) Except in Orleans Parish, the state treasurer shall pay over to the treasurer of each governing authority of the parish described in R.S. 22:343 the full amount of money due as determined by the state treasurer. These funds shall be allocated, distributed, and paid to each parish on the basis of a determination of the established population category of each parish as shown by the latest federal census or as determined by the Louisiana State University and Agricultural and Mechanical College Agriculture Center, Department of Agricultural Economics and Agribusiness, under the latest federal-state cooperative program for local population estimates. Such determination shall be submitted by the Louisiana State University and Agricultural and Mechanical College Agriculture Center, Department of Agricultural Economics and Agribusiness, to the state treasurer annually not later than January fifteenth of each calendar year. Any parish governing authority which is aggrieved by such determination may file a petition for administrative review with the state treasurer not later than March fifteenth of each calendar year. The determination so submitted shall have no effect on the distribution for the fiscal year in which it is made,

but shall be utilized for purposes of this Subpart for distribution during the next ensuing fiscal year as follows:

(i) Those regularly paid fire departments of an incorporated municipality or fire and waterworks district in any unincorporated municipality or active volunteer fire departments having a population within its geographical area of one to two thousand five hundred shall receive seven hundred fifty dollars per annum.

(ii) Those regularly paid fire departments of an incorporated municipality or fire and waterworks district in any unincorporated municipality or active volunteer fire departments having a population of two thousand five hundred one to five thousand shall receive one thousand dollars per annum.

(iii) Those regularly paid fire departments of an incorporated municipality or fire and waterworks district in any unincorporated municipality or active volunteer fire departments having a population of five thousand one or more shall receive one thousand two hundred fifty dollars per annum.

(b) Additional funds shall be distributed to each parish based on the following population formula:

(i) Where the population is twenty-four thousand or less, the parish shall receive thirty-four cents for each inhabitant.

(ii) Where the population is twenty-four thousand one to fifty-five thousand inclusive, the parish shall receive thirty-seven cents per inhabitant.

(iii) Where the population is fifty-five thousand one to one hundred thousand inclusive, the parish shall receive forty cents per inhabitant.

(iv) Where the population is one hundred thousand one to two hundred fifty thousand inclusive, the parish shall receive forty-four cents per inhabitant.

(v) Where the population is two hundred fifty thousand one to four hundred twenty-five thousand inclusive, the parish shall receive forty-seven cents per inhabitant.

(vi) Where the population is over four hundred twenty-five thousand, the parish shall receive fifty cents per inhabitant.

(c) Any balance which remains after making the distributions required in Subparagraph (b) of this Paragraph shall be allocated on an equal per capita basis until all of the available funds are utilized.

(d) If the total amount of monies available for distribution pursuant to Subparagraph (b) of this Paragraph is less than the one hundred percent required to fully implement such formula, the amount distributed shall be prorated equally among the formula categories by the state treasurer prior to distribution to each parish governing authority.

B. These funds shall be allocated, distributed, and paid by each parish governing authority to each regularly constituted fire department of the municipality or district, or active volunteer fire department certified by the parish governing authority, based on the population within the area serviced by said regularly constituted fire department of the municipality or district, or active volunteer fire department. In order to determine the amount of the funds which shall be paid to each fire department, district, or municipality, from the parish governing authority, the following formula shall be applied:

(1) Total population serviced by all certified fire units in the parish divided into the total monies received by the parish from this tax equals the per capita available for distribution to certified local fire units.

(2) Total population serviced by each certified local fire unit in the parish multiplied by the per capita available as determined by Paragraph (1) of this Subsection equals the funds due each certified local fire unit in the parish.

C. The distribution of the proceeds from the premium tax shall in no way be considered as a basis for reduction of any additional parish funds currently remitted to local fire units for the purpose of fire protection.

D. (1) All money received under the provisions of R.S. 22:342 through 349 by the treasurer of the governing authority of the parish shall, within thirty days from the time it is received, be paid over by the treasurer to the fiscal representative of the regularly constituted fire department of the municipality or district or active volunteer fire department, as the case may be. If any of these funds are not so distributed either by mutual consent or without consent of the regularly paid fire department of the municipality or district or active volunteer fire department certified by the parish governing authority, such funds shall be invested in an interest-bearing account and any accrued interest on the investment of funds shall be credited and distributed per capita to the regularly paid fire department of the municipality or district or active volunteer fire department, as provided by this Section.

(2) Such money shall be used only for the purpose of rendering more efficient and efficacious the regularly paid fire department of the municipality or district or active volunteer fire department, as the case may be, in such manner as the governing body shall direct.

E. In Orleans Parish the state treasurer shall pay over to the secretary-treasurer of the board of trustees of the Firefighter's Pension and Relief Fund of the city of New Orleans all monies due shall be used only for the purpose of rendering more efficient and efficacious the pension system of the fire department of the city of New Orleans in such manner as the governing body of said pension fund shall direct as provided by law.

APPENDIX 4 – TAX LEVIES

Montana
SENATE BILL NO. 54 (as introduced 12-12-2012)

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Workers' compensation for volunteer firefighters -- definitions.**
(1) As of July 1, 2014, an employer shall provide workers' compensation coverage as provided in Title 39, chapter 71, to any volunteer firefighter who is listed on a roster of service.

(2) An employer may purchase workers' compensation coverage from any entity authorized to provide workers' compensation coverage under plan No. 1, 2, or 3 as provided in Title 39, chapter 71.

(3) (a) Except as provided in subsections (3)(b) and (3)(c), an employer shall by the first Tuesday in September of each year certify to the county governing body the dollar amount of workers' compensation premiums paid or expected to be paid for the employer's volunteer firefighters' annual policy period.

(b) (i) By September 3, 2013, an employer not exempted under [section 3(6)] shall provide the county governing body with an estimate of the dollar amount anticipated as necessary to provide annual workers' compensation coverage, starting no later than July 1, 2014, for volunteer firefighters as provided in this section.

(ii) An employer that has provided volunteer firefighters with workers' compensation coverage with funding subject to the limitations in 15-10-420 may choose to provide coverage through the permissive levy allowed in [section 3] and, if that choice is made, shall base the estimated dollar amount under subsection (3)(b)(i) on actual coverage costs.

(c) An employer exempted under [section 3(6)] is not subject to the reporting requirements in this subsection (3) unless the employer requests funding under the permissive levy provided for in [section 3].

(4) The county governing body shall reimburse employers the actual costs as certified in subsection (3) for the workers' compensation coverage for volunteer firefighters from the fund established in [section 2].

(5) An employer shall file a roster of service with the clerk and recorder in the county in which the employer is located and update the roster of service monthly if necessary to report changes in the number of volunteers on the roster of service. The clerk and recorder shall file the original and replace it with updates whenever necessary.

NEW SECTION. **Section 2. Fund for volunteer firefighters' workers' compensation.**
(1) Each county governing body shall establish a special revenue fund known as the volunteer firefighters' workers' compensation fund.

(2) Levies imposed pursuant to [section 3] must be placed in the fund.

(3) Expenditures from the fund may be made only to provide reimbursements to employers, as defined in [section 1], for workers' compensation premiums required by [section 1].

(4) Money in the fund must be invested as provided in 7-6-202. Interest and income from the investment of money in the fund must be credited to the fund.

NEW SECTION. **Section 3. County tax levy to pay volunteer firefighters' workers' compensation coverage.**
(1) Subject to subsection (6), the county governing body shall levy an annual property tax in the amount necessary to:

(a) fund premiums for workers' compensation for volunteer firefighters as provided in [section 1]; and

(b) establish a reserve in accordance with 7-6-4034(2)(a). ……

(6) Property located within the boundaries of any incorporated city or town that on or after July 1, 2014, provides workers' compensation coverage to employees as defined in 39-71-118 is not subject to the levy provided for in this section.

NEW SECTION. **Section 4. Public hearing requirement.** Each year prior to implementing a levy as provided in [section 3] and after giving notice of a hearing as provided in 7-1-2121, the county governing body shall hold a public hearing regarding implementation of the levy.

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Construction Industry Workers' Compensation Coverage Act

Approved by the NCOIL Executive Committee on November 22, 2009.

To be considered for re-adoption by the NCOIL Workers' Compensation Insurance Committee on July 13, 2018

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Section 1. Summary

This Act mandates workers' compensation coverage in the construction industry, with certain exemptions; establishes auditing procedures; specifies liability; provides penalties for insurance fraud; and addresses enforcement powers.

Section 2. Definitions

A. "Employee" means any entity as defined by [Insert Applicable Reference to State Definition].

B. "Employer" means any entity as defined by [Insert Applicable Reference to State Definition].

C. "Partner" means any person as defined by [Insert Applicable Reference to State Definition].

D. "Principal Contractor" and "subcontractor" mean any entity as defined under [Insert Applicable State Agency].

E. "Sole proprietor" means any entity as defined under [Insert Applicable Reference to State Definition].

Section 3. Coverage Requirements

A. Every person engaged in the construction industry, including principal contractors, intermediate contractors and subcontractors shall be required to carry workers' compensation insurance, regardless of the number of employees, unless exempted as indicated in subsections (C) and (D).

Drafting Note: States may want to consider the cost impact of this subsection on sole proprietors and self-employed small contractors. Options to consider include exemptions for individuals with high-quality health insurance plans, the use of deductibles to bring down insurance costs, and monthly premium payment plans.

B. For purposes of this Section, "a person engaged in the construction industry" means any person or entity assigned to the Contracting Group as those classifications are designated by the rate service organization designated by the [Insert State Department of Insurance].

Drafting Note: For the purposes of this Act, the [Insert State Department of Insurance] could use standard industrial classification codes and the definitions thereof developed by the National Council on Compensation Insurance (NCCI) and the U.S. Department of Labor Bureau of Labor Statistics (BLS) North American Industry Classification System (NAICs) codes to meet the criteria of the term "construction industry" as set forth in this Act.

C. A sole proprietor or partner engaged in the construction industry shall not be required to carry workers' compensation on themselves if they are doing work directly for the owner of the property pursuant to Section 3(D), but shall be required to carry workers' compensation insurance on any subcontractor, employee or worker not otherwise covered by a policy of workers' compensation; however, if a sole proprietor or partner is working as an intermediate contractor or subcontractor then workers' compensation insurance shall be required on themselves.

D. The provisions of this Section shall not apply to individuals performing work on their own property. As used in this subsection (D), an individual is a natural person.

Drafting Note: States may want to look to state definitions of employer, employee, and existing treatment of homeowners on residential projects to avoid duplicating and conflicting language.

Section 4. Liability

A. Every principal contractor shall be responsible to ensure that any subcontractor with which it directly contracts is either self-insured or maintains workers' compensation coverage throughout the periods during which the services of a subcontractor are used and, further, if the subcontractor is neither self-insured nor covered, then the principal contractor rather than the [Insert State Uninsured Employer Fund], if applicable, should be responsible for the payment of statutory benefits.

B. If an employee of a subcontractor suffers an injury or disease and, on the date of injury or last exposure, his or her employer did not have workers' compensation coverage or was not an approved self-insured employer, and the principal contractor did

not obtain certification of coverage from the subcontractor, then that employee may file a claim against the principal contractor for which the subcontractor performed services on the date of injury or last exposure, and such claim shall be administered in the same manner as claims filed by injured employees of the principal contractor,
provided that an intermediate subcontractor that subcontracts with another subcontractor shall, with respect to such subcontract, become the principal contractor for the purposes of this section.

C. 1. The contractor and subcontractor shall provide proof of continuing coverage to the principal contractor throughout the term of the contract between the contractor and subcontractor by providing a certificate showing current as well as renewal or replacement coverage during the term of the contract between the principal contractor and the subcontractor.

2. A subcontractor who allows coverage to lapse because of non-payment during a contract but fails to notify a contractor under Subsection (C) becomes liable to the injured employee and subject to all recovery of payments, plus administrative costs and attorneys' fees.

D. 1. If a claim of an injured employee of a subcontractor is accepted or conditionally accepted into the [Insert State Uninsured Employer Fund], if applicable, both the principal contractor and subcontractor are jointly and severally liable for any payments made by the [Insert State Uninsured Employer Fund], and the [Insert State Insurance Commissioner] may seek recovery of the payments, plus administrative costs and attorneys' fees, from the principal contractor, the subcontractor, or both.

2. A principal contractor who is held liable pursuant to this subsection for the payment of benefits to an injured employee of a subcontractor may recover the amount of such payments from the subcontractor, plus reasonable attorneys' fee and costs.

Section 5. Employer/Contractor Disclosure Requirements

A. Employers shall make available to their workers’ compensation insurance carrier all records necessary for the payroll verification audit and permit the auditor to make a physical inspection of the employer's operation.

B. A principal contractor may require a subcontractor to provide evidence of workers' compensation insurance.

C. An insurance carrier may require each employer to submit a copy of the quarterly earning report at the end of each quarter to the insurance carrier and submit self-audits supported by the quarterly earnings reports and the rules adopted by the state agency providing unemployment tax collection services. The reports must include an attestation by an officer or principal of the employer attesting to the accuracy of the information contained in the report.

D. A principal contractor may require a subcontractor to be able to produce on demand at their principal place of business information required by Section 5(B).

Section 6. Payroll Audit Procedures

A. In no event shall employers in the construction class, generating more than the amount of premium required to be experience rated, be audited less than annually. A minimum of ten percent of employers in the construction class that do not generate more than the amount of premium required to be experience rated will be inspected annually and audited, if necessary. The annual audits required for construction classes shall consist of physical onsite audits.

B. Payroll verification audit rules must include, but need not be limited to, the use of state and federal reports of employee income, payroll and other accounting records, certificates of insurance maintained by subcontractors, and duties of employees.

C. Upon conclusion of an employer audit, the insurance carrier shall report to the [Insert State Workers' Compensation Department or Appropriate Agency] any unresolved employee or independent contractor misclassification, any uncovered or unreported employees, and any other violation of this Act.

Section 7. Penalties

A. For the purposes of this section, "securing the payment of workers' compensation" means obtaining coverage that meets the requirements of Section 3. However, if at any time an employer materially understates or conceals payroll, materially misrepresents or conceals employee duties so as to avoid proper classification for premium calculations, or materially misrepresents or conceals information pertinent to the computation and application of an experience rating modification factor, such employer shall be deemed to have failed to secure payment of workers' compensation and shall be subject to the sanctions set forth in this section.

B. In addition to any other penalty prescribed by this section, the department shall assess against any employer who has failed to secure the payment of compensation as required by Section 3 a penalty equal to 2 times the amount the employer would have paid in premium when applying approved manual rates to the employer's payroll during periods for which it failed to secure the payment of workers' compensation required by this section within the preceding 3-year period or $750, whichever is greater.

C. 1. Any person that knowingly submits an initial application, renewal application, or certificate of insurance as proof of coverage, that is false, forged, misleading, or incomplete information for the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage is subject to a civil penalty, per violation, not less than [Insert Applicable Amount].

2. In determining intent, the [Insert Appropriate State Agency] shall consider whether a person or organization in a similar size and type of business could reasonably be expected to understand that information being submitted was false or likely to mislead. In assessing the amount of the civil penalty, the [Insert Appropriate State Agency] shall consider any one or more of the relevant circumstances presented by any of the parties to the case, including, but not limited to, the following:

a. the nature and seriousness of the misconduct;
b. the number of violations;

c. the persistence of the misconduct;
d. the length of time over which the misconduct occurred;
e. the willfulness of the defendant's misconduct; and
f. the defendant's assets, liabilities, and net worth.

3. The [Insert Appropriate State Agency] may also require, as civil penalty, that the entity repay any compensation received through such violation, with interest at the rate of [Insert Applicable Percentage].

Drafting Note: States can insert references to existing criminal penalties in their workers' compensation or insurance fraud codes.

D. 1. Whenever the [Insert State Workers' Compensation Department or Appropriate Agency] determines that an employer who is required to secure the payment to his or her employees of the compensation provided for by this Act has failed to secure the payment of workers' compensation required by this Act or to produce the required business records under Section 5 within five (5) business days after receipt of the written request of the [Insert State Workers' Compensation Department or Appropriate State Agency], such failure shall be deemed an immediate serious danger to public health, safety, or welfare sufficient to justify service by the [Insert State Workers' Compensation Department or Appropriate State Agency] of a stop-work order on the employer, requiring the cessation of all business operations. If the [Insert State Workers' Compensation Department or Appropriate State Agency] makes such a determination, the [Insert State Workers' Compensation Department or Appropriate State Agency] shall issue a stop-work order within 72 hours.

2. In addition to serving a stop-work order at a particular worksite which shall be effective immediately, the department shall immediately proceed with service upon the employer which shall be effective upon all employer worksites in the state for which the employer is not in compliance; provided that, if the employer cannot be found and served under due diligence the department may execute service by publishing the stop work order for one week in a news publication having general circulation in the [names of cities] metropolitan areas.

3. A stop-work order may be served with regard to an employer's worksite by posting a copy of the stop-work order in a conspicuous location at the worksite. The order shall remain in effect until the [Insert State Workers' Compensation Department or Appropriate State Agency] issues an order releasing the stop-work order upon a finding that the employer has come into compliance with the coverage requirements of this Act and has paid any penalty assessed under this section.

4. The [Insert State Workers' Compensation Department or Appropriate State Agency] may issue an order of conditional release from a stop-work order to an employer upon a finding that the employer has complied with coverage requirements of this section and has agreed to remit periodic payments of the penalty pursuant to a payment agreement schedule with the [Insert State Workers' Compensation Department or Appropriate State Agency]. If an order of conditional release is issued, failure by the employer to meet any term or condition of such penalty payment agreement shall result in the immediate

reinstatement of the stop-work order and the entire unpaid balance of the penalty shall become immediately due.

5. The [Insert State Workers' Compensation Department or Appropriate State Agency] may require an employer who is found to have failed to comply with the coverage requirements of Section 3 to file with the [Insert State Workers' Compensation Department or Appropriate State Agency], as a condition of release from a stop-work order, periodic reports for a probationary period that shall not exceed 2 years that demonstrate the employer's continued compliance with this section. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall by rule specify the reports required and the time for filing under this subsection.

E. Stop-work orders and penalty assessment orders issued under this section against a corporation, partnership, or sole proprietorship shall be in effect against any successor corporation or business entity, including spouses, that has one or more of the same principals or officers as the corporation or partnership against which the stop-work order was issued and are engaged in the same or equivalent trade or activity.

F. It shall be unlawful for any person to knowingly violate a stop-work order issued by the [Insert State Workers' Compensation Department or Appropriate State Agency] and it is punishable as a felony of the third degree.

G. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall assess a penalty of not less than $1,000 per day against an employer for each day that the employer conducts business operations that are in violation of a stop-work order.

H. Any agency action by the department under this section, if contested, must be contested as provided in [Insert State Chapter Relating to Judicial or Administrative Review].

Section 8. Enforcement

The [Insert State Workers' Compensation Department or Appropriate State Agency] shall have the authority to enforce the requirements of this Act.

Drafting Note: States may wish to consider the following enforcement provisions:

A. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall enforce workers' compensation coverage requirements, including the requirement that the employer secure the payment of workers' compensation, and the requirement that the employer provide the carrier with information to accurately determine payroll and correctly assign classification codes. In addition to any other powers under [Insert State Statute], the [Insert State Workers' Compensation Department or Appropriate State Agency] shall have the power to:

1. Conduct investigations for the purpose of ensuring employer compliance.

2. Enter and inspect any place of business at any reasonable time for the purpose of investigating employer compliance.

3. Examine and copy business records.

4. Administer oaths and affirmations.

5. Certify to official acts.

6. Issue and serve subpoenas for attendance of witnesses or production of business records, books, papers, correspondence, memoranda, and other records.

7. Issue stop-work orders, penalty assessment orders, and any other orders necessary for the administration of this section.

8. Enforce the terms of a stop-work order.

9. Levy and pursue actions to recover penalties.

10. Seek injunctions and other appropriate relief.

B. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall designate representatives who may serve subpoenas and other process of the [Insert State Workers' Compensation Department or Appropriate State Agency] issued under this Act.

C. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall specify by rule the business records that employers must maintain and produce to comply with this Act.

D. Any law enforcement agency in the state may, at the request of the [Insert State Workers' Compensation Department or Appropriate State Agency], render any assistance necessary to carry out the provisions of this section, including, but not limited to, preventing any employee or other person from remaining at a place of employment or job site after a stop-work order or injunction has taken effect.

E. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall adopt rules to administer this section.

Drafting Note: States could use part or all of penalties in Section 7 to offset enforcement and other expenses incurred by the implementation of this Act.

Section 9. Severability

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

Section 10. Effective Date

This Act shall take effect immediately.

Drafting Note: States would benefit by comparing data from different state agencies, e.g. Unemployment and Workers' Comp Departments, to help identify problem employers.

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS

Model Act Regarding Workers' Compensation Insurance Coverage in Professional Employer Organization (PEO) Relationships

Readopted by the Executive Committee on November 24, 2013 and by the Workers' Compensation Insurance Committee on November 21, 2013. Originally adopted by the Executive Committee on November 17, 2007, and by the Workers' Compensation Committee on November 15, 2007. Sponsored by Sen. Carroll Leavell (NM)

To be considered for re-adoption by the NCOIL Workers' Compensation Insurance Committee on July 13, 2018

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Section 1. Short Title

This Act may be called the Model Act Regarding Workers' Compensation Insurance Coverage in Professional Employer Organization (PEO) Relationships.

Section 2. Purpose

The purpose of this Act is to require the registration of professional employer organizations (PEOs) and to regulate the use of experience ratings for workers' compensation insurance in PEO relationships.

[Drafting Note: This model is specifically designed to address the registration and use of experience ratings by PEOs in workers' compensation insurance. Some states may wish to address additional PEO rights and responsibilities, or require PEOs to be licensed.]

Section 3. Definitions

A. “Client” means any employer that enters into a Professional Employer Agreement with a PEO.
B. “Covered Employee” means an employee of the Client whose employment responsibilities are shared between the Client and a PEO.

[Drafting Note: Workers’ compensation law governs whether or not the PEO is considered to be an employer of an individual for workers’ compensation purposes. States must determine if a PEO agreement is consistent with the law.]

C. “Direct hire employee” means an individual who is an employee of the Client and who is not a Covered Employee.

D. “Professional Employer Organization” or “PEO” means an entity or group of entities that offers professional employer services in this State under a PEO agreement.

1. An entity engaged in the business of entering into professional employer agreements, as defined herein, is acting as a PEO regardless of its use of other terms such as “staff leasing company,” “registered staff leasing company,” “employee leasing company,” “administrative employer,” or any other name.

2. A PEO does not include:

a. temporary help services (an entity that recruits and hires its own employees; assigns them to clients on a temporary basis to support or supplement the Client’s work force in special work situations such as employee absences, temporary skill shortages, and seasonal workloads; and customarily attempts to reassign the employees to other clients when they finish each assignment) or

b. independent contractor arrangements

[Drafting Note: This definition establishes a single regulatory category and terminology for these entities, regardless of the terminology used by the parties. In particular, this category of “PEOs” is intended to encompass what was once commonly referred to as “employee leasing firms.” Therefore, states with existing laws governing employee leasing should repeal those laws to the extent that they are superseded by this Model Act or otherwise obsolete, and should update the terminology and substance of any remaining provisions as necessary.]

E. “Professional employer agreement” or “PEO agreement” means an agreement between a PEO and a Client under which the PEO agrees to assume specified employment responsibilities for all or part of the Client’s work force.

F. “Insurer” means an insurance company authorized to do business in this State.

G. “Designated advisory organization” means the entity designated by the [insurance authority in the state] for the reporting of claims and experience data and for the administration of the workers’ compensation experience rating system.

Section 4. Registration Requirements

A. A PEO shall be registered as a Professional Employer Organization with the [insert appropriate state agency]. An insurer may not issue a workers' compensation insurance policy to a PEO that is not registered, nor enter into an agreement with an unregistered PEO to issue policies to Clients of the PEO.

B. An applicant shall file an application for registration with the [insert appropriate state agency] on a form approved by the [insert appropriate state agency] accompanied by a [insert application and fee amounts].

[Drafting Note: Requirements including PEO registration information, timeframe of the initial registration, and renewal procedures should be consistent with existing state law, if any. States that do not currently have statutory PEO registration requirements may wish to review requirements codified by other states.]

Section 5. General Rules

A. The responsibility to obtain workers' compensation coverage for Covered Employees in compliance with all applicable law shall be specifically allocated in the Professional Employer Agreement to either the Client or the PEO. If such responsibility is allocated to the PEO under any such agreement, the agreement shall require that the PEO maintain and provide workers' compensation coverage for the Covered Employee from an insurer authorized to do business in this State, for as long as the agreement is in effect.

B. The Client is responsible for maintaining workers' compensation insurance for the Client's Direct Hire and Covered Employees, either through a PEO agreement for covered employees or through an authorized insurer doing business in this state. The PEO agreement shall not relieve the Client of its responsibility for demonstrating compliance with this State's workers' compensation statute. A policy that excludes coverage for the Client's Direct Hire Employees shall not be accepted as proof of coverage pursuant to Section [insert appropriate reference to proof-of-coverage statute] of the Workers' Compensation Act.

C. A PEO may only provide workers' compensation benefits through a policy written by a licensed insurer. The licensed insurer shall be responsible for the payment and administration of all workers' compensation claims.

Section 6. Experience Rating

A. Workers' compensation insurance premiums with respect to any Client for which a PEO performs services shall be determined based on the experience modification factor of the Client, provided that the Client has sufficient workers' compensation premium volume to be experience rated. The Client's experience modification factor shall be based on exposures and claims for both Covered and Direct Hire employees of the Client. Otherwise the premiums shall be at the rate approved by [insert appropriate state agency] for an employer that cannot be experience rated.

[Drafting Note: A state may consider that alternative rating mechanisms could be permitted as long as the PEO and insurer are in agreement and both the clients and the integrity of the experience rating system are protected.]

B. The PEO shall maintain separate payroll records and separate records of work-related injuries and illnesses for each Client company and shall report these in a timely and ongoing manner to its insurer.

C. The insurer shall report all loss and payroll information to the designated advisory organization in a manner approved by the commissioner [or other state official if appropriate] that identifies the Client and allows the calculation of an accurate experience rating for the Client on an ongoing basis.

D. Within 60 days after the termination of a PEO agreement, the PEO shall provide the Client with records regarding the payroll and loss experience related to workers' compensation insurance provided to Covered Employees.

Section 7. Severability

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

[Drafting Note: States should consider whether to include rulemaking authority for the appropriate state agencies as part of this Act.]

Section 8. Effective Date

This Act shall take effect on [insert date].