TENTATIVE GENERAL SCHEDULE
NCOIL ANNUAL MEETING
DECEMBER 5 - 8, 2018

As of November 6, 2018, and Subject to Change

Renaissance Oklahoma City Convention Center Hotel
Oklahoma City, Oklahoma

NCOIL ANNUAL MEETING
Oklahoma City, Oklahoma
December 5 - 8, 2018
TENTATIVE SCHEDULE

WEDNESDAY, DECEMBER 5TH

Registration	1:00 p.m.	-	6:30 p.m.
Oklahoma State Capitol Tour	3:00 p.m.	-	4:00 p.m.
IEC Board Meeting	5:30 p.m.	-	6:30 p.m.
Welcome Reception	6:30 p.m.	-	7:30 p.m.

THURSDAY, DECEMBER 6TH

Registration *Exhibits Open: 8:00 a.m. – 5:30 p.m.*	7:00 a.m.	-	5:30 p.m.
Welcome Breakfast	8:15 a.m.	-	10:00 a.m.
Networking Break	10:00 a.m.	-	10:15 a.m.
Life Insurance & Financial Planning Committee	10:15 a.m.	-	11:30 a.m.
General Session: Examining the Role of ERISA in the State Based System of Insurance Regulation: Can Meaningful State Reforms be Achieved in an ERISA-Dominated Marketplace?	11:30 a.m.	-	1:00 p.m.
The Institutes Griffith Foundation Legislator Luncheon - A Primer on Catastrophe Modeling for Public Policymakers (Open to Public Policymakers Only)	1:00 p.m.	-	2:15 p.m.

Financial Services Committee	2:15 p.m.	-	3:30 p.m.
Networking Break	3:30 p.m.	-	3:45 p.m.
Innovation General Session: Understanding InsurTech and FinTech – What Legislators and Regulators Can do to Promote Innovation in the Insurance and Financial Services Industries	3:45 p.m.	-	5:15 p.m.
Budget Committee	5:15 p.m.	-	5:45 p.m.
Adjournment			5:45 p.m.
CIP Member & Sponsor Reception	5:45 p.m.	-	6:45 p.m.

FRIDAY, DECEMBER 7TH

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	7:00 a.m.	-	5:00 p.m.
Property & Casualty Insurance Committee	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
General Session: Reverse Preemption - How States can Preempt Federal Insurance Laws and Regulations through use of the McCarran-Ferguson Act	10:45 a.m.	-	12:00 p.m.
Luncheon with Keynote Address	12:00 p.m.	-	1:15 p.m.
Legislative Micro Meetings	1:15 p.m.	-	1:45 p.m.
NCOIL – NAIC Dialogue	1:45 p.m.	-	3:15 p.m.
Networking Break	3:15 p.m.	-	3:30 p.m.
Joint State Federal Relations and International Insurance Issues Committee	3:30 p.m.	-	5:00 p.m.
Articles of Organization and Bylaws Review Committee	5:00 p.m.	-	5:30 p.m.

Nominating Committee (Members Only)	5:30 p.m.	-	6:00 p.m.
Adjournment			6:00 p.m.

SATURDAY, DECEMBER 8TH

Registration *Exhibits Open: 8:00 a.m. – 10:00 a.m.*	8:00 a.m.	-	9:00 a.m.
Health, Long Term Care and Health Retirement Issues Committee	9:00 a.m.	-	11:00 a.m.
Networking Break	11:00 a.m.	-	11:15 a.m.
Workers' Compensation Insurance Committee	11:15 a.m.	-	12:30 p.m.
Business Planning Committee and Executive Committee	12:30 p.m.	-	1:30 p.m.
Adjournment			1:30 p.m.

******Please Note all speakers listed are scheduled to speak as of Nov. 6, 2018. There may be modifications between now and the start of the Meeting*****

WEDNESDAY, DECEMBER 5, 2018

Oklahoma State Capitol Tour
Wednesday, December 5, 2018
3:00 p.m. – 4:00 p.m.

IEC Board Meeting
Wednesday, December 5, 2018
5:30 p.m. – 6:30 p.m.

Welcome Reception
Wednesday, December 5, 2018
6:30 p.m. – 7:30 p.m.

THURSDAY, DECEMBER 6, 2018

Welcome Breakfast
Thursday, December 6, 2018
8:15 a.m. – 10:00 a.m.

1. Welcome to Oklahoma City
2. President Welcome
   Senator Jason Rapert (AR)
3. New Member Welcome and Introduction
   Senator Jason Rapert (AR)
4. Keynote Address from the 27th and Current Governor of Oklahoma The Honorable Mary Fallin
5. Presentation of Law Review Article
   Connecticut Insurance Law Journal, Vol. 25, 2018. Available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3239966
   Prof. Daniel Schwarcz, Univ. of Minnesota Law School
6. Any Other Business
7. Adjournment

Networking Break
Thursday, December 6, 2018
10:00 a.m. - 10:15 a.m.

Life Insurance & Financial Planning Committee
Thursday, December 6, 2018
10:15 a.m. – 11:30 a.m.

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

1. Call to Order/Roll Call/Approval of July 12, 2018 Committee Meeting Minutes
2. Examining President Trump's Executive Order on Retirement Planning
   Michael Kreps, Esq., Principal, Groom Law Group
   Bruce Ferguson, Senior Vice President, State Relations, ACLI
3. Update on Life Insurance Industry "Hot Topics" – An Actuary's View on Principle Based Reserving (PBR) and Variable Annuity Reserve and Capital Reforms
   Lisa Kuklinski, Actuarial Consultant
4. Discussion on the Use of Genetic Testing in Insurance Underwriting
   Prof. Anya Prince, University of Iowa College of Law
   Bruce Margolis, Pacific Life Insurance Co.
5. Any Other Business
6. Adjournment

Health General Session
Examining the Role of ERISA in the State Based System of Insurance Regulation: Can Meaningful State Reforms be Achieved in an ERISA-Dominated Marketplace?
Thursday, December 6, 2018
11:30 a.m. – 1:00 p.m.

Moderator: Rep. Tom Oliverson, M.D. (TX)

Professor Jonathan B. Forman
Kenneth E. McAffee Centennial Chair in Law
University of Oklahoma College of Law

Professor Elizabeth McCuskey
Co-Director, JD/MD & JD/MPH Joint Degree Programs
University of Toledo College of Law

James Gelfand
Senior Vice President, Health Policy
ERISA Industry Committee (ERIC)

The Honorable Jessica Altman
Commissioner
Pennsylvania Department of Insurance

The Institutes Griffith Foundation Legislator Luncheon
A Primer on Catastrophe Modeling for Public Policymakers
Thursday, December 6, 2018
1:00 p.m. – 2:15 p.m.

*****Open to Public Policymakers Only*****

Financial Services Committee
Thursday, December 6, 2018
2:15 p.m. – 3:30 p.m.

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

1. Call to Order/Roll Call/Approval of July 13, 2018 Committee Meeting Minutes
2. Update on Data Protection and Breach Notification Laws
   Paul Ferrillo, Shareholder, GreenbergTraurig
   Justin Brookman, Director, Consumer Privacy and Technology Policy, ConsumersUnion
   Michael Gugig, Transamerica
3. Discussion/Consideration of Resolution in Support of State Regulated Health Savings Account-Based Coverage
   Rep. Steve Riggs (KY) – NCOIL Immediate Past President
4. Discussion/Consideration of Resolution Asserting McCarran-Ferguson Reverse Preemption over the Supervision of Insurance Companies by the Federal Reserve Board and its Examiners
   Sen. Dan "Blade" Morrish (LA) – NCOIL Vice President
5. Adjournment

Networking Break
Thursday, December 6, 2018
3:30 p.m. – 3:45 p.m.

Innovation General Session
Understanding InsurTech and FinTech – What Legislators and Regulators Can do to Promote Innovation in the Insurance and Financial Services Industries
Thursday, December 6, 2018
3:45 p.m. – 5:15 p.m.

Moderator: Rep. Martin Carbaugh (IN)

Julie Sherlock
Head of Insurance Strategy
Boost Insurance

Rick MCathron, CPCU, CIC
Head of Insurance
Hippo Insurance

Shane Foster
Senior Litigation Counsel
Consumer Protection & Advocacy Sectio –Civil Litigation Division of the Arizona Attorney General's Office
Member of Arizona's FinTech Sandbox Team

Budget Committee
Thursday, December 6, 2018
5:15 p.m. – 5:45 p.m.

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

1. Call to Order/Roll Call/Approval of July 12, 2018 Committee Meeting Minutes
2. Consideration of 2019 Budget
3. Consideration of Updated Financial Model
4. Any Other Business
5. Adjournment

CIP Member & Sponsor Reception
Thursday, December 6, 2018
5:45 p.m. – 6:45 p.m.

FRIDAY, DECEMBER 7, 2018

Property & Casualty Insurance Committee
Friday, December 7, 2018
9:00 a.m. – 10:30 a.m.

Chair: Rep. Richard Smith (GA)
Vice Chair: Rep. David Santiago (FL)
Acting Chair: Rep. Matt Lehman (IN) – NCOIL Treasurer

1. Call to Order/Roll Call/Approval of July 12, 2018 Committee Meeting Minutes
2. Update on NFIP and Private Flood Insurance Market
   Daniel Kaniewski, PhD, Deputy Administrator, Resilience, FEMA
3. Discussion on the Development of Model Legislation in Response to the ALI's Restatement of the Law of Liability Insurance
4. Discussion on Risks Associated with/Insurance Issues Related to "Last Mile" Scooters
   Ashley Scott, Policy Counsel, Lime
   NAMIC Representative
5. Discussion on Insurance Modernization Initiatives
6. Any Other Business
7. Adjournment

Networking Break
Friday, December 7, 2018
10:30 a.m. – 10:45 a.m.

General Session
Reverse Preemption: How States Can Preempt Federal Insurance Laws and Regulations through Use of the McCarran-Ferguson Act
Friday, December 7, 2018
10:45 a.m. – 12:00 p.m.

Moderator: Asm. Ken Cooley (CA) – NCOIL Secretary

The Honorable Nat Shapo
Partner – Katten Muchin Rosenmann, LLP
Former Illinois Director of Insurance

The Honorable Michael McRaith
Managing Director – Blackstone Insurance Solutions
Former Director of Federal Insurance Office (FIO)
Former Illinois Director of Insurance

Luncheon with Keynote Address
Friday, December 7, 2018
12:00 p.m. – 1:15 p.m.

Legislative Micro Meetings
Friday, December 7, 2018
1:15 p.m. – 1:45 p.m.

Facilitator: Hon. Tom Considine, NCOIL CEO

NCOIL – NAIC Dialogue
Friday, December 7, 2018
1:45 p.m. – 3:15 p.m.

Chair: Sen. Dan "Blade" Morrish (LA)
Vice Chair: Sen. Jim Seward (NY)

1. Call to Order/Roll Call/Approval of July 13, 2018 Committee Meeting Minutes
2. Discussion on NAIC Cannabis Insurance Working Group
3. Discussion on Proposed Amendments to NAIC Credit for Reinsurance Model Law and Regulation
4. Update on NAIC Annuity Suitability Working Group
5. Discussion on NAIC PBM Regulatory Issues Subgroup
6. Update on NAIC Life Insurance Illustration Policy Overview Developments
7. Any Other Business
8. Adjournment

Networking Break
Friday, December 7, 2018
3:15 p.m. – 3:30 p.m.

Joint State-Federal Relations and International Insurance Issues Committee
Friday, December 7, 2018
3:30 p.m. – 5:00 p.m.

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

1. Call to Order/Roll Call/Approval of July 12, 2018 Committee Meeting Minutes
2. Discussion on Federal Insurance Office (FIO) Priorities
   The Honorable Steven J. Dreyer, Director, FIO
3. Discussion on Insurance Business Transfer (IBT) Laws
   Buddy Combs, Oklahoma Deputy Commissioner of Insurance Business Transfers
   Luann Petrellis, Managing Director, PricewaterhouseCoopers, LLP
4. Balance Billing – Is a Federal Solution Finally in Sight and is it Right?
   Erin Trish, Assoc. Dir. of Health Policy, USC Schaeffer Center for Health Policy and Economics
5. Discussion on Changes to the 1332 Waiver Program – Will State Relief and Empowerment Waivers (SREW) Help Consumers?
6. Any Other Business
7. Adjournment

Articles of Organization & Bylaws Review Committee
Friday, December 7, 2018
5:00 p.m. – 5:30 p.m.

Chair: Rep. Joe Fischer (KY)
Vice Chair: Rep. Martin Carbaugh (IN)

1. Call to Order/Roll Call
2. Discussion/Consideration of Proposed Amendments to Bylaws
3. Any Other Business
4. Adjournment

Nominating Committee (Members Only)
Friday, December 7, 2018
5:30 p.m. – 6:00 p.m.

Co-Chairs: Rep. Steve Riggs (KY)
Sen. Travis Holdman (IN)

SATURDAY, DECEMBER 8, 2018

Health, Long Term Care, and Health Retirement Issues Committee
Saturday, December 8, 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 July 14, 2018 and October 25, 2018 Committee Meeting Minutes
2. Discussion on Pharmaceutical Value-Based Contracting
   Burl Beasley, Director of Pharmacy Services, Oklahoma Health Care Authority
   Joe Vandingo, Director, Policy & Research, PhRMA
3. Introduction of NCOIL Model Law Framework on Drug Pricing Transparency
   Rep. Tom Oliverson, M.D. (TX)
   Sen. Dan "Blade" Morrish (LA)
4. Consideration of NCOIL PBM Licensure and Regulatory Model Act
   Sen. Jason Rapert (AR)
5. Review of Ohio Auditor of State Report on Ohio's Medicaid Managed Care Pharmacy Services
   Sean Busken, Director of Policy & Legislative Affairs, Ohio Auditor of State office
6. Any Other Business
7. Adjournment

Networking Break
Saturday, December 8, 2018
11:00 a.m. – 11:15 a.m.

Workers' Compensation Insurance Committee
Saturday, December 8, 2018
11:15 a.m. – 12:30 p.m.

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

1. Call to Order/Roll Call/Approval of July 13, 2018 Committee Meeting Minutes
2. Consideration of Proposed Amendments to NCOIL Model Act on Workers' Compensation Repackaged Pharmaceutical Reimbursement Rates
   Karl Aumann, Chair, Maryland Workers' Compensation Commission
   John Ruser, President & CEO, WCRI
   Gene Ransom, CEO, Maryland State Medical Society (MedChi)
   Erin Collins, Asst. Vice President, State Affairs, NAMIC
   Brian Allen, Vice President, Gov't Affairs, Mitchell
3. Marijuana in the Workplace – What do States Need to Know as the Legalization of Marijuana Increases?
   Chester McPherson, Senior Division Executive, External & Gov't Affairs, NCCI
   Michael Correia, Director of Government Relations, National Cannabis Industry Association

Adria Berry, Vice President of Gov't Affairs, State Chamber of Oklahoma

4. Any Other Business
5. Adjournment

Business Planning and Executive Committee
Saturday, December 8, 2018
12:30 p.m. – 1:30 p.m.

Chair: Sen. Jason Rapert (AR)
Vice Chair: Sen. Dan "Blade" Morrish (LA)

1. Call to Order/Roll Call/Approval of July 15, 2018 Committee Meeting Minutes
2. Future Meeting Locations
3. Administration
   a.) Meeting Report
   b.) Receipt of Financials and Audit
4. Consent Calendar
   -Committee Reports Including Model Laws Adopted/Re-adopted Therein
5. Consideration of Model Act to Support State Regulation of Insurance Through More Informed Policymaking
   Asm. Ken Cooley (CA) – NCOIL Secretary
6. Articles of Organization & Bylaws Revision Committee Report
7. Other Sessions
   a.) The Institutes Griffith Foundation Legislator Luncheon
   b.) Featured Speakers
8. Nominating Committee Report/Election of Officers
9. Any Other Business
10. Adjournment

Atlantic Corporate Center
2317 Route 34, Suite 2B
Manasquan, NJ 08726
7312-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

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

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To be considered by the NCOIL Executive Committee on December 8th, 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 Council 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 of state law 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 as it appears 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) The Insurance Department shall put in writing the information which is required to be provided or presented in accordance with subdivisions (a), (b), (c), (d), and (e), and will share that information along with any updates either yearly or once during each biennium session with relevant policy committees.

(g) 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 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 for no more than two policy committee members from each house and one budget committee member.

> ***Drafting Note:*** *States may opt to revise Section 2(g) pertaining to whether the source of funding for legislator participation at an NAIC National Meeting is sourced from the State Insurance Department or from the State's General fund or other fund.*

(h) In the event that the NAIC opts to conduct training for lawmakers, the following conditions must be met:

(i) the information provided in association with the training must be provided in writing.
(ii) the training must be held in a forum that is open to the public.

(i) The Insurance Department shall report, in writing, annually or once for each legislative biennium on the nature of its NAIC participation, including such matters as the number of staff attending NAIC meetings, the key policy issues of interest to the state that staff are participating in the development of, and what the state Insurance Department is specifically advocating on those topics of state interest.

(j) Information provided in accordance with subdivisions (f), (h), and (i) of this section shall be made available online via a publicly accessible website.

(k) 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 Council of Insurance Legislators.

> ***Drafting Note:*** *States may wish to revise Section 2(k) pertaining to whether the source of funding for legislator participation in NCOIL is sourced from the State Department of Insurance or from the State's General fund or other fund.*

Section 3. Effective Date
This Act shall take effect _____

Atlantic Corporate Center
2317 Route 34, Suite 2B
Manasquan, NJ 08726
7312-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL <u>COUNCIL</u> ~~CONFERENCE~~ OF INSURANCE LEGISLATORS (NCOIL)

Workers' Compensation Pharmaceutical Reimbursement Rates Model Act

Drafting Note: This model language is intended for inclusion in state insurance codes or regulations related to workers' compensation medical fee schedules. <u>*This model succeeds and augments the previous model Act on Workers' Compensation Repackaged Pharmaceutical Reimbursement Rates adopted by NCOIL on July 12, 2013.*</u>
<u>*Re-adopted by the NCOIL Workers' Compensation Insurance Committee on July 13, 2018 and the NCOIL Executive Committee on July 15, 2018 (per NCOIL bylaws, 5 year re-adoption is pending while amendments are being considered)*</u>

<u>*To be discussed and considered by the Workers' Compensation Insurance Committee on December 8, 2018*</u>

<u>*Proposed Amendments Sponsored by Rep. Marguerite Quinn (PA)</u>

Discussion Draft

<u>Table of Contents</u>

Section 1. Short Title

This Act shall be known as the "~~*Model Act on*~~ *Workers' Compensation* <u>*Pharmaceutical Reimbursement*</u> ~~*Repackaged Pharmaceutical Reimbursement*~~ *Rates* <u>*Model Act*</u>."

Section 2. 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 3. Definitions

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

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

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

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

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

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

Section 4. Reimbursement for Repackaged Pharmaceutical Products**

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

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

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

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

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

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

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

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

~~C. 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:~~

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

1. The fee schedule amount of the underlying or original manufacturer's NDC, assigned by the FDA; or
2. The contract rate as agreed upon between the payer and the provider

~~D. 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.~~

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

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

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

Section 5. Reimbursement for Physician Distributed Pharmaceutical Products

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

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

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

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

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

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

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

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

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

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

(1) A licensed pharmacist must dispense the medications.

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

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

Section 6. Reimbursement for Compounded Pharmaceutical Products

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

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

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

Section 7~~5~~.. Enforcement

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

Section 8~~6~~. Effective Date

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

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

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National Council of Insurance Legislators (NCOIL)

Pharmacy Benefits Manager Licensure and Regulation Model Act

***Sponsored by Sen. Jason Rapert (AR)**
***To be discussed and considered during the Health, Long Term Care and Health Retirement Issues Committee on December 8, 2018**

Please note that the Sponsor, Sen. Jason Rapert (AR), reserves the right to make sponsor's amendments to the Model between now and the December 8, 2018 meeting of the Health, Long Term Care and Health Retirement Issues Committee

Table of Contents

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) Promote the solvency of the commercial health insurance industry, the regulation of which is reserved to the States by the McCarran-Ferguson Act (15 U.S.C. §§ 1011 – 1015), as well as provide for consumer savings, and fairness in prescription benefits.

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

(4) 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) "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.

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

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

(e) "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.

(f) (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

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) 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. Gag clauses prohibited

Drafting Note: *In addition to the Model language set forth below, States seeking to enact "gag clause" legislation may look to Federal law for guidance. Specifically, S.2553 – The Know the Lowest Price Act of 2018" – and S. 2554 – The Patient Right Know Drug Prices Act."*

(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 6. 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][1] of this State

Section 7. Rules

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

(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 Act and rules adopted under this Act.

[1] 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.

Drafting Note: *Although Section 7(a) expressly authorizes rules not inconsistent with this Act, as opposed to those merely implementing it, states may also wish to consider providing the Insurance Commissioner with specific guidance to adopt regulations relating to:*

(1) Pharmacy benefits manager network adequacy;

(2) Prohibited market conduct practices;

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

(4) Rebates;

(5) Prohibitions and limitations on the corporate practice of medicine (CPOM)[2]

(6) Compensation;

(7) Procedures for pharmacy audits conducted by or on behalf of a pharmacy benefits manager;

(8) Medical loss ratio (MLR) abuses;

(9) Affiliate information sharing;

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

Section 8. 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 self-funded health benefit plans, as they do not constitute the business of insurance; thus, the regulation of such self-funded plans is not specifically reserved to this State and the several States by the McCarran-Ferguson Act of 1945, 15 U.S.C. §§ 1011 – 1015.

[2] 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

******Drafting Note:*** *To resolve disputes between pharmacies and pharmacy benefit managers over reimbursements for drugs, states may wish to consider implementing an independent dispute resolution program, which would appear as Section 9. NCOIL suggests the following language*********

Section 9. Independent Dispute Resolution

(a) A program of Independent Dispute Resolution (IDR) for disputes between pharmacies and pharmacy benefit managers over reimbursements for drugs shall be established and administered by the National Council of Insurance Legislators (NCOIL).

(1) NCOIL shall develop forms and procedures for the implementation and administration of the IDR program.

(2) NCOIL may charge the parties participating in the IDR program such fees as necessary to cover its costs of implementation and administration.

(3) NCOIL shall maintain a list of qualified reviewers.

(b) The sole issue to be considered and determined in an IDR proceeding is the reasonable amount that a pharmacy should be reimbursed by the pharmacy benefit manager for the drug or drugs purchased by the pharmacy.

(c) To be eligible to serve as an independent reviewer, an individual must be knowledgeable and experienced in applicable principles of contract and insurance law and the healthcare and pharmaceutical industries generally.

(1) In approving an individual as an independent reviewer, NCOIL shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an IDR proceeding.

(d) Either party to an IDR proceeding may request an oral hearing.

(1) If no oral hearing is requested, the independent reviewer shall set a date for the submission of all information to be considered by the independent reviewer.

(2) Each party to the IDR shall submit a "binding award amount"; the independent reviewer must choose one party's or the other's "binding award amount" based on which amount the independent

reviewer determines to closest to the reasonable amount for reimbursement, with no deviation.

(3) If an oral hearing is requested, the independent reviewer may make procedural rulings.

(4) There shall be no discovery in IDR proceedings.

(5) The independent reviewer shall issue his or her written decision within ten (10) days of submission or hearing.

(e) Unless otherwise agreed by the parties, each party shall:

(1) Bear its own attorney fees and costs; and

(2) Equally bear all fees and costs of the independent reviewer.

(f) The decision of the independent reviewer is final and shall be binding on the parties. The prevailing party may seek enforcement of the independent reviewer's decision in any court of competent jurisdiction.

Section 9. 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 10. Effective Date

This Act is effective immediately.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

AN ACT CONCERNING PRESCRIPTION DRUG COSTS

Sponsored by Rep. Tom. Oliverson, M.D. (TX)
Co-Sponsored by Sen. Dan "Blade" Morrish (LA)

*****Please note that this document represents only a suggested initial framework for an NCOIL Drug Pricing Transparency Model. The concepts set forth in this framework will be discussed during the Health Committee at the 2018 NCOIL Annual Meeting and throughout 2019*****

Table of Contents

Section 1. Title

This Act shall be known as the [State] Health Care Cost Transparency Act.

Section 2. Purpose

The purpose of this Act is to promote prescription drug price transparency and cost control.

Section 3. Definitions

"Board of Pharmacy" or "board" means the [State] Board of Pharmacy.

"Commissioner" means the Insurance Commissioner.

"Department" means the Insurance Department.

“Director” means the Medicaid Director.

"Drug" means (A) articles recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement to any of them; (B) articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans or other animals; (C) articles, other than food, intended to affect the structure or any function of the body of humans or any other animal; and (D) articles intended for use as a component of any articles specified in this subdivision; but shall not include devices or their components, parts or accessories;

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

"Health carrier" or “Health insurer” means an insurance company, a health maintenance organization, or a hospital and medical service corporation.

“Net spending” means the cost of prescription drugs minus any discounts that lowers the price of the drugs, including, but not limited to, rebates, fees, retained price protections, retail pharmacy network spread, and dispensing fees.

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

"Pharmacy benefits manager" means any person that administers the prescription drug, prescription device, pharmacist services or prescription drug and device and pharmacist services portion of a health care plan offered in the state on behalf of a [HEALTH CARRIER/INSURER].

"Rebate" means any discount or concession which affects the price of a prescription drug to a pharmacy benefits manager or health [CARRIER/INSURER] for a prescription drug manufactured by the pharmaceutical manufacturer.

“Specialty drug” means a prescription drug outpatient specialty drug covered under Medicare Part D program established pursuant to Public Law 108-73, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended from time to time, that exceeds the specialty tier cost threshold established by the Centers for Medicare and Medicaid Services.

“Utilization management” means a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

“Wholesale acquisition cost” means, with respect to a pharmaceutical drug or biological product, the manufacturer's list price for the pharmaceutical drug or biological product to wholesalers or direct purchasers in the United States for the most recent month for which the information is available, as reported in wholesale price guides or other publications of pharmaceutical drug or

biological product pricing data, not including any rebates, prompt pay or other discounts, or other reductions in price.

Section 4. Disclosure of prescription drug pricing information.

(a)(1) Not later than January 1, 2020, and annually thereafter, each drug manufacturer shall submit a report to the [INSURANCE COMMISSIONER] no later than the fifteenth day of January, April, July, and October with the current wholesale acquisition cost information for the United States Food and Drug Administration approved drugs sold in or into the state by that manufacturer.

(2) The commissioner shall develop a website to contain prescription drug price information submitted pursuant to subsection (a)(1) of this section. The website shall be made available on the [INSURANCE DEPAREMENT'S] website with a dedicated link that is prominently displayed on the home page, or by a separate easily identifiable internet address.

(b)(1) Not more than thirty days after an increase in wholesale acquisition cost of fifty percent or greater for a drug with a wholesale acquisition cost of one hundred dollars or more for a thirty-day supply, a pharmaceutical drug manufacturer shall submit a report to the [COMMISSIONER OF INSURANCE]. The report shall contain the following information:

(A) Name of the product;

(B) Whether the drug is a brand name or a generic;

(C) The effective date of the change in wholesale acquisition cost;

(D) Aggregate, company-level research and development costs for the prior calendar year;

(E) The name of each of the manufacturer's prescription drugs that was approved by the federal Food and Drug Administration in the previous five calendar years; and

(F) The name of each of the manufacturer's prescription drugs that lost patent exclusivity in the United States in the previous five calendar years.

(2) The quality and types of information and data that a pharmaceutical manufacturer submits to the commissioner pursuant to this subsection shall be consistent with the quality and types of information and data that the manufacturer includes in their annual consolidated report on Securities and Exchange Commission Form 10-K or any other public disclosure.

(3) Within sixty days of receipt, the commissioner shall publish the report on the [INSURANCE DEPARTMENT'S] prescription drug price information website developed pursuant to subsection (a)(2) this section.

(c) A manufacturer shall notify the commissioner in writing if it is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D program. The manufacturer shall provide the written notice within three calendar days following the release of the drug in the commercial market. A manufacturer may make the notification pending approval by the U.S. Food and Drug Administration (FDA) if commercial availability is expected within three calendar days following the approval.

(d) The commissioner may adopt regulations to implement the provisions of this section.

Section 5. Disclosure of pharmacy benefit management information.

(a)(1) Not later than February 1, 2020, and annually thereafter, each pharmacy benefits manager shall file a report with the commissioner. The report shall contain the following information for the immediately preceding calendar year:

(A) The aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical manufacturers;

(B) The aggregated dollar amount of rebates, price protection payments, fees and any other payments collected from pharmaceutical manufacturers that were passed to health [CARRIERS/INSURERS];

(C) The aggregated dollar amount of rebates, price protection payments, fees and any other payments collected from pharmaceutical manufacturers that were passed to enrollees at the point of sale.

(2) Reports submitted by pharmacy benefit managers shall not disclose the identity of a specific health benefit plan or enrollee, the prices charged for specific drugs or classes of drugs, or the amount of any rebates or fees provided for specific drugs or classes of drugs.

(3) Within sixty days of receipt, the commissioner shall publish the report on the [INSURANE DEPARTMENT'S] prescription drug price information website developed pursuant to subsection (a)(2) of section (1) of this Act.

(b) The commissioner may adopt regulations to implement the provisions of this section.

Section 6. Disclosure of health [CARRIER/INSURER] spending information.

(a)(1) Not later than February 1, 2020, and annually thereafter, each health [CARRIER/INSURER] shall submit a report to the commissioner. The report shall contain the following information for the immediately preceding calendar year:

(A) The names of the twenty-five most frequently prescribed prescription drugs across all plans;

(B) Percent increase in annual net spending for prescription drugs across all plans;

(C) Percent increase in premiums that were attributable to prescription drugs across all plans;

(D) Percentage of specialty prescription drugs with utilization management requirements across all plans;

(E) Premium reductions that were attributable to specialty drug utilization management.

(2) Within sixty days of receipt, the commissioner shall publish the report on the [INSURANE DEPARTMENT'S] prescription drug price information website developed pursuant to subsection (a)(2) of section (1) of this Act.

(b) Reports submitted by [CARRIERS/INSURERS] shall not disclose the identity of a specific health benefit plan or the prices charged for specific drugs or classes of drugs.

(c) The commissioner may adopt regulations to implement the provisions of this section.

Section 7. Severability

If any provisions of this Act or the application of this Act to any person or circumstances 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 8. Effective Date

This Act is effective immediately.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION
AND
BYLAWS

ARTICLES OF ORGANIZATION

PREAMBLE

We, duly elected representatives of the People to the Legislatures of the 50 sovereign States, being concerned with the economic and social importance of insurance to our constituents, to the peoples of the States, to all Americans, and to the enterprises and economic resources of our nation and to its strength in world trade and commerce, and seeking a more effective exchange of insurance information among the legislatures of the States, consumers, and other concerned parties; and seeking to provide a forum for legislators to resolve and communicate their positions on insurance and related issues on a State-by-State basis, do hereby proclaim the need for creating and maintaining the resources and capacity of State legislatures to deal with insurance legislation and regulation.

I. NAME

The name of the organization shall be the National Council of Insurance Legislators (hereinafter "NCOIL.")

II. PURPOSE

The general purpose of NCOIL is to advance the knowledge and effectiveness of legislators and legislatures when dealing with matters pertaining to insurance law, participate in the formulation of model legislation addressing insurance and financial services issues, serve as a clearing house for information, reaffirm and advocate for the traditional and proper primacy of the States in the regulation of insurance, prepare special studies on insurance or insurance legislation, disseminate educational materials, communicate positions adopted by NCOIL, and any other activities that will promote the general purposes of NCOIL. These purposes may also extend into these same activities in the other areas of financial services, over which the vast majority of committees of insurance jurisdiction in the legislatures of the 50 states also have oversight.

III. MEMBERSHIP

A. General Membership shall be afforded to all States and territories of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

B. General Members who remit to NCOIL annual dues (which shall not be prorated) in an amount fixed by the Executive Committee shall be considered to be Contributing States. In order to remain in good standing as a Contributing State, a General Member must pay all dues previously billed by the end of that General Member's state's fiscal year.

C. Each General Member and Contributing State shall be represented by its legislators who are permitted to attend NCOIL meetings and seminars.

D. The Executive Committee may, at any regular meeting, confer the title of "Honorary Member" on any individual who has served in the legislature of a General Member but is no longer a member of the legislature, and who the Executive Committee wishes to recognize for outstanding service to NCOIL, and all registration fees shall be waived for a person so titled, unless such person is employed in or providing services to the insurance industry, in which case no such waiver shall be provided.

E. The Executive Committee of NCOIL shall, in accord with the "Purpose" as stated in Section II of the Articles of Organization, offer affiliate non-voting memberships to comparable legislative organizations in non-United States jurisdictions.

IV. MEETINGS/VOTING

A. NCOIL shall meet at times and places designated by the Executive Committee. Special meetings may be called by the President and also shall be called if requested by ten or more members of the Executive Committee.

B. At any meeting of NCOIL, each Committee member shall be entitled to vote on measures before their Committee.

C. A majority vote of those Committee members present and voting shall constitute the requisite vote necessary on measures before their Committee.

D. Voting by proxies shall not be permitted.

V. OFFICERS/EXECUTIVE COMMITTEE

A. The officers of NCOIL shall consist of the following six (6) officers: a President, Vice President, Secretary, Treasurer, and two Immediate Past Presidents. No person shall be elected as an officer of NCOIL who is not a member of the Executive Committee.

B. The Executive Committee shall consist of the six (6) officers, (as stated in Article V, Section A) and at least one (1) and not more than four (4) representatives of each Contributing State of NCOIL. New members of NCOIL Contributing States shall be elected by a majority of the Executive Committee Members. Notwithstanding any other provision of the NCOIL Articles of Organization or Bylaws, the chair of the committee responsible for insurance legislation in each legislative house of each Contributing State shall automatically, by the nature of his or her office, be a voting member of the Executive Committee at his or her first meeting. A state committee chair from a Contributing State must attend the Executive Committee meeting at his or her first NCOIL conference to be recognized as a new Executive Committee member. Past Presidents who are still state legislators shall be voting, ex-officio members of the Executive Committee and shall not constitute a representative of a member State. The President shall not constitute a representative of his state during his term.

C. There may be a Parliamentarian appointed by the President.

D. In addition to the representatives of each Contributing State, the chairs of all NCOIL standing committees, who are not members of the Executive Committee, shall become members of the Executive Committee and shall continue to be members of the Executive Committee as long as they remain as chairs.

E. The Officers of the Executive Committee shall be elected at the annual meeting of NCOIL. Members of the Executive Committee shall be elected at any meeting of the Executive Committee.

F. Persons elected as officers or members of the Executive Committee must be representatives of Contributing States in good standing at the time of their election. The office of an officer or of an Executive Committee member shall be vacant if the member state of which such person is a Legislator ceases to be a Contributing State in good standing, or if the person shall no longer serve in the Legislature.

G. A majority vote of those present and voting at a meeting of the Executive Committee shall constitute the requisite vote necessary to decide any proposition except as otherwise specified in these Articles of Organization.

H. Except as stated in Article V, Section B, A representative of a Contributing State must attend two meetings prior to being considered for membership on the Executive Committee.

I. Each Executive Committee Member must attend in person at least one Executive Committee meeting annually, or be excused by the President for good cause shown, or his/her executive committee membership will terminate automatically.

VI. DUTIES OF OFFICERS AND THE EXECUTIVE COMMITTEE

A. The President shall be the highest ranking officer in the NCOIL corporate structure. She or he shall direct the general supervision of the business and affairs of NCOIL, see that all orders and resolutions of the Executive Committee are carried into effect, perform all duties incident to the office of President, perform the usual duties of the presiding officer at the meetings of NCOIL, preside over meetings of the Executive Committee, and appoint Chairpersons of all committees and members of committees in accordance with NCOIL Bylaws and perform such other duties as are provided in the Bylaws.

B. The Vice President shall chair committees and meetings chaired by the President in the absence of the President and shall perform such other duties as are assigned him/her by the President and the Bylaws.

C. The Treasurer shall be entrusted with the receipt, care and disbursement of funds of NCOIL, provided however, that if the Executive Committee shall appoint an Executive Director or CEO, the Treasurer shall coordinate and work with the that appointee in those duties.

D. The Secretary shall have charge of all correspondence to and from NCOIL, manage records of meetings including preparation of the minutes, provided, however, that if the Executive Committee shall appoint an Executive Director or CEO, the Secretary shall coordinate and work with that appointee in those duties.

E. The Executive Committee shall have charge of the management of NCOIL and the direction of its activities. The President shall fill vacancies in the offices of Committee Chairs between

annual meetings. The Executive Committee may appoint any individual or organization to function, at its discretion, as Chief Executive Officer or Executive Director. Pursuant to these duties, the Officers, in consultation with appropriate Committee Chairs as needed, shall have, between meetings of NCOIL, the ability to make temporary decisions on behalf of NCOIL pending Executive Committee approval.

VII. AMENDMENTS

These Articles of Organization may be amended or repealed at any meeting of the Executive Committee by a favorable vote of two-thirds of the members present and voting, provided however, that notice and text of any proposed amendments shall be given in summary form to the NCOIL Chief Executive Officer or Executive Director at least thirty (30) days prior to the date of that meeting in accordance with the NCOIL 30-day rule for submission of documents to NCOIL for approval or disapproval, as stated in NCOIL Bylaws, Section IV. G. Amendments shall become effective immediately upon adoption unless otherwise provided therein.

BYLAWS

I. QUORUM

A quorum for any meeting of any committee of NCOIL consists of forty percent (40%) of such members of said committee's roster; however, those members of the committee present may reduce the required quorum percentage for good cause as long as they are meeting with twenty four (24) hours notice to all members with said notice setting forth the date, time and place of such meeting

II. VOTING

Voting at meetings of the Executive Committee or any other Committee shall be by voice vote except that a roll call vote shall be taken at the direction of the Chair or upon the request of two members of that Committee.

III. EXECUTIVE COMMITTEE MEETINGS

A. The Executive Committee shall meet at each of the three yearly NCOIL conferences or at the call of the President or upon the written request of ten or more members thereof. Notice shall be given to each member of the Executive Committee setting forth the date, time and place of such meeting.

B. Standing Committees of NCOIL shall be:

1. A Joint State-Federal Relations and International Insurance Issues Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting State-Federal relations and international issues related to insurance and coordinating activities of NCOIL relating to Congressional or Federal agency action affecting insurance and the State regulation thereof.

2. A Workers' Compensation Insurance Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting workers' compensation insurance.

3. A Property-Casualty Insurance Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting property casualty insurance.

4. A Health Insurance~~,~~ and Long-Term Care ~~& Health Retirement~~ Issues Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting health insurance~~,~~ and long-term care~~, and health retirement~~ issues.

5. A Life Insurance & Financial Planning Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting life insurance and financial planning.

6. A Financial Services Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting financial services.

~~7. An International Insurance Issues Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting international issues related to insurance.~~

7~~8~~. An Audit Committee, consisting of a minimum of three (3) members and chaired by the Vice President with the responsibility for arranging for and reviewing the audits of NCOIL funds and making recommendations to the Executive Committee with respect to procedures relating thereto. The Treasurer shall be a non-voting, ex-officio member. The Treasurer may vote if the Executive Committee appoints a Chief Executive Officer or Executive Director under Article VI, E of the Articles of Organization.

8~~9~~. An Articles of Organization and Bylaws Revision Committee, consisting of at least seven (7) members appointed by the President with the responsibility for reviewing the Articles of Organization and Bylaws of NCOIL at each annual meeting.

9~~10~~. A Budget Committee, consisting of a minimum of seven (7) members appointed by the President and chaired by the Treasurer with the responsibility of developing annual budget proposals pursuant to the process enumerated in these Bylaws. The Treasurer may vote if the Executive Committee appoints a Chief Executive Officer or Executive Director under Articles VI, E of the Articles of Organization.

10~~11~~. A Nominating Committee, consisting of all NCOIL past presidents, the current NCOIL president, and current standing committee chairs with one year or more of service as a standing committee chair that shall interview potential officers for the upcoming year, report nominations for officers to the annual meeting of NCOIL, and reconvene when there becomes a vacancy among the officers in order to nominate a replacement. A Nominating Committee member wishing to be a candidate for an officer shall recuse herself or himself from Nominating Committee participation.

11~~12~~. A Business Planning Committee, consisting of a minimum of seven (7) members appointed by the President with responsibility for membership, site selection, revenue and legislator participation in NCOIL activities and programs.

C. The Chair and Vice Chair of any standing or special committee shall be appointed by the President and shall serve at the will of the President. Only members of Contributing States in good standing are eligible to be Chairs or, Vice Chairs of any standing or special committee. Legislators from Member States may sign up for Committees one (1) through seven (7) listed above.

D. The Chair of any Committee with the approval of the President may appoint a chair and members of task forces and subcommittees to assist in the work of NCOIL. Only members of Contributing States in good standing are eligible for appointment as a chair of a task force or subcommittee. A task force or subcommittee shall continue in existence until it has accomplished the purposes for which it was created or until the next annual meeting of NCOIL, whichever occurs earlier.

E. All Standing Committees, except the Nominating Committee, shall be continuing committees and the members thereof shall serve one-year terms or until their successors are appointed.

1. Standing Committees shall be open to all NCOIL Member Legislators during an Open Registration period. At the Annual Meeting each year, Standing Committee Registration Forms for the upcoming year shall be available in the registration area, on which NCOIL Member Legislators shall register for the Standing Committees on which they will serve in the upcoming year, whether or not they currently serve on those committees.

2. Standing Committee Open Registration shall remain so until January 15th of the year of committee service. In the period after the Annual Meeting through January 15th NCOIL Member Legislators wishing to serve on Standing Committees but who had not registered during the Annual Meeting shall send an e-mail or letter to the NCOIL Chief Executive Officer or Executive Director stating the Standing Committee(s) on which she or he will serve.

3. From January 16th through the remainder of the year, NCOIL Member Legislators wishing to serve on Standing Committees shall send an e-mail or letter to the NCOIL Chief Executive Officer or Executive Director stating the Standing Committee(s) on which she or he wishes to serve, and the NCOIL Chief Executive Officer or Executive Director will present the request to either the Standing Committee Chair or the NCOIL President for Appointment.

F. Special Committees may be created by NCOIL at the annual meeting of NCOIL, by the Executive Committee at any meeting of the Executive Committee, or by the President between meetings of the Executive Committee and of NCOIL. Any action creating a Special Committee shall specify its size and duties, and may specify the manner of appointment of members thereof. A Special Committee shall continue in existence until it has accomplished the purposes for which it was created or until the next annual meeting of NCOIL, whichever occurs earlier.

G. 1. Any resolution or other document submitted to NCOIL for its approval or disapproval shall be submitted and sponsored by a legislator to NCOIL at least 30 days prior to the next scheduled NCOIL Conference or Annual Meeting. If a document or substantive amendment to a document is not submitted prior to the 30-day deadline, it shall be subject to a two-thirds vote for Committee consideration and a separate two-thirds vote for adoption. This section is intended to provide advance notice of the matters and items on which NCOIL will vote; it is not intended to limit germane amendments that arise during a discussion. Such germane amendments shall not trigger a supermajority vote.

2. Notwithstanding the existence of the requirement that any resolutions or documents be submitted to NCOIL at least 30 days prior to the next scheduled NCOIL Conference or Annual Meeting, such documents may pass through committees to the Executive Committee at a duly called meeting of the Executive Committee. Any resolution or other document properly considered and adopted by an NCOIL Committee shall be referred to the Executive Committee for its consideration and vote. If adopted by the Executive Committee such resolution or other document shall be considered the official NCOIL position on such matter covered.

H. Members of the committee responsible for insurance legislation in each legislative house of each Member state shall be a voting member at his or her first NCOIL conference in meetings of standing committees that he or she has joined.

I. Legislators from Member states who are not members of state committees responsible for insurance legislation shall be eligible to vote on a standing committee of which he or she is a member at her or his second NCOIL conference.

J. NCOIL meetings are open meetings except those involving discussions of the general reputation and character or professional competence of an individual; the legal ramifications of threatened or pending litigation; security issues; price of real estate or professional transactions; and matters involving a trade secret.

V. FINANCES

The fiscal year of NCOIL shall commence on January 1 of each year and end on December 31 of the same year.

A. The Chief Executive Officer or Executive Director shall submit to the Executive Committee a proposed budget for the ensuing fiscal year 10 days before the annual meeting of NCOIL. The Executive Committee shall have the power to approve, modify or reject, in whole or in part, the budget.

B. The Executive Committee at the annual meeting of NCOIL shall adopt a budget for the ensuing fiscal year.

C. During the fiscal year, the Executive Committee may provide for an increase or decrease of an appropriation. Such increase or decrease shall only be upon the certification by the Committee of the need thereof.

D. The moneys budgeted pursuant to these Bylaws may include money for the retention of staff, the reimbursement of expenses of staff, and the expenses of Legislators for activities on behalf of NCOIL other than expenses of attending regularly scheduled NCOIL meetings.

E. Checks drawn for expenditures of less than one thousand, five hundred ($1,500) dollars shall be signed by the Chief Executive Officer or Executive Director who shall submit a monthly report of all such checks to the President of NCOIL. No more than one such check shall be paid for any one purpose without the prior express written consent of the President. All other checks drawn upon the funds of NCOIL shall be signed by both the Chief Executive Officer or Executive Director and either the President or Vice President. Notwithstanding the foregoing sentence, the NCOIL Officers may approve a system they deem sufficiently secure whereby the NCOIL President approves in writing expenditures other than by the physical signing of the check. Such system shall be endorsed by NCOIL's outside auditor.

F. The Executive Committee shall, at the annual meeting of NCOIL, select an independent auditor who shall review NCOIL's books and accounts for the current fiscal year. The auditor shall submit its report to the Audit Committee by June 30 of the next calendar year. The Audit Committee shall submit its report at the next succeeding meeting of the Executive Committee.

G. In the event that NCOIL shall, for any reason, discontinue its activities and cease to function, any monies remaining in its possession or to its credit after the payment of outstanding debts and obligations shall be distributed in equal shares to the Contributing States of NCOIL in good standing at the time of distribution.

VI. RULES OF PROCEDURE

A. Each model act adopted by NCOIL shall be reviewed by the Committee of original reference every five (5) years. The respective Committee shall vote to readopt the model act for an additional five (5) years, readopt the model act for an interim period to allow for additional study or drafting, amend and readopt the model act, or allow the model act to "sunset." Readopted models shall be sent to the Executive Committee for final adoption.

B. The NCOIL committees shall review previously adopted NCOIL model laws in order to provide an appropriate sunset schedule. Such documents shall be reviewed in the following manner: Spring Meeting shall be Life Insurance & Financial Planning Committee and the Health~~,~~ and Long-Term Care ~~& Health Retirement~~ Issues Committee. Summer Meeting shall be Workers' Compensation Insurance Committee and Property-Casualty Insurance Committee. The Annual Meeting shall be the Joint State-Federal Relations and International Insurance Issues Committee, Financial Services ~~& Investment Products~~ Committee, and Executive Committee. Model laws shall sunset every five (5) years within the Committee. Committees shall have the authority to extend the model laws from meeting to meeting.

C. In any issue not covered by the Articles or Bylaws, Robert's Rules of Order shall be the standard authority.

VII. AMENDMENTS

These Bylaws may be amended or repealed at any meeting of the Executive Committee by a favorable vote of two-thirds of the members present and voting, provided however, that notice and text of any proposed amendments shall be given in summary form to the NCOIL Chief Executive Officer or Executive Director at least thirty (30) days prior to the date of that meeting in accordance with the NCOIL 30-day rule for submission of documents to NCOIL for approval or disapproval, as stated in Section IV.G of the Bylaws. Amendments shall become effective immediately upon adoption unless otherwise provided therein.

ARTICLES OF ORGANIZATION/BYLAWS AMENDMENTS

Adopted 4th Annual Meeting, San Francisco, November 28, 1972;
Amended 10th Annual Meeting, Detroit, November 14, 1978;
Amended 11th Annual Meeting, Charleston, November 14, 1979;
Amended 12th Annual Meeting, San Antonio, November 22, 1980;
Amended 16th Annual Meeting, Little Rock, November 17, 1984;
Amended 17th Annual Meeting, Phoenix, November 24, 1985;
Amended 18th Annual Meeting, Nashville, November 16, 1986;
Amended 19th Annual Meeting, Palm Springs, November 18, 1987;
Amended 23rd Annual Meeting, Scottsdale, November 20, 1991;

Amended 24th Annual Meeting, Charleston, November 18, 1992;
Amended 26th Annual Meeting, New York City, November 13, 1994;
Amended 27th Annual Meeting, San Francisco, November 11, 1995;
Amended 28th Annual Meeting, Austin, Texas, November 20, 1996;
Amended 30th Annual Meeting, San Diego, California, November 21, 1998;
Amended 31st Annual Meeting, Orlando, Florida, November 19, 1999;
Amended Spring Meeting, San Francisco, California, February 25, 2000;
Amended 32nd Annual Meeting, New Orleans, Louisiana, November 16, 2000;
Amended Summer Meeting, Williamsburg, Virginia, July 11, 2003;
Amended Summer Meeting, Chicago, Illinois, July 16, 2004;
Amended Annual Meeting, San Diego, California, November 19, 2005;
Amended Summer Meeting, Boston, Massachusetts, July 21, 2006;
Amended Annual Meeting, Napa Valley, California, November 10, 2006;
Amended Summer Meeting, Seattle, Washington, July 21, 2007;
Amended Annual Meeting, Las Vegas, Nevada, November 17, 2007;
Amended Spring Meeting, Washington, DC, March 1, 2008;
Amended Summer Meeting, New York, New York, July 11, 2008;
Amended Annual Meeting, Duck Key, Florida, November 20, 2008;
Amended Spring Meeting, Isle of Palms, South Carolina, March 7, 2010;
Amended Summer Meeting, Newport, Rhode Island, July 17, 2011;
Amended Annual Meeting, Santa Fe, New Mexico, November 20, 2011;
Amended Summer Meeting, Philadelphia, Pennsylvania, July 14, 2013;
Amended Annual Meeting, Nashville, Tennessee, November 24, 2013;
Amended Summer Meeting, Boston, Massachusetts, July 13, 2014;
Amended Annual Meeting, San Francisco, California, November 20, 2014;;
Amended Spring Meeting, Charleston, South Carolina, March 1, 2015;
Amended Summer Meeting, Portland, Oregon, July 14, 2016;
Amended Annual Meeting, Phoenix, Arizona, November 19, 2017.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

RESOLUTION ASSERTING MCCARRAN-FERGUSON REVERSE PREEMPTION OVER THE SUPERVISION OF INSURANCE COMPANIES BY THE FEDERAL RESERVE BOARD AND ITS EXAMINERS

***Sponsored by Sen. Dan "Blade" Morrish (LA)**
***To be discussed and considered during the Financial Services Committee on December 6, 2018**

WHEREAS, the Congress, having concluded that the states, by virtue of their experience and proximity to consumers, are best suited to regulate the business of insurance, a critically important part of the nation's economy. Thus, Congress formalized the longstanding system of state regulation by passing the McCarran-Ferguson Act, "declar[ing] that the … regulation and taxation by the several States of the business of insurance is in the public interest," instructing that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business," and implementing a unique reverse preemption regime, under which "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance … unless such Act specifically relates to the business of insurance," resulting in the states retaining the jurisdiction and authority to regulate the market conduct and solvency of insurance companies operating within the states; and

WHEREAS, the states conduct both market conduct examinations to review the compliance of insurance companies with state consumer protection laws and execute financial examinations to ensure the solvency, and ultimate ability to honor policyholder obligations, of insurance companies in accordance with state laws; and

WHEREAS, although Congress has, from time to time, passed laws that specifically relate to insurance for the purpose of establishing limited and specific federal oversight and/or standards, no federal laws alter the basic jurisdiction of the states over, and responsibility for, nor enable the dual regulation of, insurance companies' market conduct and solvency; and

WHEREAS, Congress, in passing the Gramm-Leach-Bliley Financial Services Modernization Act of 1999, recognized that the proper regulation of complex financial services holding company systems required that "[t]he insurance activities of any person … shall be functionally regulated by the States";

WHEREAS, the Federal Reserve Board in the Dodd-Frank Act has been given limited and targeted authority over certain insurance holding companies for the purpose of furthering their supervision of those holding companies' Federally regulated banking subsidiaries;

WHEREAS, Dodd-Frank requires the Federal Reserve Board, "to the fullest extent possible, rely on … the examination reports made by other Federal or State regulatory agencies relating to a savings and loan holding company and any subsidiary," to "consult with … the appropriate … State regulatory agency … for … a functionally regulated subsidiary," and, "to the fullest extent possible, avoid duplication of examination activities, reporting requirements, and requests for information";

WHEREAS, the Federal Reserve Board has conceded that, "for all the broadening of our statutory mandate, one feature of the financial regulatory system that the Dodd-Frank Act preserved was the functional regulation of holding company affiliates based on the kind of financial intermediation in which they are engaged";

WHEREAS, inconsistent with this framework, and despite the comprehensive and effective regulation of insurance companies' market conduct and solvency by State insurance regulators, the Federal Reserve Board has over-extended its examination powers by routinely requiring insurance companies to supply information and responses to inquiries of the sort in practice that are the province of those of the day-to-day functional regulator of these companies, on whose work Federal Reserve Board examiners are statutorily required "to the fullest extent possible, rely on" and "avoid duplication" with, and that relate solely to the insurance operations of insurance companies that also have a federally regulated bank; and

WHEREAS, the Federal Reserve Board's examiners' exercise of such powers will most likely conflict with, the jurisdiction of State insurance regulators over solvency and market conduct regulation or, at best, will be duplicative; and

WHEREAS, such practices by Federal Reserve Board examiners are inconsistent with the testimony given by Vice Chairman of Supervision for the Federal Reserve Board Randal Quarles in Congress on April 17, 2018 and again on April 19, 2018;

BE IT NOW THEREFORE RESOLVED, that the National Council of Insurance Legislators (NCOIL) calls upon the Federal Reserve Board to direct its examiners that the insurance operations of state-regulated insurers, including those affiliated with a financial institution, are regulated by the individual states and that the Federal Reserve Board's examinations are, to the fullest extent possible, to rely upon the examination reports and other work of state insurance regulators and not to duplicate and/or conflict with the states' regulatory powers over the insurers' market conduct or solvency; and

BE IT NOW FURTHER RESOLVED, that NCOIL encourages Congress to provide oversight and, if necessary, enact legislation to ensure that the Federal Reserve Board's supervisory rules are limited as identified herein, particularly as they relate to the Federal Reserve Board's examination of insurers, including those that are affiliated with a federally regulated financial institution; and

BE IT NOW FURTHER RESOLVED, consistent with the McCarran-Ferguson Act, the Gramm-Leach-Bliley Act, and the Dodd-Frank Act, and in the interests of avoiding duplicative and conflicting regulation of the insurance industry which is a substantial and critically important part of the country's economy, NCOIL calls upon the Federal Reserve Board to consult with, defer to, and rely on to the fullest extent possible, and to avoid, to the fullest extent possible, duplication of, the work of state insurance regulators on matters involving the regulation of insurance operations and solvency of insurers, regardless of the insurers' affiliations with federally-regulated financial institutions;

AND, BE IT FURTHER RESOLVED that a copy of this Resolution be sent to the President of the United States, the Chairman of the Board of Governors of the Federal Reserve, the Secretary of the U.S. Treasury, the Director of the Federal Office of Insurance, the Chairman of the U.S. Senate Committee on Banking, Housing and Urban Affairs, and the Chairman of the Committee on Financial Services of the U.S. House of Representatives.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Resolution in Support of State Regulated Health Savings Account-Based Coverage

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To be discussed and considered by the Financial Services Committee on December 6, 2018

Sponsored by: Rep. Steve Riggs (KY)

WHEREAS, Health Savings Accounts (HSAs) insure tens-of-millions of Americans in the employer market and millions more who shop within each state's individual market; and

WHEREAS, HSAs are regulated primarily by the Internal Revenue Service (IRS), one critical feature of qualification being the prohibition of covering medical expenses that are not preventive in nature without cost-sharing; and

WHEREAS, HSAs in the insured marketplace require qualified insurance designed and licensed under the laws of the several states but in conformance with IRS regulations; and

WHEREAS, States, pursuant to federal law, regulate the business of insurance and thus the quality and quantity of health insurance products available within each state's borders; and

WHEREAS, States, at their discretion, decide what benefits must be covered by a policy of insurance within their borders, subject to federal guidelines [under the ACA]; and

WHEREAS, by enacting first dollar insurance mandates and/or coverage requirements for benefits other than preventive care, as defined by the IRS, states risk disqualifying otherwise HSA-qualified fully insured plans; and

WHEREAS, in states where a non-preventive benefit is required to be covered without cost-sharing, HSA owners become ineligible to contribute to their HSAs and must then find replacement health insurance;

NOW, THEREFORE, BE IT RESOLVED, that NCOIL policy shall be to encourage state legislators to adopt a provision of their state statutes exempting HSA-qualified insurance plans (as defined under 23 U.S.C § 223) from any requirement, past or future, to cover any benefit without such benefit being subject the policy deductible, coinsurance, or other cost-sharing unless such benefit is preventive care - as defined by the IRS;

AND, BE IT FINALLY RESOLVED, that NCOIL shall communicate adoption of this policy to the National Association of Insurance Commissioners (NAIC) and to the Secretary of Health and Human Services (HHS).

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE AND HEALTH RETIREMENT ISSUES COMMITTEE
INTERIM COMMITTEE CONFERENCE CALL
OCTOBER 25, 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 Thursday, October 25, 2018 at 2:00 p.m.

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

Other members of the Committees present were:

Rep. Sam Kito (AK)
Rep. Deborah Ferguson (AR)
Sen. Jason Rapert (AR)
Rep. Richard Smith (GA)
Rep. Matt Lehman (IN)
Sen. Dan "Blade" Morrish (LA)
Rep. Michael Webber (MI)
Rep. Justin Hill (MO)
Sen. Valerie Foushee (NC)
Sen. Jerry Klein (ND)
Sen. Neil Breslin (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Glen Mulready (OK)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Sen. Jeff Raatz (IN)
Rep. Dan Hawkins (KS)
Asm. John McDonald (NY)

Also in attendance from NCOIL were:

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

There were many interested persons also on the line. Those participating will be identified below.

INTRODUCTORY REMARKS FROM CHAIRMAN CAHILL

Assemblyman Kevin Cahill (NY), Chair of the Committee, stated that for purposes of today's meeting, the Committee will use the original version of Sen. Rapert's PBM Licensure and Regulation Model Act to review, rather than the "slimmed down" version that was released on October 15, 2018. Differences between those versions will be discussed during a section-by-section review of the original version. Asm. Cahill stated that at the end of the meeting, he intends to ask the Committee members if there is a sense of the body to approve which version would be offered up for consideration at the NCOIL Annual Meeting in December. Asm. Cahill noted that Sen. Rapert is of course free to offer any amendments to the Model between now and the December meeting but in the interest of efficiency it would be helpful to arrive at a consensus regarding which version to proceed with.

Asm. Cahill noted that the National Association of Insurance Commissioners (NAIC) has a comprehensive Model Law that touches upon PBMs but to the best of his knowledge the Model has not been adopted by any states. Asm. Cahill stated that he believes Rhode Island and South Dakota are the only states that have enacted PBM licensure and regulation statutes but noted that several other states are actively considering such laws. For example, in New York, in addition to a comprehensive PBM regulatory proposal by Asm. Richard Gottfried, there are at least 7 other bills in the NY Assembly that seek to regulate some aspect of PBM business practices.

REMARKS FROM SENATOR JASON RAPERT (AR) – NCOIL PRESIDENT

Sen. Jason Rapert (AR) – NCOIL President – thanked everyone for joining the call today and thanked those who have been engaged with this issue from the beginning. Sen. Rapert noted that we have all learned a great deal about PBMs and related issues throughout this entire Model-drafting process and he hopes the process continues to be beneficial for everyone involved. Sen. Rapert stated that during today's call he would like to hear comments from both legislators and interested parties as to what their thoughts are on the "slimmed down" draft of the Model so that any necessary adjustments to the Model can be made prior to the 30-day material deadline for the NCOIL Annual Meeting in Oklahoma City.

Sen. Rapert stated that the primary reason for the current "slimmed down" version of the Model is because he believes the current version is more in-line both with his statements throughout this entire process – that his entire objective is for PBMs to have a referee – as well as with NCOIL Model Law philosophy. The underpinnings of that philosophy are that NCOIL Model Laws should not be so detailed to the point that they read like regulations. Rather, NCOIL Model Laws should set forth a legislative framework – like the foundation of a house – which states can then add to as they see fit. Sen. Rapert noted that he has been very consistent in his talking points throughout this process in saying that he does not want the Model to just be the Arkansas PBM Law with an NCOIL logo on it. Sen. Rapert further noted that, in fact, throughout this process, he has used a similar analogy to the "legislative framework" analogy to describe what he thinks is best for this Model – the Model is best viewed as a "chassis" for states to use to calm the waters to address these contentious issues.

That means that one state may want a different set of tires or a different CD player in their chassis, but what must be in the Model, which he has said from the beginning, is the regulatory referee – which means PBMs need to be licensed and regulated by the state insurance department, and the insurance department must be able to enforce any requirements set forth in the enabling statute and accompanying regulations. Sen. Rapert stated that his goal is still to have a Model prepared for a vote at the NCOIL Annual Meeting in December, so that NCOIL can provide state legislatures around the country with guidance when they come into session beginning in January.

Nevertheless, Sen. Rapert stated that the "slimmed down" version is still a draft and that he is open to hearing everyone's thoughts on it. Sen. Rapert further stated that in moving to the slimmer licensure and enforcement version of the Model, legislatures that adopt the Model are clearly authorizing the insurance commissioners to regulate, and legislatures should expect them to do just that. If not, we will all be back here a year from now seeking to amend the Model.

Sen. Rapert closed by stating that he is aware of the recently enacted Federal legislation that contains language prohibiting "gag clauses" and noted that he kept the gag clause section of the

Model in the current version because he wanted to hear comments from everyone as to whether the section is moot, or if it should be kept in and changed to mirror the Federal language. Sen. Rapert noted that the Arkansas tax code often cites to Federal statutes and that is something to consider moving forward when considering the gag clause section of the Model.

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

Legislator Comments

Asm. Cahill began the section-by-section review of the Model by asking if by removing certain definitions from Section 3 – Definitions – such as "independent pharmacy" and other terms that could be useful in determining who the consumer or patient is, the "slimmed down" draft is overly narrow and unclear as to who some of the important "players" are. Sen. Rapert asked Commissioner Tom Considine, NCOIL CEO, and/or NCOIL staff to comment on Asm. Cahill's question. Cmsr. Considine stated that the removal of certain defined terms in the definitions section was only due to the fact that those terms no longer appear in the substantive portions of the Model.

Rep. Tom Oliverson, M.D. (TX), Vice Chair of the Committee, stated that network adequacy always seems to be an important issue for consumers and certainly affects costs and accordingly asked why Section 5 – PBM Network Adequacy – was removed from the Model. Asm. Cahill stated that network adequacy is indeed an important issue for everyone, particularly the issue of PBMs including mail order pharmacies when determining network adequacy but stated that he believes the section was removed from the Model because it is in line with Sen. Rapert's "legislative framework" approach – not because network adequacy is not an important issue. Asm. Cahill also noted that NCOIL currently has other Model Laws that touch upon network adequacy with other entities and PBMs and pharmacies may be able to be included in those Models.

Sen. Rapert noted that the network adequacy section was included in the Arkansas PBM law and stated he is of course open to hearing from everyone as to whether the section should be included in the Model. Sen. Rapert stated that in trying to draft a Model that is acceptable to the large majority of NCOIL membership, he has tried to be accommodating without completely undercutting the licensure and regulatory portions of the Model. Sen. Rapert further noted that, with the "slimmed down" version, the hope is that Insurance Departments will promulgate regulations to address any issues important to that particular state. Sen. Rapert stressed that he is open to suggestions with this section because it is important to be sure that a Model is produced that will be palatable for states to "run" with.

Rep. Deborah Ferguson (AR) stated that her concern is that normal network adequacy laws don't cover PBMs. Rep. Oliverson stated that he understands that the network adequacy section is problematic for some committee members, but it is odd that the Model would direct the insurance department to license and regulate the functions of PBMs with the purposes of ensuring fairness and competition and yet network adequacy would not be addressed. Rep. Oliverson also stated that if the Model is to direct insurance departments to regulate PBMs then there should be some topics in the Model to direct the insurance department to consider. State insurance departments need some guidance in the form of general principles articulating what legislators are concerned about and network adequacy is a topic that we should be concerned about.

Cmsr. Considine then stated that in discussions with Sen. Rapert prior to the call an option that was considered was to take the regulatory topics listed in Section 9(a)(2) of the Model and reference them in a Drafting Note which would say something along the lines of: "states may wish to consider promulgating regulations on topics such as…"

Asm. Cahill then asked NCOIL staff to note the Committees deliberations on network adequacy in general and stated that what the Committee had learned in the past was that states are so diverse, and the needs of networks vary from state to state and even within a state so many times what is agreed upon ends up being so general as to be relatively meaningless. Accordingly, Asm. Cahill stated that he believes a drafting note on this topic is the best way to proceed because network adequacy standards are developed at different levels in different states and it may be appropriate to note in the Model that network adequacy standards should be developed and not go much further than that. Asm. Cahill then asked if there was a sense among the Committee to proceed in the manner. Sen. Rapert stated that at this time it is best to note the heavy interest in network adequacy and address it at a later time.

Sen. Valerie Foushee (NC) stated that with regard to Section 7 – Gag Clauses Prohibited – the language should mirror what is set forth in the recent Federal legislation that was signed into law earlier this month. Asm. Cahill stated that it is his understanding that the federal gag clause legislation applies specifically to health plans and not PBMs and it is therefore a good idea to keep the section in the Model. Asm. Cahill also noted that the gag clause section in the Model extends beyond what the federal legislation states and what other states have enacted. Asm. Cahill therefore recommended that the gag clause section, as currently drafted, should be kept in the Model. Sen. Rapert agreed with Asm. Cahill.

With regard to Section 9 – Rules – Asm. Cahill noted that NAIC's Model Laws often mirror regulations as to their level of specificity and NCOIL Model Laws do not follow that approach. Asm. Cahill further noted that in New York, he and his colleagues in the Assembly have experienced situations where regulators took advantage of ambiguity or areas of statutes that did not directly proscribe regulators' ability to exercise regulatory authority. Accordingly, Section 9 is a section that each individual legislator in accordance with the experience in their state should review very carefully and adapt it to the needs of that specific state. Asm. Cahill stated that, as an example, he tries not to offer any legislation in New York that gives the NY DFS Superintendent much "wiggle room" and noted that the proposed drafting note mentioned earlier could serve to quell any concerns about not offering enough guidance to regulators. Sen. Rapert stated that with the Arkansas PBM law he was in favor of specifically delineating the topics of regulation for the reasons stated by Asm. Cahill and noted that the Rules section is very important because NCOIL is in a position to offer their expertise to legislators and regulators across the country on these issues. What no one wants to see happen is the Model sent out to states and state legislators and regulators do things that are wholly inconsistent with the purpose of the Model.

Rep. Matt Lehman (IN) – NCOIL Treasurer – applauded Sen. Rapert for the "slimmed down" version of the Model and stressed that NCOIL Model philosophy is to provide states with a legislative framework which states can add "drapes and curtains" to if they need to. Rep. Lehman stated that he knows that some provisions in the Model would have to change if it was adopted in Indiana but that does not affect his support for the Model as each state's needs vary.

Asm. Cahill stated that in Section 12 – Maximum Allowable Cost (MAC) Lists – he knows there is some concern about the technical ability to work with the MAC lists and that this section is supposed to serve as a framework but there is a fundamental concept that underlies this section

which is to protect pharmacists from being required to pay more for drugs than PBMs reimburse them for. Asm. Cahill stated that he would appreciate it if between now and December some mechanism was in the Model to make sure that does not happen. Asm. Cahill acknowledged that some MAC statutory provisions are subject to some controversy, but it is important to provide pharmacists with a level of protection. Sen. Rapert appreciated Asm. Cahill's comments and stated that he does not want to see a situation arise where PBMs can capitalize on there being no MAC provisions in the Model and noted that one of the fundamental problems that Arkansas faced was that independent pharmacists had to close their doors because they were not being reimbursed at a proper level. Sen. Rapert acknowledged the lawsuits that have been filed dealing with MAC statutes and stressed that it would be ideal if there is a way to protect pharmacists from such reimbursement problems without running into any of the issues raised in such litigation.

Rep. Glen Mulready (OK) stated that if the Model is to serve as a legislative framework then he is not sure if he would agree with including the MAC section unless a cap was included that limited the maximum profit that could be made. It would be odd to have one without the other.

Rep. Oliverson stated that in other areas of practice where you have practitioners interfacing with insurers and a dispute arises about what is fair in terms of payment, having a mediation or arbitration process is helpful. There should be a dispute resolution process envisioned for these issues. Perhaps the maximum and minimum amounts should not be listed in the statute but there should be a process that is not internal to the pharmacist appealing to the PBM but rather utilizes a third party like the Insurance Department to "referee" disputes regarding unfair reimbursements. Either party could trigger the process.

Rep. Ferguson asked if putting a cap on maximum profit would even matter because the PBM sets the payment amount so it is not as if pharmacists can arbitrarily charge more – they take what the PBM pays. Asm. Cahill stated that he believes Rep. Oliverson was simply stating that there should be a process for disputes to be resolved by a third party regardless of listing maximum or minimum amounts. Rep. Oliverson agreed. Rep. Ferguson agreed but stated that pharmacists are not arbitrarily setting rates – the PBMs set the rates.

Before taking comments from interested persons present on the call, Asm. Cahill noted two issues that have emerged since this Committee started its discussion about PBMs several months ago. Those issues are related to the mergers and acquisitions that have been taking place that involve PBMs. Specifically, during a legislative hearing about said mergers and acquisitions, two issues arose: a.) the privacy of information and the data being used by PBMs to possibly encourage subscribers to use a different pharmacy, and having some protections for the internal regulation of the privacy of that information; and b.) the medical loss ratio (MLR) is a regulated portion of an insurance premium and when an insurer owns a PBM and owns a pharmacy and owns in some cases even medical practices, the MLR is very susceptible to manipulation and therefore some regulatory means by which we can ensure that such manipulation does not occur is important. Asm. Cahill noted that those two issues are only generalized concerns at this point and he does not have specific proposals at this point but asked that such issues be considered between now and December.

Sen. Rapert stated that Asm. Cahill made valid points and that overall, the goal is to produce a Model that can make a difference and provide some stability with these issues. Sen. Rapert stated that the two issues raised by Asm. Cahill are moving targets but that if there is a way to address them in the Model, the Committee should do so.

Interested Party Comments

Matthew Magner of the National Community Pharmacists Association (NCPA) stated that NCPA appreciates the goal of the "slimmed down" version of the Model – to create a legislative framework for states to customize at their own level – but NCPA thinks too much has been removed from the original version and there is not enough guidance in the "slimmed down" version for insurance commissioners to promulgate rules. NCPA requests that more guidance be included in the Model and is happy to hear that the Committee is considering a drafting note in Section 9 that would detail specific regulation topics.

Sen. Rapert asked Mr. Magner if NCPA's request for more guidance is limited to Section 9. Mr. Magner stated that NCPA believes some of the prohibited practices set forth in Section 6 – Compensation, Prohibited Practices – should be included in the Model as they are good policy and still provide enough flexibility for states to modify if they so choose. Sen. Rapert requested that NCPA's comments that were sent to him earlier be distributed to the Committee.

Joshua Keepes of America's Health Insurance Plans (AHIP) stated that AHIP is generally supportive of the "slimmed down" version of the Model and that AHIP is appreciative of the opportunities that have been provided throughout the Model drafting process to voice their comments. Many of AHIP's concerns that were voiced to Sen. Rapert and members of the Committee have been addressed in the "slimmed down" version. The "slimmed down" version provides states with a better opportunity to conform the Model to the aspects of their particular market which is fundamental to any Model Law. Mr. Keepes stated that AHIP does still have some concerns with the "slimmed down" version of the Model but that AHIP looks forward to working with the Committee to address those concerns. AHIP's remaining concerns are primarily technical in nature. AHIP looks forward to seeing inclusion of the drafting notes mentioned earlier in Section 9 – Rules – or Section 5 – PBM Network Adequacy – which are sections that AHIP supported removing from the original version of the Model.

Melodie Shrader of the Pharmaceutical Care Management Association (PCMA) thanked Sen. Rapert and the Committee for this open and transparency Model drafting process and for spending the time to understand these complex issues. Although PCMA still has some concerns, which are technical in nature, PCMA is pleased to see the "slimmed down" version of the Model. PCMA looks forward to sharing those concerns before the December meeting and to continuing to be a part of this process.

Saiza Elayda of the Pharmaceutical Research and Manufacturers of America (PhRMA) stated that PhRMA supports adding provisions from Section 5 – PBM Network Adequacy – and Section 6 – Compensation, Prohibited Practices – into a drafting note in Section 9 – Rules for states to consider. PhRMA also supports that Section 7 – Gag Clauses Prohibited – look more like the new Federal gag clause language and that can serve as a floor for states to consider rather than as a ceiling. Ms. Elayda then asked why the Model's definition of PBM excludes any "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." (Section 3(f)(2)(iv) of the "slimmed down" version). PhRMA believes that exclusion is odd since many states have been examining PBM business practices with regards to the state Medicaid program.

Sen. Rapert asked Ms. Elyada to clarify PhRMA's concerns with that exclusion. Ms. Elayda stated that said exclusion was a red flag for PhRMA because PhRMA was under the impression that spread pricing being used by PBMs in State Medicaid programs was an issue of importance to several states and therefore states should be given more control over their Medicaid

programs. Sen. Rapert stated that is a valid point and that it would be up to the will of the Committee as to whether that language was removed from the Model. Sen. Rapert stated that such language was included in the Arkansas PBM Law, and correspondingly, the initial drafts of the NCOIL PBM Model, because Arkansas was trying to exclude Medicaid from its reforms.

Sen. Bob Hackett (OH) stated that Ohio experienced a lot of difficulties with PBMs using spread-pricing in the Ohio Medicaid program especially as applied to generic drugs. Spread pricing had increased tremendously because there was not enough transparency.

Leanne Gassaway of AHIP noted that the exclusion that PhRMA cites to in the Model applies to fee-for-service Medicaid, not managed Medicaid which is typically where you will find various payment options such as per-prescription spread pricing, rebate sharing, etc. Accordingly, a drafting note may be appropriate in that section of the Model so that someone can check with the state Medicaid Director as to how the Model would impact that state's Medicaid program.

Julie Roberts, a healthcare consultant from Texas, stated that she appreciates the Committee's efforts to create a legislative framework for states to consider, and appreciates that the Model does not reference ERISA. Ms. Roberts asked if the Committee plans to have the Model cover all health benefit plans or is the Model only applicable to Medicare and Medicaid. Asm. Cahill stated that the Model intends to cover all health benefit plans that are regulated by the states. Sen. Rapert stated that the intent of the Arkansas PBM law was to apply to commercial retail health benefit plans and to stay away from ERISA-plans and Medicaid.

Sen. Hackett stated that the Model is meant to apply to fully-insured plans and the market has really changed in that many employers are moving to self-insured plans which state legislators and regulators do not have authority over. Ms. Roberts asked if the Committee ever deals with its Federal colleagues on these issues because not being able to address plans regulated by ERISA leaves over 60% of Americans left out of the Model's protections. Asm. Cahill stated that NCOIL regularly interacts with Federal legislators but that is not the subject of this Committee meeting.

Jeremey Crandall of the Blue Cross Blue Shield Association (BCBSA) thanked Sen. Rapert and the Committee for their work on this issue and echoed AHIP's comments on the Model in that BCBSA is supportive of the "slimmed down" version of the Model.

Duane Galligher of the Texas Independent Pharmacy Association (TIPA) thanked Sen. Rapert, Rep. Oliverson, and the Committee for their efforts thus far and stated that TIPA agrees with NCPA's preference that the Model be more robust. Mr. Galligher urged the Committee to look more closely at some of the provisions of the Model that are being proposed to be removed and while TIPA understands the Committee' rationale in moving to the "slimmed down" version, TIPA prefers the original version.

John Heal of PBA Health/Texas TrueCare echoed Mr. Galligher's comments and stated that he will work with NCPA to ensure that the Model is the best possible work product for states to consider.

John Vinson of the Arkansas Pharmacists Association (APA) thanked Sen. Rapert for his leadership on these issues and stated that APA is concerned with the "slimmed down" version of the Model because it does not provide enough guidance to states as to what the Model is really trying to accomplish. There are as many as five (5) other states that have enacted PBM licensure laws but they did not have good enough language on problematic business practices

of PBMs that should be prohibited. As an example, with anti-competitive actions, there is data from pharmacies with real explanations of benefits data that shows where a particular PBM was paying itself $63 more per-prescription than what it was paying independent pharmacies. Mr. Vinson stated that such a practice should be listed in the Prohibited Practices section of the Model and he would be disappointed if other states did not see it that way.

Debra Garza of the Texas Pharmacy Association (TPA) echoed Mr. Galligher's and Mr. Heal's comments and stated that TPA agrees with NCPA's comments regarding the original version of the Model being preferable over the "slimmed down" version since the original version provides more guidance to the states, particular regarding listing certain prohibited practices. Ms. Garza also stated that TPA supports Rep. Oliverson's statements regarding a dispute resolution process being set up for reimbursement disputes.

Ms. Roberts stated that if Section 6 – Compensation, Prohibited Practices – is added back into the Model that might raise some ERISA-preemption issues. Accordingly, the "slimmed down" version of the Model may be a better starting point for states to consider. Sen. Rapert asked Ms. Roberts to clarify her comment. Ms. Roberts stated that if the Model lists the prohibited practices and the enforcement provisions and sets forth things that the PBM can and cannot do, that can often be an issue in litigation. Asm. Cahill stated that the Committee would be happy to include Ms. Robert's comments in its future deliberations if they could be submitted in a memo-format.

Sen. Rapert stated that there is a tremendous amount of disagreement in the legal community as to what amounts to an ERISA-related problem when it comes to preemption of state law. Mr. Magner stated that NCPA has not seen any ERISA-preemption issues relating to the prohibited practices section of the Model in states that have passed similar provisions. Asm. Cahill noted that the "slimmed down" version of the Model specifically excludes ERISA from its scope, but it is a worthy topic for discussion to avoid any complications down the road.

Kathy Febraio of the Pharmacists Society of the State of New York (PSSNY) thanked the Committee's work in understanding the importance of the relationship between PBMs and independent pharmacies and looks forward to being a part of the Committee's conversations going forward.

John Covello of the Independent Pharmacy Cooperative (IPC) stressed IPC's experience with recent legislation related to PBMs that was enacted in Florida. The lack of rule specificity regarding how the department would regulate the administration of benefits has created situations where a state regulatory framework is not expansive in their overall powers. Accordingly, the specificity needs to be in the Model and what has been proposed by NCPA is very reasonable as to what must be part of the "chassis" so that consumers are protected. Additionally, Mr. Covello stated that the issue of MLR's needs to be examined as part of the overall benefit administration that happens with state commercial plans.

Ms. Gassaway stated that AHIP has serious concerns with Section 6 – Compensation, Prohibited Practices – being put back in the Model as that section has the most specificity of any section other than the MAC section. Including Section 6 in the Model would run counter to the idea of the Model being a "chassis" and the idea of including drafting notes for states to consider addressing such issues in a way that addresses the state's personal needs.

Asm. Cahill then closed off the comment portion of the call and asked, if not objected to by Sen. Rapert, for a Motion that the "slimmed down" version of the Model be moved for consideration

during the Committee's meeting in December. Sen. Rapert stated that he is not in a position yet for such a Motion and asked for some time to consider the comments made on the call today and then release the version of the Model to be considered in December in the 30-day materials. Cmsr. Considine stated that he believes the goal of Asm. Cahill's proposed Motion was to be clear that the "slimmed down" version of the Model is the basis for discussion going forward and whether that is achieved through the sponsor's amendments that appear today or by having the Committee specifically vote that the "slimmed down" version is the basis for discussion going forward to which certain provisions may get added back in, is a matter for the Chair to decide in conjunction with the sponsor.

Sen. Rapert stated that he would like to hold off any votes in order to make sure that there is time for considering any changes to the Model before the 30-day materials deadline and that all committee members are clear as to what they will be voting on in December.

Sen. Hackett stated that some committee members, including himself, have serious concerns about putting Section 6 – Compensation, Prohibited Practices – and Section 9 – Rules – back into the Model. Sen. Hackett stated that he hopes that Sen. Rapert has not changed his mind from the "slimmed down" version because the people that have objected to that version have objected all long. The independent pharmacists have objected all along to the slimmed down version, and, having worked in the system before, Sen. Hackett stated that the system was worse when the independent pharmacists were in control. Sen. Hackett stated that he supports the "slimmed down" version of the Model but not the original version.

ADJOURNMENT

There being no further business, the Committee adjourned at 3:30 p.m. upon a Motion made by Sen. Rapert and seconded by Sen. Hackett.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE FEDERAL-RELATIONS AND INTERNATIONAL INSURANCE ISSUES COMMITTEE
NCOIL SUMMER MEETING - SALT LAKE CITY, UTAH
JULY 12, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at the Little America Hotel in Salt Lake City, Utah on Thursday, July 12, 2018 at 10:15 a.m.

Senator Dan "Blade" Morrish of Louisiana, NCOIL Vice President and Chair of the State-Federal Relations Committee, presided.

Other members of the Committees present were:

Rep. Sam Kito (AK)
Sen. Jason Rapert (AR)
Rep. David Livingston (AZ)
Asm. Ken Cooley (CA)
Rep. Richard Smith (GA)
Rep. Matt Lehman (IN)
Sen. Jeff Raatz (IN)
Rep. Joseph Fischer (KY)
Rep. Steve Riggs (KY)
Rep. Lois Delmore (ND)
Sen. Bob Hackett (OH)
Sen. Roger Picard (RI)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Edmond Jordan (LA)
Sen. Brian Feldman (MD)
Rep. Michael Webber (MI)
Rep. Joe Hoppe (MN)
Sen. Paul Utke (MN)
Asw. Maggie Carlton (NV)
Rep. Rodney Anderson (TX)
Rep. Joe Schmick (WA)

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 March 2, 2018 meeting in Atlanta, GA.

DISCUSSION ON GENERAL DATA PROTECTION REGULATION

Judy Selby, Principal - Judy Selby Consulting, LLC, stated that contrary to a lot of popular opinion and thought, the General Data Protection Regulation (GDPR) is not new – it is an outgrowth of a prior directive from the EU. Nevertheless, it is groundbreaking. The purpose of GDPR is to protect and empower individuals and its approach is different than what we see in the U.S. as a lot of approaches here are based on cybersecurity whereas GDPR is focused what companies are doing with the information they have about individuals. GDPR applies to

people in the EU – not necessarily EU citizens – and its definition of "personal data" is very broad and includes anything that can be traced back to someone. GDPR also applies to processing of personal data which means collecting, organizing, altering, storing, retrieving, using, erasing – essentially anything done with personal data.

Ms. Selby stated that there are two levels of personal data: regular and sensitive. Sensitive data deals with things like race, ethnic origin, sexual orientation, but surprisingly not financial information. One key factor of GDPR is that the regulation follows the data so in theory, if the data is in any country outside of the EU, GDPR applies to whoever is holding the data. GDPR applies to organizations that offer goods or services to, or monitor behavior of, data subjects in the EU and to organizations that target EU residents via the internet with services, goods, or for monitoring. What makes GDPR groundbreaking is the concept of accountability that it is imposing on whoever holds the data. It is a new concept that was not in the prior directive and it forces documentation of compliance.

To comply to GDPR, organizations need to embed six privacy principles within their operations: a.) lawfulness, fairness and transparency – you cannot hide anything from data subjects and the privacy statement has to be clear about what you are doing; b.) purpose limitation - data can only be used for a specific processing purpose that the subject has been made aware of and no other, without further consent; c.) data minimization - data collected on a subject should be adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed. In other words, no more than the minimum amount of data should be kept for specific processing; d.) accuracy - reasonable steps must be taken to erase or rectify inaccurate and incomplete data; e.) storage limitation – must delete data when it's no longer necessary for the purpose for which it was collected; f.) integrity and confidentiality – this is the only GDPR principal that deals with security and it is purposefully vague as it is understood to be risk-based for each organization and it acknowledges that technology changes frequently. GDPR requires processors to handle data in a manner that ensures appropriate security of the personal data including protection against unlawful processing or accidental loss, destruction or damage.

Ms. Selby stated that another important concept in GDPR is that of data subject rights. Data subjects have the following rights under GDPR: right to information; right to access; right to rectification; right to withdraw consent; right to object; right to object to automated processing – as an example, this comes into play when someone is applying for a mortgage and the person says they want to be looked at as a person not profiled based on where they live, etc.; right to be forgotten; right to data portability. Each of these "rights" has a 30-day time limit which is creating operational challenges for companies since they must verify a request when it comes in which sometimes requires the data subject to send their passport which creates separate issues.

Ms. Selby stated that GDPR is important to insurers because processing data is a fundamental part of the business of insurance. Insurers use huge amounts of data for risk analysis, claims analysis and payment, underwriting, detecting fraud, and marketing. Ms. Selby further stated that under GDPR, insurers must always have an appropriate legal basis for processing personal data. GDPR identifies 6 legal grounds for such processing, including consent, which Ms. Selby stated is one of the worst a company should based their processing decisions on since consent can be withdrawn. Ms. Selby stated again how the requirement for companies to respond to data subject requests within 30 days creates difficult operational and technical challenges and insurers are no different.

Ms. Selby further stated that there are very important requirements in GDPR regarding how companies deal with service providers who are processing data on their behalf. GDPR allows for direct liability of the service providers which is a big change, and it requires certain contractual provisions to ensure that service providers are compliant with GDPR. Many companies also must hire a data protection officer (DPO). Another obligation falls under the concept of "privacy by design and default" which means whenever a company is trying something new such as a process or product, the company must consider data protection and the consideration must be documented.

Companies (including insurers) must also conduct a risk assessment of proposed processing activity that is likely to result in a high risk to data subject rights – this must be done before the processing takes place and if high risks are identified, the insurer must consult with the supervisory authority. That affects insurers quite a bit to the extent that they use profiling or artificial intelligence to make decisions. GDPR also states that to transfer personal data outside of the EU, insurers must make sure that the target company is based in a country that has adequate protection rules. Additionally, GDPR sets forth data breach notification requirements, including a 72 deadline to notify the supervisory authority. Ms. Selby also noted that there are three types of data breaches: a.) confidentiality – when confidential information is disclosed/hacked/stolen; b.) availability – occurs when the data is not available such as ransomware and denial-of-service attacks; and c.) integrity – when the data is corrupted or inaccurate.

Ms. Selby stated that much has been made of the fines and penalties set forth in GDPR. GDPR permits regulators to look at each violation in context pursuant to certain criteria and the highest level is the higher of €20 million or 4% of the worldwide annual revenue of the prior financial year. There is also an ability under GDPR for data subjects to receive compensation if they are affected by a violation.

Ms. Selby noted that the other way insurers are affected by GDPR is through insuring for GDPR liability through cyber insurance policies. Today's cyber insurance policies generally provide good coverage available for standard confidentiality breaches, but things get tricky when you delve into some specific GDPR obligations such as assessment, documentation, and DPO hiring requirements. Some policies in the U.S. tie coverage to only specific types of data breaches. Coverage for fines and penalties also gets tricky, especially when fines and penalties are punitive in nature - GDPR sates that fines and penalties must be dissuasive. Another key issue is coverage for directors and officers as more and more data legislation and regulation, including GDPR, puts more responsibility on them.

Rep. Joe Schmick (WA) stated that many of the terms described by Ms. Selby sound very subjective and thus, it represents a transfer of authority to regulators. Ms. Selby agreed and stated that many terms are vague, and many companies are simply taking a wait and see approach regarding how to comply with GDPR and what provisions of GDPR regulators will deem most important.

Sen. Dan "Blade" Morrish (LA), Chair of the State-Federal Relations Committee and NCOIL Vice President, asked what specifically triggers GDPR's obligations, and who is currently subject to GDPR. Ms. Selby noted that there is no size-limit regarding company applicability and that currently, if you fall within the GDPR's definitions, in theory, you are subject to its obligations.

EXAMINING THE TRUMP ADMINISTRATION'S "PLAN" TO LOWER DRUG PRICES AND REDUCE OUT-OF-POCKET COSTS

Greg Gierer of America's Health insurance Plans (AHIP) stated that addressing rising prescription drug prices is an urgent national problem and bold steps are needed, both at federal and state levels, to ensure people and patients have access to life-saving and affordable medications. Last year alone, the U.S. spent $457 billion on prescription drugs, representing about 16.7% of total U.S. healthcare spending. Prescription drugs are rising faster than inflation and overall healthcare costs. Employers in the commercial market now spend more on prescription medications for their employees than they pay for in-patient hospitalizations. In fact, 22% of all healthcare costs in the commercial market are spent on prescription medications.

These price increases are making coverage less affordable for covered employees and putting strains on the U.S. healthcare system and Federal budget. The price increases are being driven by high launch prices for specialty medications and biologics as well as price increases for brand name drugs that have been on the market for many years. Because of this, action is critically needed and AHIP commends the Trump Administration's focus on rising prescription drug prices, and HHS Secretary Azar's leadership in releasing the HHS prescription drug blueprint.

The blueprint contains several important near and long-term policy options to both lower drug prices and reduce out of pocket costs. The blueprint is organized in four major areas: a.) improving competition; b.) enhancing better private sector negotiations; c.) lowering list prices; and d.) reducing out of pocket costs. AHIP is working closely with its members to develop comprehensive comments and recommendations to Secretary Azar which are due on July 16. Mr. Gierer stated that AHIP wholeheartedly and unequivocally agrees with the goal of lowering list prices and reducing prescription drug prices. Moreover, AHIP agrees with HHS' goal of getting the most clinically effective drugs into the hands of patients at the lowest possible cost.

Several of the HHS blueprint proposals show promise in lowering prescription drug prices that are consistent with a market-oriented approach to addressing the problem. First, AHIP supports promoting generic competition and supports efforts to spur greater generic availably and uptake of generic drugs. Such efforts include preventing some of the shenanigans that are going on with brand name manufacturers such as withholding samples that generic drug companies need to bring their products to market. Second, AHIP supports creating a robust and competitive marketplace for biosimilars. AHIP supports efforts to improve the availability, competitiveness and adoption of biosimilars as affordable alternatives to branded biologics. Third, AHIP supports enhanced benefit flexibility and expansiveness of private sector negotiation tools – the goal being to bring the effective tools and cost containment strategies that have worked in the private sector to public programs like Medicare Part D, which includes supporting the blueprint's consideration of allowing Medicare Part D plans to address price increases for a sole source generic drug, and providing plans with more flexibility in using formulary management tools for high cost drugs for which rebates are often limited or unavailable. Fourth, AHIP supports provisions in the blueprint that aim to increase prescription drug price transparency, including the proposal to include list prices in direct to consumer advertising, and ongoing efforts to promote transparency in public programs like Medicare and Medicaid. Finally, AHIP supports efforts to update the star rating methodology as a way to ensure that part D plans are appropriately managing the utilization of high cost drugs.

Mr. Gierer stated that AHIP also has some concerns with the blueprint, particularly those dealing with prescription drug rebates. AHIP is concerned with some of the commentary around curtailing, limiting, or even eliminating the role of rebates. Rebates are a mainstay of prescription drug coverage in the private and public markets, and they are a part of the private sector tools to provide high quality and affordable prescription drug coverage. Rebates are also part of private sector negotiations. AHIP strongly supports lower list prices and net costs, and rebates are not related to that. Rebates are a way to drive down costs and they are primarily a function of leverage, not incentives. The challenge is that health plan formularies provide leverage that drive drug makers to provide discounted prices as manufactures compete for formulary placement. Rebates do not cause high list prices and price increases, rather, rebates are a market-based response to lower prices for consumers and the savings come through in the form of lower premiums and out of pocket costs.

Mr. Gierer stated that many of the blueprint's proposals are promising but the challenge now is to put them into action at both the federal and state level. Market oriented and pro-competitive policies such as those in the blueprint hold tremendous promise of getting at the core issue of the problem of rising prescription drug prices.

Sen. Bob Hackett (OH) stated that he is a supporter of rebates, but he is concerned as to how small businesses are hurt by them and asked Mr. Gierer how that can be resolved. Mr. Gierer stated that small businesses are indeed feeling the effects of drug price increases. To the extent that the market is able to act on some of the policies set forth in the blueprint, that would help lower drug prices overall. There is bi-partisan support for many of the blueprint's proposals.

Emily Donaldson of Pharmaceutical Research and Manufacturers of America (PhRMA) stated that the blueprint's request for information (RFI) comes at a time when we are in an era of medicine in which breakthrough science is transforming patient care and enabling us to effectively treat chronic disease which is the biggest cost driver in our healthcare system. There has been an evolution in the supply chain of the overall healthcare system that has left patients facing increased out of pocket costs due to rising list prices and high deductibles and coinsurance. This crossroads situation helps explain why there are over 150 questions in the RFI.

The RFI creates a unique opportunity to take a wide view and address all the factors that influence the cost of medicines. PhRMA is committed to help solve those problems and it supports efforts to make the fundamental policy changes needed to provide solutions. The RFI contains potential policy changes that would re-make key aspects of the market for prescription medicines and have a far-reaching impact on the cost and access of medicines, and significantly affect not just manufacturers but all stakeholders in the supply chain. PhRMA and its members support improving the status quo for Americans who rely on medicines and it believes that it needs to address some of the market distortions like changing supply chain incentives which would have positive consequences for both patients and payors.

However, Ms. Donaldson stated that there are some policies in the RFI that could harm access and increase out of pocket costs. Accordingly, caution is urged when considering such policy changes, particularly when the changes would affect very vulnerable populations such as those in the Medicaid and Medicare programs. With regard to rebates, Ms. Donaldson stated that the RFI correctly identifies a clear problem. While the current system of rebates, list prices, and net prices, has somewhat constrained overall drug spending, it can work better for everyone involved – most importantly, patients. Reforming the system will not be easy and must be done

with great care and consideration. One issue that must be dealt with carefully is that of existing contractual relationships that exist among players in the supply chain that cannot be immediately upended. Special attention must also be paid to how policy changes could affect the ability for stakeholders to enter into voluntary, value-based arrangements.

Ms. Donaldson stated that health plans typically do use some portion of the negotiated rebates to reduce premiums for enrollees but in the current system, we have started to create a system of reverse insurance where sometimes the sicker patients who are high utilizers of medicines pay more at the pharmacy and more in overall out of pocket costs and since they are not getting the rebates there and the rebates are spread across the premiums, it is almost as if sicker patients are subsidizing healthier patients. Everyone seems eager to work together to solve that problem. The RFI also discusses anti-kickback statutes and there are many considerations the PhRMA will take into account and submit in its comments on the RFI.

Ms. Donaldson stated that PhRMA believes that any reforms to Medicare Part D should be developed with a focus on ensuring that Medicaid beneficiaries have access to and can afford the medicines they need no matter what health conditions they are facing. PhRMA believes that it is time for a "tune-up" of Medicare Part D to make sure that it continues to function appropriately and is sustainable. Some Part D reform proposals in the RFI are promising such as passing through a share of the negotiated rebates at the point of sale and establishing an annual maximum out of pocket spending limit. Those proposals could provide immediate financial relief to patients facing high pharmacy costs. However, some proposed changes to Part D, such as changes to the protected classes or eliminating the two drug per class requirement, could increase costs for beneficiaries and jeopardize the health of seniors and those with disabilities.

Approaches to change Medicare Part B are also referenced in the RFI and PhRMA believes that HHS should pursue approaches that improve value holistically across the treatment continuum and focus on empowering patients to make informed choices and treatment decisions rather than restricting their choices and treatment options. PhRMA also believes changes should be avoided that contain incentives that would undermine the existing Part B market base and transparent average sales price system. With regard to Medicaid, the RFI does contemplate eliminating the ACA's maximum rebate amount provision which is essentially a cap that keeps Medicaid rebates from exceeding the payment a manufacture receives for a drug – PhRMA will be providing specific comments on that proposal. PhRMA encourages CMS to preserve and improve access to medicines for vulnerable Medicaid patients whom are often those with the most complex and chronic conditions that require access without delay to a broad range of treatments as prescribed by their physicians. Those patients are also typically financially vulnerable so access to treatments needs to be a primary objective.

The 340B drug pricing program is also referenced in the RFI and PhRMA believes that 340B is an important program but the size of it has created some incentives that affect consumer prices for medicines as it shifts care to more expensive hospital settings and accelerates provider consolidation. A significant amount of data shows that the 340B program is driving up costs for everyone. PhRMA will be providing specific comments on improving the program.

Ms. Donaldson stated that co-pay assistance cards are referenced in the RFI and a recent study stated that such cards can mitigate patient abandonment rate (i.e. when a patient gives up their prescription at the pharmacy counter because it is too expensive) by up to 50%. The study also found that in 2017, only 0.4% of commercial claims were filled with a cost-sharing assistance card for brand medicine where there is a generic available. PhRMA will be submitting specific

comments on the RFI's questions regarding the impact of ending the current policy of excluding manufacture sponsored drug discount programs from the determination of average manufacturer price (AMP) and best price.

Ms. Donaldson stated that value-based contracting is featured prominently in the RFI and it is good news that the FDA has now addressed a key barrier to value-based arrangements by issuing guidance to allow certain communications between manufacturers and payers. Such communications are essential in making sure that value-based contracting arrangements can move forward. PhRMA urges CMS to continue with that momentum because such arrangements can offer important clinical gains and overall cost-savings to payers, providers, and the system as a whole, including Medicare and Medicaid and their beneficiaries. PhRMA looks forward to working with the federal government and states to identify and address other barriers to value-based contracting. Something that states might be interested in are state anti-kickback statutes and making sure that such statutes are properly applied and are not imposing outdated barriers to value-based contracting.

Caitlin Westerson, of the Colorado Consumer Health Initiative (CCHI) stated that CCHI is a non-profit, non-partisan advocacy organization and its membership is based on organizations that do grassroots organizing. CCHI represents consumers in the health policy world through its members. Spending on prescription drugs is having a negative impact on the overall healthcare system, especially when it impacts premiums and consumer's out of pocket costs. Ms. Westerson stated that the crux of the issue is that patients are caught in the middle and drugs don't work if people can't afford them. One in four Americans report not being able to afford their prescription drugs and when they can't afford the drugs they don't adhere to their regimen and that ends up costing the healthcare system a lot of money downstream. One study estimates that such a cycle costs between $100 billion and $290 billion annually.

Ms. Westerson stated that the blueprint is a step in the right direction, contains promising ideas, and is a great opportunity for consumer advocates, policymakers, and other players in the industry to engage in a robust conversation. However, there is room for improvement and there are a few things in the blueprint that consumers find concerning. Additionally, several of the blueprint's proposals are modest and are not fleshed out enough yet to determine if they will have a real impact. An example is the blueprint's focus on Medicare and lack of focus on the commercial market as only 1/3 of Americans are insured through Medicare.

Ms. Westerson stated that more flexibility in the Medicare formulary and value-based purchasing sound like great ideas, but the devil is in the details and it depends on how those proposals are structured and what guardrails are implemented to ensure that consumers are protected from predatory behavior and loss of coverage. The blueprint also misses some opportunities as there is a lot of political salience on these issues right now and the polling indicates that voters, both Republicans and Democrats, support bold measures to address prescription drug costs – measures that are bolder than what are contained in the blueprint. There typically is not as much common ground as currently existing on both sides of the aisle on healthcare reform so it needs to be capitalized on. There are also ideas floating around that did not get into the blueprint such as price gouging laws, importation programs, robust transparency measures, capping co-pays, and robust patent reform.

Ms. Westerson stated that consumers see potential in the blueprint on issues such as: Medicare beneficiaries' out of pocket costs; passing savings through to consumers through additional PBM regulation; limiting rebates and discounts that contribute to an opaque supply chain and high list prices; requiring list prices to be disclosed in direct-to-consumer advertising; and

controlling Medicare part B price increases. Ms. Westerson stated that the blueprint missed the mark on directly impacting prices as there is a lot of rhetoric around negotiating prices in the Medicare program but the proposals in the blueprint are outlined as stating that each individual Medicare plan would be able to negotiate individually with the manufactures and that is not as powerful as compared to aggregating and leveraging the national purchasing power across the entire program.

The blueprint could also do more to discourage patent abuses. There is conversation surrounding Risk Evaluation and Mitigation Strategies (REMS) abuse but there is seemingly no mention of "pay-for-delay" where brand manufacturers pay generic manufactures for delaying the introduction of their drugs following patent expiration. Nor is there mention of "evergreening" where drug companies extend patents and delay the introduction of generics by making very small, not necessarily meaningful, changes to existing drugs by changing things like the coding or dosage of a drug. Ms. Westeson stated that the blueprint could also approve upon requiring more meaningful transparency. Consumers are very interested in the justification for where list prices are set and also why they continue to rise especially after they have been on the market for years. Consumers want to see anticipated price increases, research and marketing costs, and what the discounts and rebates are.

Ms. Westerson stated that consumers are also concerned about the Medicare and Medicaid programs not covering certain drugs. Regarding changing formularies for those programs, the leverage comes at the cost of the most vulnerable populations: children, seniors, low income individuals, and individuals with disabilities. That has the potential for a negative impact on the system at large. The blueprint also does not mention price gouging or bad actors in the pharmaceutical supply chain. Many consumers rely on their drugs to live which gives pharmaceutical companies a captive market and that will continue to happen at the expense of consumers unless the practices of bad actors are addressed. Ms. Westerson also stated that she does not see much value in increasing drug prices outside the U.S. and focus should be on prices within the U.S. and how they are affecting consumers. Ms. Westerson closed by stating that the Trump Administration is the first Administration in years that has shown an interest in tackling these difficult issues and consumers appreciate all efforts in giving everyone an opportunity to participate in the conversations.

Rep. Lois Delmore (ND) stated that we seem to be bombarded by advertising from drug companies and asked if there is a way to find out what percentage of their budgets is spent on advertising as compared to research, and whether that is a contributing cost increase for consumers. Ms. Westerson stated that is a question being asked by consumer advocates across the country and typically, when you see drug pricing transparency legislation, it almost always includes provisions regarding marketing and advertising costs. There is information included in a pharmaceutical companies' Form 10-k filing with the SEC, but Ms. Westerson stated she is not certain what level of detail it provides.

Ms. Donaldson stated that the level of detail varies by company and that information is public. Ms. Donaldson also stated that, while she cannot speak for individual companies, PhRMA does require its members to spend a certain percentage on research instead of marketing. Mr. Gierer stated that AHIP is concerned about the proliferation of direct-to-consumer advertisements. The blueprint contains a proposal to require manufacturers to include their list prices in such advertisements which is important as that is something consumers should know in addition to the safety and effectiveness of a drug. Mr. Gierer stated that the entire drug pricing system is opaque and that it is important to make sure that all stakeholders, including patients, understand what is making drugs unaffordable. Several states have either passed laws or are considering

passing laws that “get under the hood” of the drug pricing system. Competition and the free market work when everyone has access to the same information and, accordingly, AHIP supports drug pricing transparency legislation such as the landmark legislation passed in California last year.

DISCUSSION ON DODD-FRANK REFORM LAW – THE ECONOMIC GROWTH, REGULATORY RELIEF, AND CONSUMER PROTECTION ACT

Howard Headlee, President of the Utah Bankers Association, stated that many are probably unaware that Utah is one of the largest banking states in the country. Utah is the most diverse banking state in the country, but it is important when discussing banks to make sure that everyone knows what a bank is, because what led to Dodd-Frank was a mis-use of the word bank. Mr. Headlee stated that when he uses the word bank, it refers to an FDIC insured institution so that they can take deposits, insure them, and turn around and make loans in their communities. Those banks did not create the financial crisis. The Dodd-Frank reform legislation that was recently passed by Congress had bi-partisan support and will benefit all communities. That is something to celebrate at this time in America.

Mr. Headlee stated that it is not a coincidence that Utah is one of the largest banking states in the country and also has one of the country’s healthiest economies – the two are inextricably linked. When banks struggle, communities struggle, and vice versa. Mr. Headlee stated that embedded in tax reform, for those states that follow the federal tax system, is a tax increase on banks as the tax reform legislation eliminated the deductibility of FDIC insurance premiums for banks over $10 billion in size. In Utah, the average size bank is about $10 billion. However, just this morning, the Utah interim Revenue and Taxation Committee voted unanimously to eliminate the state tax increase that was coming automatically because of tax reform. That is representative of the mentality that Utah has regarding banking and its importance to the economy.

Mr. Headlee stated that, broadly speaking, the Dodd-Frank reform law focused on two main aspects of reform. One aspect is tailoring. Dodd-Frank implemented a one-size-fits-all regulatory approach because the problem was mis-diagnosed. A bank was going out of business every day. The banking industry is not trying to reduce regulations, it is trying to make them more efficient which is good for everybody. Dodd-Frank created arbitrary thresholds that had nothing to do with risk.

The other aspect is harmonization which requires getting everyone on the same page through increased transparency and coordination between state, federal, and international authorities. International banking is very different than U.S. banking and accordingly, international standards shouldn’t be imposed on states. Mr. Headlee stated that he understands the state insurance industry has similar views. Another piece of harmonization in Dodd-Frank is increased uniformity of standards such as liquidity standards.

Rep. Steve Riggs (KY), NCOIL Immediate Past President, stated that the country has lost banks in the past due to mis-guided regulation, but also due to them becoming too leveraged based on activities such as credit default swaps and derivatives. Rep. Riggs asked Mr. Headlee is he thinks banks have learned their lesson regarding those activities, or, are we headed back towards the abuse of those practices due to the Dodd-Frank reform legislation. Mr. Headlee stated that when discussing topics like credit default swaps it is important to make sure the discussion is focused on the proper definition of a bank. Mr. Headlee also stated that credit default swaps are a critical risk management tool and that he does not see anything

inappropriate going on with using them to mitigate risk such as interest rate risk. Mr. Headlee stated that things like The Volcker Rule never got implemented because it painted with such a broad brush which is reflective of why, when discussing Dodd-Frank, the proper definition of bank must be used.

Mr. Headlee stated that the good news with regulatory reform relates to mortgages. Mr. Headlee stated that he has no doubt that if everyone in American had gotten their mortgage from a local bank or local credit union, the financial crisis never would have occurred. Dodd-Frank caused such local banks and credit unions to shut down because of the nightmarish regulatory atmosphere. Such a large amount of mortgage business was then transferred to on-line business. The Dodd-Frank reform legislation will hopefully bring those mortgages back to local banks and credit unions.

UPDATE ON FEDERAL AND INTERNATIONAL INSURANCE DEVELOPMENTS

Dave Snyder of the Property Casualty Insurance Association of America (PCI) stated that tariffs are starting to be used by many countries to resolve trade disputes and they could end up causing higher insurance costs. Tariffs have already been imposed on imported lumber from Canada and the homebuilders estimate that will increase the cost of building a new home by $9,000. Perhaps of greatest significance is a proposal to impose tariffs on imported automobiles and automobile parts. A joint trades letter was submitted to the Department of Commerce in which it was estimated that such tariffs would add $3.4 billion in auto insurance premiums. Mr. Snyder urged NCOIL to monitor these issues as states may begin to see rising insurance costs.

Mr. Snyder stated that, on a positive note, there was an insurance-related provision include in the Dodd-Frank reform legislation that pushes towards greater transparency and greater state-federal coordination. Through its support of the state-based system of insurance regulation, NCOIL played a very large role in seeing that language included in the legislation. Additionally, yesterday, the House passed unanimously by voice vote The International Insurance Standards Act of 2018 (H.R. 4537) which calls for consultation with states and Congress when international insurance negotiations take place to ensure that international insurance standards and agreements recognize the state-based system of insurance regulation. Mr. Snyder urged NCOIL to continue supporting that bill to ensure that some version of it becomes law which would establish a positive state-federal relationship in the future, protect the state-based system of insurance regulation, and enable the federal government to be the face in international negotiations to carry forth state polices in the international realm. Doing so would ensure that things like the GDPR do not become a global standard.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
NCOIL SUMMER MEETING - SALT LAKE CITY, UTAH
JULY 13, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at the Little America Hotel in Salt Lake City, Utah on Friday, July 13, 2018 at 4:00 p.m.

Senator Dan "Blade" Morrish of Louisiana, NCOIL Vice President and Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Sam Kito (AK)
Sen. Jason Rapert (AR)
Rep. David Livingston (AZ)
Asm. Ken Cooley (CA)
Rep. Martin Carbaugh (IN)
Sen. Travis Holdman (IN)
Rep. Matt Lehman (IN)
Sen. Jeff Raatz (IN)
Rep. Joseph Fischer (KY)
Rep. Michael Webber (MI)
Rep. Lois Delmore (ND)
Rep. George Keiser (ND)
Sen. Bob Hackett (OH)
Rep. Glen Mulready (OK)
Sen. Roger Picard (RI)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Deborah Ferguson (AR)
Rep. Steve Riggs (KY)
Rep. Edmond Jordan (LA)
Asw. Maggie Carlton (NV)
Asw. Ellen Spiegel (NV)
Rep. Rodney Anderson (TX)
Rep. Joe Schmick (WA)

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 March 2, 2018 meeting in Atlanta, GA.

DISCUSSION ON ENABLING INSURTECH INNOVATION

Sen. Dan "Blade" Morrish, NCOIL Vice President and Chair of the Committee, stated that Insurtech innovation is occurring across the entire insurance value chain and across all lines of insurance, and as a result, the very nature of the business of insurance is transforming. NCOIL applauds the NAIC's efforts to stay ahead of the curve on Insurtech innovation, as demonstrated by the NAIC Innovation and Technology Task Force (Task Force). Sen. Morrish asked if an update could be provided on the Task Force, and if the Task Force is expected to produce any work product soon.

Gordon Ito, Hawaii Insurance Commissioner and NAIC Secretary-Treasurer, stated that innovation and consumer expectations are rapidly changing the insurance marketplace. Technology is changing rapidly and transforming our lives in dramatic ways. In 1975, the fastest computer cost about $5 million and today, a standard iPhone costs several hundred dollars and has much more computing power than the fastest computer available in 1975. As insurance regulators and legislators, the challenge is to balance critical consumer protections with the demand for innovation and to maintain stable and competitive markets. As an example, Cmsr. Ito recalled the discussions many years ago surrounding credit scores being used as an insurance rating factor. Cmsr. Ito stated that the past few years, the NAIC and U.S. insurance regulators as a whole have been reaching out to startups early in the process to understand the technology being developed. Insurers, as well as the innovators, understand the regulatory landscape and regulators can verify that they are following applicable laws and regulations.

Cmsr. Ito stated that insurance regulators have engaged in a strong commitment to insurance innovation by forming the Task Force. Through the Task Force, insurance regulators have been able to connect with many key players in the Insurtech arena. Insurance regulators are also examining regulatory sandboxes to lower barriers to market entry where appropriate. However, Cmsr. Ito stressed the words "where appropriate" as he noted that the current insurance regulatory structure has the ability to be adaptive to innovative practices. Cmsr. Ito stated that while innovation allows insurers to use data to more accurately price risk, it is important to ensure that any innovative practices do not harm consumers. Insurance regulators need to understand the new data sets being driven by new data collection efforts and non-traditional insurance players such as data scientists and coding analysts need to assist insurance regulators in doing so. In February of 2018, the NAIC adopted its strategic "State Ahead" plan (Plan), in part to help the NAIC meet the challenges facing the insurance industry in light of the innovative practices being developed.

The Plan capitalizes on the opportunity to build a credible state vision for evolution of the regulatory support tools to build an enduring and robust insurance regulatory framework. The Plan is designed to give state insurance regulators, through the NAIC, the tools, talent, and technology to make informed regulatory decisions. The Plan is about empowering state insurance regulators, not the NAIC, as all regulatory decisions will continue to be made by state insurance regulators. The basic format of the Plan is broken down into three core themes: a.) maintain safe, solvent and stable markets; b.) protect consumers and educate them; and c.) enable the NAIC to provide superior services and resources. Cmsr. Ito stated the Plan is necessary and important to help state insurance regulators, and the NAIC, adapt to insurance innovation.

Chlora Lindley-Myers, Director of the Missouri Department of Insurance, stated that regarding regulatory sandboxes, Missouri has a statute in place that allows the Insurance Director to issue a "no action" letter. Carriers can apply to utilize certain functions and/or practices, and it is up to the Insurance Director to determine whether the carrier will do what is necessary to ensure that consumers are not harmed, and if so, a letter can be issued.

Sen. Jason Rapert (AR), NCOIL President, stated that insurance regulators and legislators need not ignore the power of disruption that can occur in the insurance industry due to innovative ideas, and such ideas force everyone to be a quick study on all related issues. Sen. Rapert stated that he was intrigued by the appetite the British delegation had for working with the U.S. on Insurtech and Fintech innovation issues when he participated in a recent event with the Lord Mayor of London. It may be that they are finding some very willing regulatory bodies in the smaller U.S. states as such states can perhaps be more nimble than the larger ones regarding

insurance regulatory practices. Sen. Rapert noted that Insurtech company Lemonade has been approved to operate in Arkansas and stressed how it is important for insurance regulators and legislators to continue to learn as much as they can about innovative insurance practices.

DISCUSSION ON NEW FEDERAL AHP AND STLD REGULATIONS

Sen. Morrish stated that the Executive Order issued by President Trump this past October outlined several of the Administration's healthcare policies which included Association Health Plans (AHPs) and Short Term Limited Duration Insurance Plans (STLDs). Sen. Morrish asked what the NAIC's thoughts were on the recently issued AHP regulations, and their thoughts on STLDs in general as the final regulations on them are expected to be released soon.

Dean Cameron, Director of the Idaho Insurance Department, stated that the Executive Order had four major components: a.) direct the DOL to expand the rules for AHPs; b.) direct HHS to work on STLD rules; c.) direct Treasury to offer more flexible options and alternatives for health reimbursement arrangements (HRAs); and d.) direct HHS to report back on all state and federal laws and requirements that impede competition, choice, and delivery in the healthcare delivery system. With regard to AHPs, Dir. Cameron stated that the regulations expand the situations in which employers can join together and offer health insurance coverage as a single employer. Dir. Cameron stated that the NAIC is grateful for some of the language included in the regulations. Associations whose members operate in the same industry may offer an AHP. An association whose members are in the same geographic area may sponsor an AHP, including some geographic areas crossing state lines. Only employment-based associations may sponsor an AHP. Sole proprietors are able to participate and consider being both either an employer or an employee for purposes of an AHP. In the final rule, the hours per week requirement in the definition of a "working owner" was changed from 30 to 20.

Dir. Cameron stated that an AHP must have an organizational structure, which is important to the NAIC. AHPs must be controlled functionally by its members and the association must have a governing body, bylaws, and maintain legal formalities based on the type of entity of the association. The association's employer-members are required to oversee the activities directly, or indirectly by electing board members or other representatives. AHPs formed under the new rules must comply with non-discrimination provisions which the NAIC believes to be very important. AHPs are prohibited from conditioning membership in the association based on a health factor such as medical status or claims experience. AHPs must also comply with non-discrimination rules that govern benefit eligibility which includes enrollment and effective dates of coverages.

Dir. Cameron noted that existing AHPs may continue to operate under the current rules but if they want to take advantage of any new flexibility, they must comply with the new rules. Determination of whether large or small group rules apply has also changed under the new rules as it is now based on the size of the association, not the size of the individual members. Current law requires associations of small employers to comply with the small group market. The final rules also state that the enhanced enforcement tools under the ACA regarding Multiple Employer Welfare Arrangements (MEWA's) will continue which is very important to the NAIC. Multiple welfare trusts, or multiple welfare associations are currently regulated by most insurance regulators and the NAIC believes that is important to protect consumers from fraudulent activities.

Dir. Cameron stated that the final rules clearly state that all AHPs are MEWA's and as such, under ERISA, state authority to regulate them, whether fully or self-insured, is preserved. As

noted in the final rules, courts have consistently ruled in favor of state regulation of MEWA's, including rating requirements, benefit requirements, licensure or certification requirements, and other consumer protections. The final rules note that some commenters wanted to preempt such state authority, but the choice was made not to do so. Accordingly, AHPs must meet any relevant state requirements. Dir. Cameron noted that the rules state that there is "phase-in" language regarding effective dates for fully-insured plans – September 1, 2018; for existing, self-insured plans – January 1, 2019; and for new, self-insured plans - April 1, 2019.

Mike Chaney, Mississippi Insurance Commissioner, stated that the new AHP rules will present a variety of questions to state insurance regulators as to how they will regulate AHPs. For example, if multiple farm bureaus in different states form an AHP, no one state will have state regulatory sovereignty over the AHP. The NAIC looks forward to working with HHS in order to figure out some of the rule's intricacies. Cmsr. Chaney stated that the NAIC submitted comments on the proposed STLD regulations and noted that the provision in the current STLD regulations that limit such plans to 3 months is arbitrary and unnecessarily limits the ability of consumers to purchase plans to meet their needs. Returning the Federal definition of an STLD plan to "less than 12 months," as proposed, is consistent not only with longstanding federal law but also with how this term has been long defined by most states. The NAIC also believes that educating consumers and ensuring that they are aware of the limitations of these plans is paramount. Cmsr. Chaney stated that STLDs serve to fill the "doughnut hole" that occurs when people lose their job and a COBRA plan may be too expensive. The NAIC also recommended to HHS that the final regulation allow states, if they so choose, to begin enforcing the new rules in 2020, thus giving them time to review their rules and seek statutory or regulatory changes to facilitate a smooth transition. Cmsr. Chaney closed by stating there is a lot of uncertainty regarding when the final STLD regulations will be issued and states need to be prepared to act.

Sen. Morrish asked Cmsr. Chaney to clarify whether the regulations limit STLD plans to 3 months or 12 months. Cmsr. Chaney stated that no one knows yet as the final regulations have not been released. The NAIC hopes that the regulations with set the limit at 364 days. Dir. Cameron stated that in Idaho, they felt that the 3-month limitation stated in the current STLD regulations is arbitrary and each state handled the regulations differently – Idaho did not enforce the 3-month limitation. Dir. Cameron stated that he believes that it will be similar under the new STLD regulations in that different states may set different time limitations for the plans. Dir. Cameron also noted that there are other discussions about STLDs besides time limitations such as guaranteed renewability and limitations on pre-existing conditions. Cmsr. Chaney stated that most states don't enforce the current STLD regulation's 90-day time limit, and that most current sellers of STLD policies allow the consumer to renew such policies. STLD plans are not ACA compliant.

Rep. George Keiser (ND) stated that his understanding is that AHPs are not backed by state guaranty funds and asked if MEWA's are; and if not, how will state insurance regulators handle such solvency issues? Dir. Cameron stated that the jury is still out on those questions. Some states cover MEWA's under their guaranty funds and some don't. Solvency of MEWA's and AHPs is an important issue to watch going forward. Dir. Cameron also stated that it will be important to monitor the impact AHPs will have on the marketplace and on carriers. Carriers are not required to offer AHPs. The health insurance market is a management of risks and over the years, AHPs have started out great but as soon as the healthy members figure out they can purchase coverage outside of the association, they leave, and that starts a death spiral. Accordingly, carriers will have to determine how to prevent such death spirals.

Rep. Keiser asked if state insurance regulators have full authority for rate approval for AHPs. Dir. Cameron stated that it depends on the state, but most state insurance regulators don't have the authority to approve rates on health insurance but have the authority to review the rates and determine if they are unreasonable. Dir. Cameron noted that in Idaho, he has the authority to regulate MEWAs, review their rates, and to say to MEWAs whether or not the rates are adequate or unreasonable. Typically, the conversations focus on adequacy of rates and putting at risk the member's health insurance benefits.

Cmsr. Chaney stated that most states only approve individual rates and with MEWAs, most states manage them to some degree but have little, if any, regulatory authority over AHPs. The failure rate for past AHPs has been close to 90% and Cmsr. Chaney stated that it is fine to have an AHP, but they need to be sure they have enough solvency and reinsurance. Cmsr. Chaney also noted that, unrelatedly, the state guaranty funds are in for trouble regarding long term care insurance and the issue is worth monitoring. Companies and entities that did not write LTC policies are now being assessed.

Commissioner Tom Considine, NCOIL CEO, asked if the requirement in the new AHP rules for associations who offer AHPs to have its members operate in the same industry trumps the existing MEWA rule where employers in different industries could band together and start a MEWA. Dir. Cameron stated that his interpretation of the AHP rules is that for existing MEWAs, they could continue their operation but if they wanted to take advantage of the new flexibility, they would have to follow the requirements of the new rules. Cmsr. Chaney stated that the issue is that when the Federal government looked at AHPs, they did not give state insurance regulators the ability to fully run the AHPs, so what worries state insurance regulators is if AHPs get lumped together with MEWAs, which state insurance regulators do regulate, what should such regulators do if an AHP goes "belly up." Dir. Lindley-Myers stated that it is important to make sure that the AHP is not a fictitious grouping which is a big hurdle to overcome.

DISCUSSION ON MAWG ACTIVITY

Sen. Morrish stated that the NAIC Market Action Working Group (MAWG) plays a very important role in protecting consumers and asked if some background on it could be provided on what exactly MAWG is and how it carries out its functions.

Todd Kiser, Utah Insurance Commissioner, stated that MAWG was formed in 2006 to provide a forum primarily for chief regulators within NAIC jurisdictions to address multi-action state regulatory issues. There are 16 states that participate in MAWG: AR, CA, IN, IA, KS, ME, MN, MO, UT, NE, NY, NC, OH, PA, TX, and WA. Alan Kerr, Arkansas Insurance Commissioner, serves as the Chair of MAWG, and Cmsr. Kiser serves as Vice Chair. Despite having only 16 members, all state insurance departments are invited to participate. MAWG is a regulator-only workgroup because there are sensitive issues involving market action work with insurance companies.

Cmsr. Kiser stated that he believes one of the reasons MAWG is very helpful is that if a company is involved in issues in different states, many state insurance regulators don't have the ability to handle everything themselves. Accordingly, "lead states" are designated on issues in MAWG so if an insurance company is involved in activities in HI, MO, IA, UT and MS, those states can participate as "lead states" in an investigation even though they may not be members of MAWG. Accordingly, there is opportunity for regulators to involve those who are most affected by an insurance company's actions which saves insurance departments money; and it

saves insurance companies time and money since they don't have to prepare separate audits and investigative work for each insurance department.

Cmsr. Kiser stated that MAWG also permits state independence regarding request for settlements (RSA). If one state wants to pursue more penalties against an insurance company than what is set forth in the RSA, or vice versa, the state does not have to sign the RSA and can pursue its own actions. State Insurance Commissioners typically do not participate in MAWG meetings - state insurance department's chief regulators usually do. Notably, Dir. Lindley-Myers was licensed as a market conduct examiner. Cmsr. Kiser stated that he believes the purpose of MAWG is for jurisdictions to work together on multi-action issues. One big issue that was recently closed involved life insurer's use of the death master file (DMF).

Dir. Lindley-Myers stated that enforcement actions are important to look at on a state-by-state basis as there may be a law in Indiana that is not in existence in Missouri. Accordingly, state insurance regulators must be respectful of other states, and Dir. Lindley-Myers stated that she would never punish an insurer in MO for something it did in IN. MAWG is supposed to be a collaborative effort among states so that the company does not have potentially 50 jurisdictions examining them for the same issues, and at the same time, there is a realization that there are differences among the 50 states but there are some common elements that can be reviewed together.

Sen. Travis Holdman (IN), NCOIL Immediate Past President, stated that his concern relates to the protocols that are used to determine when a company should be subject to a market conduct examination. If such protocols are not standard from state-to-state, how does MAWG determine if such an examination is to be conducted? Dir. Lindley-Myers stated that the process involves several states noticing a wrongful practice by an insurance company such as perhaps late payment of claims, and those states will come to MAWG to recite the company's actions and request that MAWG get involved. Dir. Lindley-Myers also noted that sometimes companies inherit the issues of another company through purchasing that company and they might not be aware of those issues. Sen. Holdman stated that, from experience, there may be a particular Insurance Commissioner who has an axe to grind against a particular industry-type and that can influence MAWG's decisions. Cmsr. Chaney stated that has in fact been the case in the past, but such practices are not encouraged now, and he believes such practices are no longer present. The NAIC wants collaborative efforts and actions. No one wants a "Wyatt Earp" conducting a market conduction examination simply because money can be made for a particular state. Market conduct examinations are designed to protect consumers.

Dir. Cameron stated that Julie Mix McPeak, Tennessee Insurance Commissioner and NAIC President, made a dramatic change in the chairmanship of MAWG and that it should speak volumes regarding avoiding the type of practices mentioned by Sen. Holdman. Sen. Holdman asked if there is somewhere to get information as to how many states must outsource the market conduct study work itself to a firm outside the department and if there are states that have the expertise, do they conduct that work in-house. Dir. Lindley-Myers stated that it depends on the state as some have their own market conduct examiners, such as MO, NY, PA and CA, but other states hire out market conduct examination work. Generally, if you can get states that already have in-house market conduct examiners, you use those states because hiring-out the work is very expensive.

Sen. Holdman asked who ends up paying the bill for the exams. Dir. Lindley-Myers stated that the companies do. Sen. Holdman stated that if the companies pay the bill then it does not really matter if the state has the budget and/or staff. Dir. Lindley-Myers stated that what matters is

whether the company can prove to the state that they are not engaging in the suspect business practices because if the company can prove such, a market conduct exam is typically not conducted. When companies stonewall those asking the initial questions and requests for information, that is what triggers the states going to MAWG and discussing the exams. Dir. Lindley-Myers also noted that a vote must take place in MAWG as to whether to pursue a collaborative action.

Rep. Keiser stated that he thought he had heard about five years ago that the NAIC has committed to re-addressing the way in which it conducts market conduct exams, and in doing so, the NAIC agreed to move to more targeted desk exams when specific issues arose as compared to more general market conduct exams. Rep. Keiser asked if that is still the NAIC's position. Cmsr. Kiser spoke to his philosophy as Utah Insurance Commissioner. During a recent phone call, a state suggested that a MAWG action be initiated against a company, but Utah was not supportive of it as Utah saw the company's practice as an isolated incident in one state. Had 4 or 5 states cited similar complaints about the company's practice, Utah's response might have been different.

Cmsr. Kiser stated that he prides himself in his Department's efforts to educate the staff so that Utah will have qualified examiners in charge to reduce the cost to Utah domiciled insurance companies when exams are conducted. Cmsr. Kiser that at first, he thought the problem was the Department's lack of funding for qualified examiners, but in reality, the training is most important. The net result of having more qualified examiners is that instead of paying $172 per hour for an examination, companies can pay $72 per hour. Insurance companies can also deduct some of those exam expenses from the premium tax they pay the state. The more knowledge staff has, the better they are able to do their work. Cmsr. Kiser stated that he cannot speak to the past practices of MAWG but that he and Cmsr. Kerr are committed to conducing MAWG in a responsible manner.

Dir. Cameron stated that the Idaho Insurance Dep't has two market conduct personnel. The majority of all market conduct issues are resolved before they ever go to MAWG and it typically takes multiple complaints which establish a trend to get market conduct personnel involved, not just one or two complaints. Idaho has a unique feature in that it does not charge companies for market conduct exams. The Idaho Insurance Dep't runs based on the fees of the companies and agents which pay for the cost of market conduct exams. The downside is that, from a company perspective, there is not much incentive to finish the exam quickly, but, the Department believes it to be a very responsible approach.

DISCUSSION ON LICENSURE AND REGULATION OF PBMs

Sen. Morrish noted the NCOIL Health Committee's activities in developing a PBM Licensure and Regulation Model Law sponsored by NCOIL President, Sen. Jason Rapert (AR). The Model Law would, among other things, require PBMs to be licensed by state insurance departments. Sen. Morrish stated that NCOIL understands that the NAIC did not have specific comments on that Model because when the NAIC was updating its "Health Carrier Prescription Drug Benefit Management Model Act," there was a lack of consensus among NAIC members, and accordingly, the NAIC Model does not address regulation or licensure of PBMs. However, Sen. Morrish asked if the Directors and Commissioners present could provide their individual experience with PBMs in their respective states.

Dir. Cameron thanked NCOIL and Sen. Rapert for exhibiting great leadership in having discussions about the licensure and regulation of PBMs. There several different approaches

that several different states have taken regarding PBM licensure and regulation, and since the NAIC is committed to the state-based system of insurance regulation, it decided to let the states develop their own PBM licensure and regulation practices. However, PBM licensure and regulation is an important issue to the NAIC as indicated by inviting Sen. Rapert to discuss that issue at the NAIC Spring National Meeting.

Dir. Cameron stated that the topic of state PBM legislative and regulatory activities will be on the NAIC Health Insurance and Managed Care Committee's (B Committee) agenda at the NAIC Summer Meeting, and most likely on the agenda at the NAIC Fall National Meeting. The B Committee wants to hear what states are considering regarding PBM regulation, and it also wants to maintain a good working relationship with NCOIL and Sen. Rapert. Currently, the NAIC does not anticipate having its own PBM Model. Dir. Cameron also noted that Idaho is in the midst of discussing what the proper path is for PBM regulations and the Arkansas approach is part of those discussions.

Cmsr. Chaney stated that Mississippi has had a PBM law since 2006 and in 2008 the pharmacy board took over the PBMs and many of the problems that other states are having with PBMs have been alleviated. PBMs do a good job if they are responsible to the pharmacy board or state insurance department. The NAIC did not take a position on the larger issue of PBM reimbursement to pharmacies. Cmsr. Chaney stated that if thought about in the light of what Home Depot did to small hardware stores, the real issue for legislators to discuss is the giant mergers of companies such as CVS, Aetna, and Walgreens resulting in the loss of local pharmacies. State regulators will do their best to enforce the laws as written by legislators. Cmsr. Chaney then reiterated Dir. Cameron's explanation of why the NAIC did not address PBM licensure and regulation when the NAIC updated its "Health Carrier Prescription Drug Benefit Management Model Act."

Dir. Lindley-Myers stated that in Missouri the Division of Professional Registration is part of the Department of Insurance and the Division provides administrative support to 41 professional licensing boards and commissions responsible for licensing and regulating the activities of approximately 430,000 Missourians. The Missouri Board of Pharmacy is one of those 41 professional licensing boards. Missouri is trying to figure out its path forward regarding PBM regulation because one of the largest PBMs, Express Scripts, is located in St. Louis, MO, and is being bought by Cigna. At this point, Missouri requires PBMs to register with the state, and Missouri has maximum allowable cost (MAC) legislation but there is a concern at both the legislative and regulatory levels about what the path forward should be.

Cmsr. Ito stated that his Department's first foray involving PBM's was when the Hawaii legislature got involved in the issue getting local pharmacies access to the PBM's networks. Cmsr. Ito stated that his initial reaction to that law was the pharmacy board should be handling it since they have the expertise but at the end of the day, local pharmacist's complaints were resolved. Last year, Hawaii passed a law requiring PBMs to be licensed by the Insurance Division and this year, the intent was to move MAC pricing appeals from the Dep't of Health to the Insurance Division, but the bill died. Cmsr. Ito stated that he has come to learn that when discussing PBMs, the real issue is transparency more than anything else.

Cmsr. Kiser stated that about three years ago, the Utah legislature proposed legislation that called on the Utah Insurance Department to regulate PBMs, however, due to a large fiscal note that the Dep't attached to the bill, the sponsor did not think it would pass, so he transferred that authority to the Utah Department of Commerce. PBMs are now required to register with the Dep't of Commerce. Cmsr. Kiser stated that he welcomes further discussions on PBMs in Utah.

Sen. Rapert stated that he understands the NAIC's position regarding licensure and regulation of PBMs, but he also hears a chorus of voices within the NAIC and he believes that everyone will meet at the end on this issue. Sen. Rapert also stated that it is very telling that only four states in the nation do not have some form of PBM regulation. It is great for NCOIL to be in a position to take the best of the PBM regulatory approaches that have been enacted in the states and to put together a framework for states to consider that can calm the waters in the PBM arena.

Sen. Rapert also noted that during the past few days, Ohio Governor John Kasich and Ohio Attorney General Mike DeWine have called for state efforts to ensure that Ohio taxpayers are getting their money's worth for middlemen who are getting more than $200 million per year to process drugs for the poor and disabled. A consultant hired by the Ohio Department of Medicaid discovered that the PBMs are getting three to six times the usual market rate. CVS Caremark and OptumRX are the two PBMs in the Ohio Medicaid program. Sen. Rapert also referenced the recent actions by the Kentucky Department of Insurance: it issued an Order of Civil Penalty and Probation against PBM CaremarkPCS Health, LLC for multiple violations of the Kentucky Insurance Code. As a result, Caremark's PBM license has been placed on probation for twelve (12) months and Caremark has been assessed a fine of $1,551,500. The Order cites four hundred fifty-four (454) violations related to reimbursement claim denials issued to pharmacists across Kentucky, an additional thirty-eight (38) violations where Caremark provided inaccurate or inconsistent information to the Department and four hundred fifty-four (454) violations of the Unfair Claims Settlement Practices Act for procedural violations in each pharmacy claim.

Sen. Rapert closed by stating that he hopes the NCOIL PBM Licensure and Regulation Model can serve as a chassis by which states can implement positive change in PBM's business practices to better protect consumers. Insurance companies are overseen by insurance departments, pharmacists are overseen by pharmacy boards, and doctors are overseen by medical boards, but PBMs answer to no one. Sen. Rapert stated that he looks forward to working with everyone to ensure there is a fair and level playing field for all involved in the drug supply chain.

Rep. Rodney Anderson (TX) stated that Texas has heavily investigated the issues surrounding PBMs. Rep. Anderson read an excerpt from an SEC report looking into how the money flows in the drug supply chain: "With generic drugs, the story is different. Manufacturers capture $36 of every $100 while companies in the supply chain capture $64." Rep. Anderson stated that does not sound like cost savings are being passed along to taxpayers, whether it be in Texas, Kentucky, or Arkansas.

Cmsr. Chaney stated examining the business practices of PBMs is important, but drug costs are too high. Drug costs are 30-32% of every health insurance premium dollar and drug companies are not regulated. Cmsr. Chaney stated that his quinine pills to treat leg cramps have risen exponentially simply because the federal government does not regulate pharmaceutical companies – that is the real issue.

UPDATE ON CYBERSECURITY DEVELOPMENTS

Sen. Morrish stated that cybersecurity is perhaps the most important topic in the insurance sector today and NCOIL applauds the NAIC for development of its Insurance Data Security Model Law. Sen. Morrish asked how the Model has been progressing through state

legislatures, and if there is potential for Congress to step in and pass legislation on data security that would preempt state laws.

Cmsr. Ito stated that since the Data Security Model was adopted by the NAIC, it has been adopted in South Carolina and introduced in Rhode Island. The NAIC anticipates a number of states to introduce the Model during the next legislative session which is important to prevent Congress from stepping into the data security realm. At the present time, Congress has a draft bill entitled the "Data Acquisition and Technology Accountability and Security Act" but due in part to efforts by the NAIC, the bill excludes insurance from its scope.

Cmsr. Ito stated that as cybersecurity becomes more important it is important to keep a regulatory eye on cyber insurance and the pricing of that product. The NAIC also plans to hold another joint cybersecurity forum with Stanford University to further explore how insurers and cybersecurity experts can better work together to solve cybersecurity challenges facing the nation's technology infrastructure.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE AND HEALTH RETIREMENT ISSUES COMMITTEE
NCOIL SUMMER MEETING - SALT LAKE CITY, UTAH
JULY 14, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health, Long Term Care and Health Retirement Issues Committee met at the Little America Hotel in Salt Lake City, Utah on Saturday, July 14, 2018 at 8:45 a.m.

Representative Tom Oliverson, M.D. (TX), Vice Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Sam Kito (AK)
Rep. Deborah Ferguson (AR)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Richard Smith (GA)
Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Rep. Joseph Fischer (KY)
Rep. Jim Gooch (KY)
Rep. Bart Rowland (KY)
Sen. Dan "Blade" Morrish (LA)
Rep. Michael Webber (MI)
Rep. Joe Hoppe (MN)
Rep. Lois Delmore (ND)
Rep. George Keiser (ND)
Asw. Maggie Carlton (NV)
Sen. Neil Breslin (NY)
Sen. Bob Hackett (OH)
Rep. Glen Mulready (OK)
Rep. Jim Dunningan (UT)

Other legislators present were:

Rep. David Livingston (AZ)
Rep. Steve Riggs (KY)
Rep. Edmond Jordan (LA)
Sen. Brian Feldman (MD)
Asw. Ellen Spiegel (NV)
Rep. Rodney Anderson (TX)
Sen. Paul Utke (MN)
Rep. Joe Schmick (WA)

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 March 4, 2018 meeting in Atlanta, GA, and its June 8, 2018 interim conference call committee meeting minutes.

DISCUSSION ON THE STATUS OF HEALTHCARE AND SHORT TERM LIMITED DURATION INSURANCE PLANS

Jan Dubauskas of IHC Carrier Solutions – Independence Holding Group, stated that IHC consists of three carriers: Standard Security Life Insurance Company of New York; Madison National Life Insurance Company, Inc; and Independence American Insurance Company. IHC

is a leader in the specialty health product segment, particularly short term limited duration insurance plans (STLDs).

Ms. Dubauskas first provided an overview of the status of the Affordable Care Act (ACA). The majority of Americans have insurance through their employers. According to the 2016 U.S. Census Bureau, of the 67.5% of Americans who have private health insurance, 55.75% is employer-based, 19.4% is through Medicaid, and 16.2% is through the direct-purchase market. The ACA has done a lot of good, but there are still 28.1 million Americans uninsured (8.8% of the population), and minorities are those impacted the most by that statistic. Ms. Dubauskas stated that from the group who has health insurance in America, 98.8% of those 65 years and older have coverage, 94.6% of children up to 19 years old have coverage, and 87.9% of those aged between 19 and 64 have coverage; 91.2% of the disabled aged 19 to 64 have coverage; 84.5% of full time employees have coverage at some point during the year, and 69% of part-time employees have coverage.

Over the past several years we have seen the number of insured increase: 271,606,000 in 2013 and 292,320,000 in 2016. The reasons for that increase has been: the ACA, Medicaid expansion, and social awareness of the importance of being insured. The Trump Administration has been very involved with healthcare, most notably by issuing an Executive Order in October directing the Department of Labor (DOL), Department of Health and Human Services (HHS) and Internal Revenue Service (IRS) to develop regulations related to association health plans (AHPs) and short term STLDs. Also, in December, the tax reform law set the individual mandate penalty to $0.

Ms. Dubauskas noted that the final rule on AHPs was issued on June 19 and it will greatly impact sole proprietors and small businesses. The anticipated impact of the rule is that 3,600,000 people insured under the ACA will leave the ACA and 400,000 uninsured will gain coverage. The STLD proposed rule was issued on February 20 and the final rule is expected to be issued very soon. The proposed rule seeks to return the time limit of STLDs back to 364 days from its current limit of 90 days. The time limit was changed during the Obama Administration because it was concerned that too many people were purchasing STLDs instead of ACA-compliant plans. IHC's experience prior to the time limit change was that the average duration of a STLD was 4.2 months which meant that most people purchasing STLDs were doing so to fill in the gap – most likely a gap in employment. Many employers have a 90-day waiting period for health insurance to kick-in for new employees, so those in-between jobs obviously need more than 90 days of coverage.

Ms. Dubauskas also stated that the proposed STLD regulations propose a question: should STLDs be available for more than 12 months? The product is priced and developed today through underwriting to be available for 12 months so if the plans are extended beyond that time, perhaps through a renewal process, that would change the pricing and make it a different product. Accordingly, Ms. Dubauskas stated that she does not believe STLDs as written today could stay the same to accommodate that change. They would have to undergo changes including going through state insurance departments.

The proposed STLD rules also suggest changing the disclaimer language to make sure that everyone understands what they are buying and ensure that there is language indicating whether there are limitations and exclusions in the product. Ms. Dubauskas stated that she is concerned with the fact that the disclaimer language in current STLDs is in capital letters and most people do not read language in capital letters. Also, despite the fact that agents are required to explain the product to consumers, some of the disclaimer language needs to be

changed from complex insurance terms to easier to understand terms. Ms. Dubauskas stated that the anticipated impact of the STLD regulations is that between 100,000 and 200,000 people will leave the ACA and purchase STLDs, but the hope is that a high number of uninsured will purchase STLDs.

Ms. Dubauskas stated that the Centers for Medicare and Medicaid Services (CMS) has also been active in relation to the ACA. On April 9, the hardship exemptions expanded; on July 7, the risk adjuster payments were put on hold; and on July 10, the navigator funding was reduced. Ms. Dubauskas stated that due to many of the actions she discussed today, ACA premiums are going to increase. As an example, the 2019 premiums on the Maryland Health Insurance Exchange are expected to increase as follows: lowest cost bronze - $443 (up 41%); 2nd lowest silver - $622 (up 36%); lowest cost gold - $606 (up 35%). The people impacted the most by those increases will be those not subject to any of the ACA's subsidies.

Ms. Dubauskas stated that she believes that with regard to the future of the ACA, the train has already left the station in that the ACA has already been irrevocably changed, and healthcare reform needs to be thoroughly discussed. Ms. Dubauskas stated that NCOIL can help by adopting a Model Law that mirrors the final STLD regulations so that there can be uniformity and efficiency for insurers and state departments of insurance.

Rep. Glen Mulready (OK) asked Ms. Dubauskas for some insight on STLDs and pre-existing conditions. If STLDs were available for those with and without pre-existing conditions, would IHC sell both? Ms. Dubauskas stated that IHC is the first company that has implemented a limited pre-existing coverage. The coverage is called Connect Plus and was released on April 19 in over 20 states. For up to $25,000 in coverage of pre-existing conditions there is a 12-point cost differential so a STLD plan would be raised from $100 to $112 per month. Ms. Dubauskas noted that you still must qualify through underwriting for Connect Plus. IHC did file for and obtained approval for unlimited pre-existing condition coverage which is now required in California. IHC will begin to offer that product in CA on September 1 and the price differential is 22 points. Ms. Dubauskas stated that IHC will see how the product does in CA before rolling it out in other states, and that IHC believes that it will be attractive to those in the 40-60 age group because they are making too much money to qualify for ACA subsidies but don't want to pay $600 per month for coverage with a large deductible.

CONTINUED DISCUSSION ON REPORTING AND NOTIFICATION REQUIREMENTS ON PRESCRIPTION DRUG MANUFACTURERS RELATED TO DRUG PRICING

Emily Donaldson of the Pharmaceutical Research and Manufactures of America (PhRMA) stated that spending for pharmaceuticals has recently slowed but patient costs have continued to rapidly increase. Policymakers are aiming to improve affordability and access and when they do that they often look to the list price of medicines for answers to the challenges that surround improving the goals of improved access and affordability. Oftentimes the legislation seen in these areas would require manufacturers to report a broad range of information in hopes that it benefits consumers. PhRMA understands why people want to see such information and that is why PhRMA has crafted a policy for consideration for NCOIL that PhRMA believes gets policymakers the information they need from pharmaceutical manufactures in a way that protects proprietary information as recommended by the Federal Trade Commission (FTC). PhRMA also wants to make sure that policymakers are getting the full picture because there several factors that affect prices for patients and payors and they are all connected. PhRMA believes that states should implement targeted policies that will yield meaningful cost and access related information. PhRMA is serious about working with NCOIL to get this right.

Ms. Donaldson then discussed PhRMA's proposed draft policies and began by noting what is currently reported under SEC filings which are publicly available (10k filings). Manufactures currently report aggregated financial figures including total sales, the cost of goods sold, research and development (R&D), SGA expenses (selling, general, and administrative), net income or loss information, and share information. R&D is usually reported in total and sometimes there is discussion in the filings about key pipeline products in a business overview section and companies also sometimes include additional items.

States typically don't have the time or bandwidth to look through 10k filings and PhRMA understands that. Accordingly, PhRMA proposes that each year, if a state wishes to, it should identify up to 10 prescription drugs on which the state spends significant healthcare dollars and said dollars should take into account the amount of rebates. Ms. Donaldson stated that the agency identifying the drugs should have knowledge and expertise in healthcare and the pharmaceutical market such as a state health agency or an existing state commission that examines healthcare costs. The drugs identified in the list should represent different drug classes and include generics.

Ms. Donaldson then recited some of the specifics of PhRMA's proposal. For each prescription drug identified on the list, the manufacturer could report a schedule of the drug's wholesale acquisition cost (WAC) increase over the previous 5 calendar years; the manufacturer's aggregate, company-level R&D and other relevant capital expenditures for the most recent year for which final audited data is available; a written description, suitable for public release, of factors that contributed to the reported increases in WAC during the prior 5 calendar years. That information should be generally consistent with the level and type of data made available in a manufacture's 10-k filing or to other publicly available data sources. It will benefit consumers to have the information published on the collecting agency's or commission's website, but PhRMA also wants to make sure certain information is confidential and looks forward to working with policymakers on such language.

Ms. Donaldson then stated that it is important to discuss access issues in addition to price issues. Pharmacy Benefit Managers (PBMs) affect health insurance benefits which are largely state regulated and NCOIL's PBM licensure proposal could enable states to obtain greater insight and transparency into a major stakeholder in the pharmaceutical supply chain with great impact on consumer costs. PhRMA proposes that PBMs file a report each year that contains the following information: the aggregate rebate amounts that the PBM receives from all pharmaceutical manufactures; the aggregate amount of rebates not passed to health plans or issuers; and the administrative fees that the PBM receives. PhRMA looks forward to working with NCOIL to ensure that definitions are tight so that there is no shifting of definitions that would result in shifting money from one bucket to another. PhRMA believes that the aforementioned information could be published on a website so as to be made available to consumers, but in a way that protects proprietary and confidential information for the PBMs and the people they contract with.

PhRMA also proposes that PBMs be prohibited from penalizing pharmacies or pharmacists from disclosing: cost-sharing amounts that an enrollee must pay for a particular prescription drug under or outside his/her health plan; and the existence and clinical efficacy of therapeutic equivalent drugs that would be less expensive to the enrollee both inside and outside his/her health plan.

With regard to insurers, Mr. Donaldson stated that states may also want to consider the elements of the NAIC's Model #22 – the Health Carrier Prescription Drug Benefit Management Model Act. Generally, PhRMA believes that insurers should provide electronic access to formularies and that changes to formularies should only be made after there is appropriate notice given to beneficiaries. Beneficiaries should also be able to easily access prior authorization and step therapy requirements for drugs they are prescribed and should be able to easily see the exceptions processes, along with their cost-sharing information. There should also be some form of reporting for the rates of denials and appeals for pharmaceuticals. Ms. Donaldson stated that PhRMA looks forward to working with NCOIL on drug transparency model legislation.

Caitlin Westerson of the Colorado Consumer Health Initiative (CCHI) stated that the costs of prescription drugs are going up at an unsustainable cost due to high base prices, lack of transparency in the supply chain, marketing and advertising tactics, and insurers pushing the cost on to consumers through high cost-sharing and adverse tiering which is done by putting the most expensive drugs for single disease groups on the highest tier all of the time. Ms. Westerson stated that it is important to note that such practices are a reflection of the high cost of medications, not the cause of them, but such practices do contribute to the lack of affordability of drugs that consumers are facing.

Ms. Westerson noted that the results of a March 2018 poll conducted during the last Colorado legislative session showed overwhelming support from consumers across party lines on the issue of drug pricing regulation. Connecticut and other states also conducted similar polls and the results were very similar. Some of the questions in the Colorado poll, which were similar to those asked in the others polls were: When it comes to regulating prescription drug prices to make them more affordable, do you think the government should be doing more, doing less, or about the same they are doing now? (76% said doing more); the CO Attorney General should have the power to investigate whether a pharmaceutical corporation is artificially inflating the cost of prescription drugs and medications, and taking advantage of patients who rely on their medications (agree or disagree – 89% agreed); Would you support or oppose a legislative proposal that would require prescription drug corporations to notify the public if they plan to increase the price of a drug by 10% or more? (85% supported); Would you support or oppose a ballot initiative that would require prescription drug corporations to disclose how they come up with the prices of their prescription drugs, including how much they spend on manufacturing, production, research and development, advertising, and what their profit margins are? (84% supported)

Ms. Westerson stated that the main takeaway from the polls is that consumers want action and they want the pharmaceutical and insurance industries, and the supply chain in between, to be held accountable. Ms. Westerson stated that in the Colorado 2018 legislative session there were several bills introduced to address the cost of prescription drugs, one of which is similar to the proposals outlined by Ms. Donaldson that did not pass. Other bills focused on creating a wholesale importation program around price gouging and on PBM gag clauses which did pass. Prior to the 2018 legislative session, Colorado has done work in the regulatory space to address tiering and non-discriminatory benefit design issues as well as permitting biosimilars to be substituted by biologic drugs which is not a huge part of the market right now but will be in the future.

Ms. Westerson stated that it is important to note that federal policymakers are in a better position to bring down the overall price of drugs given the existing patent laws and market-exclusivity protections, but, it is unclear at this time what federal efforts will look like and how

quickly they can be adopted so state action on these issues is imperative. Ms. Westerson stated that during the time since the NCOIL Health Committee last met in March and discussed the California and Vermont drug pricing transparency laws, Oregon has enacted a similar law.

Ms. Westerson then noted some things that state policymakers can do to combat rising drug prices and promote transparency. One policy is to prohibit price gouging for all drugs which requires drug companies to justify their price increases or face penalties – this approach has been adopted in Maryland. Another policy is to create a drug price review commission which essentially functions as "rate review" for prescription drugs and is similar to what health insurance carriers are required to do on an annual basis. Ms. Westerson noted that the drug pricing transparency laws in CA, OR and VT are similar in intent but slightly differ in substance and stated that a Model drug pricing transparency Model Law would help to standardize the process in states.

Ms. Westerson stated that another policy is to limit or ban drug manufactures from offering gifts to physicians which is a practice called "detailing" whereby drug representatives meet face to face with prescribers and the research shows that such meetings have an impact on what drugs are being prescribed and pushing consumers to higher cost drugs. Another policy option it to provide public funding for evidence based academic "detailing" programs where physicians would still get the same educational information but not in a manner that encourages them to change their prescribing practices in a negative way. Pennsylvania has enacted that policy in its Pharmaceutical Assistance Contract for the Elderly (PACE) program and it has yielded some savings on drug spending.

One policy option that is focused on the insurance industry is limiting or prohibiting coinsurance as coinsurance puts a big burden on consumers, especially those living with chronic disease, and drug prices can change from month to month and paying a percentage rather than a fixed fee makes it difficult for consumers to budget accordingly. Some states (DE/LA/MD) have eliminated coinsurance and capped co-pays at somewhere between $150 - $200. Another school of thought is to cap co-pays at 1/12 of the out-of-pocket maximum so that your health insurance carrier still gets the same amount of money but the cost to the consumer is spread through the 12 months of the plan year rather than front-loading it in January or February for people with high cost medications. Another policy option focused on the insurance industry is to prohibit discriminatory formulary designs which has been enacted in DE, CA and CO. Said policy prohibits insurers from placing all or most drugs that treat a specific condition on a single tier. Ms. Westerson stated that she believes many of the policy options can be used in developing an NCOIL drug pricing transparency model law.

Ms. Westerson stated that there are some policy proposals that are concerning to consumers such as those that would cut prescription drug benefits, increase copays, and restrict the use of new and expensive medications. Anything that limits access for consumers is ultimately going to result in higher healthcare costs down the road due to higher emergency room use and hospitalizations.

Ms. Westerson stated that there are some other important questions to consider when developing a drug pricing transparency model law. Do existing state agencies have the authority to request data and enforce non-compliance? In Colorado, there is no existing state agency that has the authority over pharmaceutical manufactures, PBMs, or other entities in the supply chain. Does the state have the infrastructure and funding to analyze the data collected? Do states have a single-subject rule? Colorado has a single subject rule so enacting reform around the entire supply chain is difficult. Do you need legislation? Some states have

regulatory structures that would better lend themselves to drug pricing transparency reform. Ms. Westerson closed by stating that it seems that it is the first time all of the "players" are sitting down at the same table offering ways to lower costs and that CCHI looks forward to working with NCOIL moving forward.

Rep. Steve Riggs (KY), NCOIL Immediate Past President, asked for examples of discriminatory formulary design. Ms. Westerson stated that it happens most frequently with HIV and AIDS medications when all of the drugs that are used to treat those diseases are put on the highest tier so there are no lower cost options for consumers.

Sen. Brian Feldman (MD) noted that Maryland's price gouging law was struck down by the 4th Circuit and litigation is pending, and asked Ms. Donaldson how a Model drug pricing transparency would function given that states such as CA, OR and VT have laws in place that call for more transparency that what Ms. Donaldson proposed in her earlier remarks. Ms. Donaldson stated that PhRMA has concerns with laws that require advance notification of certain drug price increases as such a policy gives distributors the opportunity to stockpile drugs at a lower price and then sell them at a higher price which can cause drug shortages. With regard to a Model Law, Ms. Donaldson stated that she does not believe every state is going to approach these issues how PhRMA would like them to. Sen. Feldman stated that his point is that if CA already has a law enacted that goes further than the Model's approach, he does not think CA would adopt the Model. Ms. Donaldson agreed that CA may not adopt such a Model but noted that the CA law is currently being litigated. Ms. Donaldson also noted that in Oregon, while they may not "go back" on the law they passed, the Oregon Governor has implemented a Task Force to look at other stakeholders in the drug supply chain and what additional steps need to be taken to receive transparency from those stakeholders.

Rep. Joe Schmick (WA) asked Ms. Westerson if the policy proposals she outlined have been enacted long enough to know whether or not they have been effective. Ms. Westerson stated that the policies discussed that focus on marketing practices and reducing cost-sharing have been in-place for two years, if not longer, while the policies discussed that focus on reducing power over drug pricing and increasing transparency in the supply chain have mostly been in-place for about two to three years. There has been a lot of academic writing on the "rate review" commission proposal, but no state has enacted it. Rep. Schmick asked if there have been positive results in the states that have enacted the abovementioned reforms. Ms. Westerson replied yes - the states that prohibit coinsurance or cap co-pays have seen a reduction in consumer out-of-pocket spending but that is really the relationship between consumers and health insurance carriers so there is not much relief in the overall system because the insurers are still paying the full price or their negotiated rates for the drugs. PA has also seen savings due to its funding for evidence based academic "detailing" programs but that is only implemented through its PACE program which focuses on low-income seniors.

Rep. Tom Oliverson, M.D. (TX), Vice Chair of the Committee, stated that the only "detailing" that is left exists in the pharmaceutical industry which relates to free samples of drugs in doctor's offices, and rebate booklets, which benefits patients. Rep. Oliverson asked Ms. Westerson if discussions surrounding aggregate rebate information, rebates not being passed to the consumer, and list prices, actually get the consumer off the bench and into the market to shop around, as he is not sure that such discussions do. Rep. Oliverson also asked what state lawmakers can do to encourage consumers to be more participatory in the process of shopping around as he does not see a concerted effort in the healthcare industry to provide information in a format that is understandable for the average consumer the way it is provided for consumers with auto insurance, life insurance, or 529 plans.

Ms. Westerson stated that passing rebates through to consumers would help in addition to things like a “plan cost-finder tool” which is currently on the Colorado health insurance exchange website. Using that tool, consumers find plans that cover specifically what they need in addition to getting estimates for out of pocket spending. The tool is not a direct-dollar amount, but it will give the consumer a low, middle, and high estimate of what they can expect to pay. Ms. Westerson stated that legislation is probably not needed to implement such a tool and it would facilitate the shopping experience.

Ms. Donaldson stressed the importance of cost-sharing fairness which entails the pass-through of rebates, and part of PhRMA’s policy proposal seeks to ensure that insurers or PBMs are in some way certifying that at least a majority of rebates are being passed through to consumers. PhRMA’s policy proposal also has several options for the issues depending on how far a state wants to go. Ms. Donaldson also reiterated that PhRMA believes that insurers should provide electronic access to formularies and that changes to formularies should only be made after there is appropriate notice given to beneficiaries. Beneficiaries should also be able to easily access prior authorization and step therapy requirements for drugs they are prescribed and should be able to easily see the exceptions processes, along with their cost-sharing information. There should also be some form of reporting for the rates of denials and appeals for pharmaceuticals. All of that information should also be available to those shopping for plans, not just current enrollees.

Rep. Jim Dunnigan (UT) stated that changing to a fixed dollar co-pay does not lower costs. It gives the consumer certainty but that may not be good. As an example, under one of the plans offered in Utah the employer can choose a plan that has a 25% co-pay or a $25 co-pay for preferred brand-name drugs. That means for anything less than $100, you are better off with a percentage co-pay. Rep. Dunnigan asked where the incentive is for consumers to shop to get the best pricing on drugs if they are going to pay $20 no matter where they obtain the drug. Ms. Westerson agreed that a fixed dollar co-pay does remove the incentive to shop around but what makes it difficult when shopping for health insurance and drug coverage is that the consumer is at the will of what the carrier covers so shopping around may not be as easy as it seems when factoring in physician’s networks. Colorado passed a regulation that requires plans to offer some plans that are co-pay only, in addition to plans with coinsurance. For those with chronic diseases that need to spread the cost throughout the year, they can choose the co-pay only plan, while those that may not prioritize drugs as high could choose the coinsurance plan. The regulation has seemingly worked fairly well, and notably, the co-pay was capped at 1/12 of the out-of-pocket maximum so the consumer is ultimately paying the same amount of money throughout the year and they are just able to spread it throughout the year rather than front-loading it.

Rep. Dunnigan stated that he is focused on the situation of once the consumer has the prescription, if there is a fixed dollar co-pay the consumer will go wherever and there is no incentive to shop. Ms. Westerson stated that she was speaking to the shopping experience before a consumer is enrolled in a plan. Once they are enrolled, Ms. Westeron agreed with Rep. Dunnigan that the fixed dollar co-pay eliminates incentive to shop. Ms. Westerson noted that she is not sure how much shopping around can be done in certain states. Colorado has a large rural/urban divide and in many rural communities there is only one pharmacy.

Rep. Dunnigan asked if passing rebates through to consumers lowers overall costs or only costs for that consumer. Ms. Westerson replied that it lowers costs for that consumer. Rep. Dunnigan stated that is a problem since overall costs are not lowered. If the rebates are

currently going to the employer and factored into their overall rate and renewal, then passing the rebates to the individual employee raises the renewal rate for everyone else, which is not necessarily wrong, but overall costs have not been lowered. Ms. Westerson agreed and stated that something needs to be done regarding listing prices which is hard to tackle at the state level and is more so linked to the federal regulatory structure.

Sen. Bob Hackett (OH) asked how to solve the problem of consumers making informed decisions only to then see the formulary changed. Ms. Donaldson clarified that manufactures would not be the ones changing formularies. Ms. Westerson stated that it would be great to see consumers purchasing plans knowing that their drug is covered and the formulary is not changed for the plan-year. There have been efforts in states to eliminate mid-year formulary switching but the concern is that if you have a certain group of drugs that are locked-in for a plan-year, what happens when the prices of those drugs are raised and insurers are stuck in a situation where they cannot change.

Before moving onto the next topic on the agenda, Rep. Mulready clarified a statement made yesterday regarding the opioid epidemic and the business practices of Walmart. It was presented that if someone wants to go to another pharmacy that information goes into the prescription drug monitoring system (PDMP) and it therefore shows them as pharmacy-shopping. Rep. Mulready stated that is not the way the system works. When someone shows up with a prescription, the information only goes into the PDMP when the prescription is filled.

DISCUSSION ON IDAHO'S HEALTHCARE MARKETPLACE REFORM PROPOSALS

Dean Cameron, Director of the Idaho Department of Insurance, stated that Idaho, like many other states, is struggling with the effects of the ACA. Prior to the ACA, Idaho had some of the lowest rates in the nation and had $150 million worth of claims and $175 worth of annual premium, but those numbers rose to $600 million worth of claims and $545 million worth of annual premium. The worst disparity resulted in carriers losing $130 million in one year. Idaho has had three consecutive years of increases greater than 24% in premiums and last year the increase was 28%. Consumers in Idaho are being forced out of coverage and Idaho is starting to lose carriers as well. Idaho has been fortunate to have had five carriers participating in its state-based exchange from its inception, but now the number is down to four and two of the four are considering reductions in their footprint.

Dir. Cameron stated that Idaho has a population of approximately 1.7 million and about 250,000 of them are without coverage, an increase of approximately 60,000. Idaho is losing the young and the healthy from its insured population because they can no longer afford coverage, and because of the unfair rules of the ACA, they do not qualify for any subsidies. Many of them are going without coverage and for many states, they end up on catastrophic health rolls, indigent care rolls, and end up increasing property taxes. Some are looking to STLDs like a couple in Twin Falls, Idaho, aged 62 and 63, who could no longer afford the $1,300 per month premium so they purchased a STLD for $700 per month, and they will hop from one STLD company to another until the reach the age of 65. The tough part is that they are not receiving any benefit for any pre-existing conditions because each STLD they get resets coverage. Some are also looking to faith-based programs, but the problem is that such programs are not regulated by the dep't of insurance and are not held out to be insurance. The Idaho Insurance Dep't is starting to see a higher number of complaints relating to faith-based programs as consumers struggle to see their claims paid.

One consumer in Idaho needed a liver transplant, but the faith-based program stated that it would not cover the procedure because she had drunk alcohol at some point in her life. Another consumer was told by a faith-based program that they were not sure that her faith matched the tenants of the program's faith and denied coverage. Idaho is also seeing consumers turn to direct primary care arrangements. Dir. Cameron stated that he has no problem with faith-based programs or direct primary care arrangements, but they are not comprehensive, long term health insurance. A fundamental tenant of all insurance is a reasonable mix of healthy individuals with those with less-healthy conditions. The ACA changed the rules and those with less-healthy conditions came in droves while forcing the healthy out.

Idaho decided that something needed to be done and the approach started with Governor Butch Otter issuing an Executive Order directing Dir. Cameron to look for less expensive non-ACA compliant plans. Idaho needed to find ways to attract the healthy back into the marketplace and in order for it to be effective, Idaho could not just offer a plan that would compete with the ACA to attract the healthy back into the same risk-pool. In January, the Idaho Dep't of Insurance issued Guidance on its proposals and had worked upfront with all carriers. The Guidance was designed to follow Idaho law, as well as some provisions of federal law. Interestingly, as soon as Gov. Otter's Executive Order was issued, the Idaho Insurance Dep't received lots of national criticism and attention which was somewhat surprising because those criticizing had not read the Dept's Guidance because it had not yet been issued. Once the Guidance was issued, some, but not all, of the criticism disappeared. The fundamental fear that persisted was a state not following the ACA.

Dir. Cameron the discussed some of the main provisions in the Guidance. First, it is important to understand that in Idaho, in order to market a state-based non-ACA compliant plan, you must also market an ACA-compliant plan in the same geographic area. It is also important to understand that state-based plans must be part of the same risk-pool as ACA-compliant plans; and because those plans are in the same risk-pool, the rates are tied together so as an ACA plan rises, so does the non-ACA plan. One area of ACA non-compliance stated under the Guidance was that plans were required to cover the majority of essential health benefits (EHBs), the only exclusions being maternity coverage (provided that the majority of the carrier's plans offered such coverage), and pediatric, dental, or vision coverage. A second area of ACA non-compliance stated under the Guidance was to go back to the 5:1 age slope. The ACA required a 3:1 slope which many believe was a protection for seniors, but it wasn't. Idaho can produce data showing that whether a 5:1 or 3:1 slope is used, the price for seniors is the same – it is young adults who get hit hardest. A 21-year-old on a 3:1 slope pays about $270 per month for coverage in Idaho and that same plan under a 5:1 slope would be $89 per month.

A third area of ACA non-compliance stated under the Guidance was that Idaho plans had a provision based on state law that required a 12-month pre-existing condition clause provided that the consumer came with no previous coverage. Most people did not understand that the ACA has a waiting period. If you go to enroll in an ACA-plan outside of open enrollment, you must wait until open-enrollment or figure out some special exclusion as to why you can avoid that. So most people, when going to buy coverage who had developed a condition and did not have prior coverage, already had a waiting period.

The Guidance also sought to allow plans to have an annual limit of $1 million, however, if the consumer hit that number, they would automatically be transferred to an ACA-plan so they would not see any change or reduction in benefits. The Guidance also sought to permit plans to have different out-of-pocket maximums because consumers were saying there was no magic in the number $7,350 and some preferred to have a $10,000 or $15,000 maximum, especially

when they are healthy and not in need of additional coverage. Lastly, the Guidance permitted plans to underwrite in order to determine the appropriating rating. Consumers could not be denied coverage and the rates were not higher than ACA-plans so said plans became the ceiling. Some concerns were raised that such a practice would raise rates for those with ACA-plans, but data was able to be produced that showed that was not the case.

Dir. Cameron stated that shortly after the Guidance was issued, one carrier stepped forward, wanted to follow the guidance, and provided the Dep't with five plans which actually covered maternity and had a 4:1 slope. Shortly after that carrier filed rates with the Dep't, the Dep't received a letter from CMS. Most of the media portrayed the letter as a cease and desist letter but it was not, although it was an unusual approach from CMS because the Dep't had been having conversations with CMS prior to the letter and had received positive feedback from them. Also, Dir. Cameron stated that he was not aware of CMS having ever taken action prior to plan approval, and CMS usually reviews a state's body of work, not individual plans.

Dir. Cameron stated that the ACA calls for states to substantially enforce the law and stated that words mean everything in legislation so why would Congress put the word "substantially" in the ACA statute unless Congress anticipated some states to deviate from the ACA in some way. In fact, typically, when Congress passes legislation it does not tell states that they must enforce it – enforcement is assumed. Dir. Cameron stated that the Dep't asked CMS what "substantially" means, and it is interesting to note that under the Obama Administration, in keeping with President Obama's promise that you would be able to "keep your plan," the Administration used the "substantially" enforce language in order to allow people to keep their transitional or grandfathered plans. The Administration also used the "substantially" enforce language to allow the labor unions to keep their plans. Dir. Cameron stated that Idaho is substantially enforcing the ACA. Dir. Cameron further stated that in the multiple conversations between the Dep't and CMS, the Dep't is acquiescing too much as the Dep't has agreed to do away with the provisions regarding annual limits, EHBs, pre-existing conditions, and underwriting. Dir. Cameron stated that the Dep't will continue to work with CMS.

Rep. Schmick (WA) asked what the permissible rating factors were for underwriting in the Guidance. Dir. Cameron stated that the factors were age, tobacco use, and geography, and noted that the ACA permits a health risk assessment for group plans. The Guidance proposed using the factors from the ACA group plan health risk assessment so that a carrier could provide for some sort of credit off of the insurance such as a credit for quitting smoking, joining a fitness club, or managing diabetes. Such practices get close to underwriting, but it is not underwriting as consumers cannot be denied coverage. Dir. Cameron stated that a consumer who is not healthy may be better off with an ACA plan, but a healthy consumer, in order to get them back into the Idaho marketplace, has to be offered products and discounts in order to do so.

Rep. Jim Gooch (KY) stated that it is important to understand that young people will not buy insurance and pay an inflated rate for it when they don't think they need it. The compression of rating bands is key, and some policies had a 7:1 ratio. Moving to a 3:1 ratio probably did help seniors slightly but there is no question that when you compress from 7:1 to 3:1 you are more than doubling the price for young people and then when you also include coverage that they don't need you are forcing them out of the market. Rep. Gooch further stated that unlimited lifetime maximums are better than a plan with a $2 million or $3 million maximum, but a young person may not need that unlimited lifetime maximum because they are going to a different job or some other reason. Rep. Gooch applauded Dir. Cameron's efforts in Idaho.

CONTINUED DISCUSSION ON DRAFT NCOIL PBM LICENSURE AND REGULATION MODEL ACT

Sen. Jason Rapert (AR), NCOIL President, stated that the Committee members may be overwhelmed with comments and suggestions on the draft NCOIL PBM Licensure and Regulation Model Act (draft Model) but that is not a bad thing because the goal is to produce a Model that addresses one of the most significant issues affecting costs in the healthcare market arena that we face in our nation and it is wrapped up in many different issues. Sen. Rapert stated that 13 organizations have voiced support for the draft Model, including the American Medical Association (AMA). Sen. Rapert stated that after this meeting, he hopes the Committee members can review all of the material submitted in order to judiciously consider all suggestions and comments to produce the best possible Model.

Sen. Rapert stated that he is not trying to put forth the recently enacted Arkansas PBM law as a national Model law, rather, his goal is to produce a Model that can be a chassis for states to use in developing their own PBM laws. That means one state may want a different set of tires or a different CD player in their chassis, but Sen. Rapert stated that the one thing that he does want in the Model that many seem to agree on is licensure of PBMs, regulation of PBMs, and enforcement through a common regulator in the states that would provide a stabilizing factor to address these contentious issues. Sen. Rapert then mentioned the recent news regarding the Kentucky Department of Insurance issuing an Order of Civil Penalty and Probation against PBM CaremarkPCS Health, LLC for multiple violations of the Kentucky Insurance Code, and the recent news regarding Ohio Governor John Kasich and Ohio Attorney General Mike DeWine announcing that a consultant hired by the Ohio Department of Medicaid discovered that the PBMs are getting three to six times the usual market rate. CVS Caremark and OptumRX are the two PBMs in the Ohio Medicaid program.

Sen. Rapert stressed that PBMs play a significant and important role in the drug supply chain, but when there are bad actors involved and there are a small number of actors that control over 78% of the market, and you see some of the revelations in the news, it is clear that there are issues that need to be addressed. Sen. Rapert stated that the current draft of the Model is essentially the Arkansas PBM law but there are provisions of the Model that he is willing to amend. The Arkansas PBM law is being used as the starting point for drafting an NCOIL Model because the Arkansas PBM law is the most expansive PBM law in the nation. Sen. Rapert also noted the recent ruling from the 8th Circuit (*PCMA v. Rutledge)* that struck down the Arkansas Maximum Allowable Cost (MAC) statute as being preempted by ERISA, which is included in the draft NCOIL Model, and stated that he is open to adjusting that section of the Model to ensure that the Model is not constitutionally problematic for states.

Joshua Keepes of America's Health Insurance Plans (AHIP) stated that AHIP's primary interest in the draft Model is that AHIP's member's contract with PBMs on a regular basis because they bring tremendous value to not only health plans but to Medicaid agencies, employers, unions, and state employee programs by keeping costs down, using evidence-based care, and improving medication adherence. Mr. Keepes stated that AHIP's proposed amendments to the Model serve to build upon Sen. Rapert's main goal of having a referee in place, but AHIP believes that some provisions in the Model should be removed as the cost of them does not equate to the value they would provide. AHIP's proposed amendments rely mainly on consensus-based approaches from different states, and provisions that have already been enacted and discussed by stakeholder groups. AHIP's proposed amendments also seek to simplify and streamline some of the Model's regulatory provisions.

Mr. Keepes stated that AHIP believes its proposed amendments help protect and enhance collaboration between health plans, PBMs and pharmacists. Such collaboration provides value not only to health plans but to consumers at the pharmacy counter by keeping pharmacy costs low, and in a broader systemic point of view, keeping health insurance premiums low. AHIP hopes that their amendments have removed some duplicative requirements in the draft Model. AHIP believes that many state protections already exist in certain areas that the draft Model addresses such as network adequacy. Mr. Keepes stated that AHIP also wants to protect the experience and expertise that PBMs bring to the table for health plans.

Mr. Keepes further stated that AHIP's proposed amendments also seek to address the issue of drug pricing transparency, and the proposed language is based on the recent law passed in Oregon. AHIP understands that NCOIL is considering that issue in a separate Model but AHIP believes that the issue goes hand in hand with discussions regarding PBMs, and AHIP thinks that rising prescription drug costs, which now account for 23 cents of every health insurance premium dollar, is something that must be addressed. The equation of prescription drug benefits and prescription drug costs is incomplete without that analysis. AHIP looks forward to discussing drug pricing transparency requirements moving forward.

Mr. Keepes stated that AHIP's proposed amendments also seek to create a more level playing field by ensuring that in the contracting and regulatory processes, all parties come to the table without any thumbs on the scale. The proposed amendments focus on the role of private contractual arrangements and AHIP believes that the best way to address many of the issues that the Model seeks to resolve is to do so through the contracting process and without state intervention. Mr. Keepes noted that AHIP's proposed amendments regarding licensure and regulatory requirements are based on an enacted Tennessee law and were discussed by a large set of stakeholder groups. Similarly, AHIP has proposed changes to the MAC section of the draft Model which have been discussed and agreed upon by a large set of stakeholder groups. By using such consensus language, AHIP hopes to avoid any discrepancies or disagreements as the draft Model is discussed by the Committee and in states. Mr. Keepes stated that AHIP looks forward to continuing the discussions surrounding the Model and it is important to find a balance between consumer protection and keeping costs low.

Melodie Shrader of the Pharmaceutical Care Management Association (PCMA) stated that PBMs exist to work as a vendor for health plans. Health plans put together the benefit and PBMs administer that benefit. PBMs negotiate rebates, provide clinical tools to ensure adherence, and build networks with pharmacies. Ms. Shrader stated that referees enforce rules, but they are not the rule makers, and that is PCMA's major concern with the draft Model – it is taking legislator's responsibility to develop rules and abdicating it to the regulators. PCMA looks forward to working with NCOIL to ensure that the Model sets forth the appropriate rulemaking authority to the legislators who have been elected by the citizens of their states.

Ms. Shrader stated that PCMA is very concerned the MAC section of the draft Model as it mirrors the Arkansas MAC statute which was recently ruled by the 8th Circuit as preempted by ERISA. Ms. Shrader also noted that between now and the NCOIL Annual Meeting in December, PCMA will welcome NCOIL to participate in a webinar that will discuss the 8th Circuit's ruling, and ERISA in general. Ms. Shrader acknowledged Kentucky's PBM licensure and regulation law, as well as the recent news regarding the Kentucky Insurance Dep't issuing an Order of Civil Penalty and Probation against PBM CaremarkPCS Health, LLC. Ms. Schrader stated that it appears that the Kentucky law is working which is a good thing and that CaremarkPCS Health will have an opportunity to appeal.

Ms. Shrader stated that the situation in Arkansas was unique and the conversation was initially dominated due to changes in its Medicaid program. Arkansas' Medicaid program is a product on the Arkansas exchange and last year many of the exchange products had rate increases. In healthcare, when you push one way, something comes out the other end and that is what happened in Arkansas since there was a structured benefit and a structured number of dollars which resulted in rate cuts. Ms. Shrader noted that doctors are used to losing money in Medicaid, so their voice was not heard a lot in Arkansas, but the pharmacists certainly raised their voice.

Ms. Shrader stated that PCMA is not here to just say "no" and PCMA looks forward to looking at provisions in several state PBM laws to include in the Model so that the Model can in fact be a chassis for states to use when they encounter unique situations relating to PBMs. Ms. Shrader noted that Florida recently passed a PBM licensure law that, among other things, sets forth a referee and prohibits gag clauses which is something that PCMA supports as customers should always pay the lowest price at the point of sale. The FL law also has a MAC section that PCMA believes would not be challenged. PCMA looks forward to continuing the dialogue on the Model between now and December.

Ronna Hauser of the National Community Pharmacists Association (NCPA) stated that it is important to note that the number of independently owned rural pharmacies declined by 12.1% between 2003 and 2013. The number of retail pharmacies that were the only pharmacy in their community declined steadily between 2003 and 2009. There are currently only approximately 1,800 pharmacies serving as the sole provider in their community. Those statistics are from the Rural Policy Research Institute. Ms. Hauser stated that based on those statistics, it is vital that those healthcare providers remain in business and provide care to their patients at a local level. Unfortunately, their existence is threatened by certain PBM tactics and regulation of PBMs is sorely lacking. As the sole entity in the entire drug supply chain responsible for deciding which drugs your doctor can prescribe, which drugs you can take, which pharmacy you can go to, how much the drugs cost, and how much providers get paid, common sense regulation such as licensure, enforcement and audit authority is desperately warranted.

Ms. Hauser stated that today, PBMs control the pharmacy benefits of more than 253,000,000 Americans. After numerous acquisitions and consolidations, just 3 PBMs control 78% of prescription drug benefit transactions in the U.S. Since the advent of PBMs, there has been a 169% increase in consumer out-of-pocket drug costs. During that same time, PBM profits have soared, begging the questions that both federal and state elected officials are asking: what is the true role of PBMs related to soaring drug costs? How do we best regulate them? Where are the savings they tout going? NCPA believes that the draft Model is a very positive step in the right direction to address those unanswered questions.

Ms. Hauser stated that PBM licensure and regulation is not duplicative or unnecessary. PBMs have argued, and courts have ruled, that health insurer regulations do not apply to PBMs. The public must be protected from PBM misconduct. In states where PBM regulations have been implemented, there have been issues with enforcement, in part because pharmacies feel contractually prohibited from contacting the Insurance Cmsr. or other oversight entities to report issues. Ms. Hauser noted that AHIP's comments on the Model request that such pharmacist protections be removed from the Model. Ms. Hauser closed by stating that NCPA strongly supports the Model and that NCPA's suggested amendments will put the Insurance Cmsr. in a better position to regulate PBMs. NCPA looks forward to continuing the discussions surrounding the Model between now and December.

Rep. Dunnigan stated that the section in the Model that allows the pharmacist to decline providing pharmacist services to a patient if the pharmacist is not getting reimbursed enough to cover the drug concerns him. Rep. Dunnigan stated that if he goes to a pharmacist with 3 prescriptions and the pharmacist only fills two of them because only two are profitable, that does not seem to benefit the consumer, particularly when consumers are often anxious to get the prescription to start using it. Ms. Hauser stated that she shares Rep. Dunnigan's concerns and it is unfortunate that in the current environment in which pharmacists practice in, that they are filling many prescriptions under-water. However, by their nature, pharmacists are going to provide care to their patients. Ms. Hauser stated that NCPA is open to discussing and compromising on the section Rep. Dunnigan references.

Rep. Joseph Fischer (KY) stated that he has not read the aforementioned 8th Circuit opinion yet but asked that since most of the work of PBMs is related to group health plans, what is the limit of state's authority to license and regulate PBMs. Ms. Shrader stated that the 8th Circuit opinion said that the business of insurance is regulated by states, so states can put certain requirements on health plans regarding their risk pooling activity. Ms. Shrader stated that if an employer is based in Texas and has employees in both Texas and Arkansas, ERISA wants to make sure that the administration of that health plan is seamless. The 8th Circuit opinion supported that notion and stated that the PBM's contract needed to be consistent with that approach. Ms. Shrader noted that ERISA has a number of limitations regarding state authority and PCMA typically only challenges state laws that are egregiously preempted by ERISA. PCMA has not challenged the Florida law. Ms. Hauser stated that it is important to note that the 8th Circuit's opinion only applies to the 8th Circuit and that case dealt with several provisions of the Arkansas MAC statute being preempted by ERISA and Medicare Part D. However, the provisions of that MAC statute still apply to non-ERISA and non-Medicare part D plans. Ms. Shrader agreed but stated that it is important to note that the only plans the MAC statute will apply to now are those in the individual market and in Arkansas they would be sold on the exchange.

Sen. Rapert stated that the Arkansas PBM law was drafted to consolidate disparate things that have been done to try and address the many issues Arkansas was experiencing with PBMs. The 8th Circuit opinion only dealt with Arkansas' MAC statute which is overseen by the Arkansas Attorney General's Office. The only reason the MAC statute was included in the Arkansas PBM law was because of an effort to bring together all of Arkansas' approaches in dealing with PBMs into one law. Sen. Rapert noted that all of the other sections of the Arkansas PBM law remain intact despite the MAC statute being ruled as being preempted. Sen. Rapert also noted that dealing with ERISA in state legislation is very tricky and even mentioning ERISA in certain legislation can be problematic and grounds for being preempted. Sen. Rapert further stated that NCOIL may be the proper forum to have discussions about ERISA impeding upon the ability of state regulation. Sen. Rapert closed by reiterating his earlier comment that he is open to amending the Model with regard to the MAC section because it does no good to offer a Model to states that will be constitutionally problematic. Rep. Fischer asked if the 8th Circuit opinion only struck down the Arkansas MAC statute. Sen. Rapert replied, yes, and stated that there was not a lawsuit on the Arkansas PBM law, rather, the lawsuit was only focused on the Arkansas MAC statute.

Rep. George Keiser (ND) stated that PBM contracts with pharmacists are binding and confidential and asked Ms. Shrader if PCMA would support opening up the definitions section of contracts for legislators and the public. Ms. Shrader stated that she believes that would be an individual company issue and could not answer that question without conferring with PCMA's members. Rep. Keiser stated that North Dakota is somewhat ahead with a lot of the issues the

Model seeks to address and noted that one contract in North Dakota with a PBM defines "specialty drugs" arbitrarily as the 10 most prescribed drugs in the state and that specialty drugs could only be filled by mail-order which obviously has serious implications for local pharmacies. Rep. Keiser stated that definitions should not be proprietary and if you cannot see the definitions you cannot understand what is happening in the contracts. Sen. Rapert clarified that Rep. Keiser's statements did not address any provisions in the Model but rather focused on whether PCMA was willing to consider some North Dakota approaches relating to PBM contracts.

Asm. Ken Cooley (CA), NCOIL Secretary, stated that ERISA was signed into law by President Gerald Ford in the 1970s and the nature of health plans as understood back then is not how health plans function today. Asm. Cooley stated that state legislators hold the power of their citizenry to think about the future and to enact laws to impact the future. Asm. Cooley stated that he is concerned that artful lawyering has caused ERISA to evolve into something that was not in President Ford's contemplation when he signed it into law. Asm. Cooley agreed with Sen. Rapert's earlier statement that it may be time for NCOIL to discuss ERISA as a whole so that everyone can understand how it has evolved into what it is today, and an opportunity can be provided for state legislators and interested parties to ask questions about the proper role of ERISA in relation to the system of federalism. Rep. Oliverson agreed with Asm. Cooley. Rep. Deborah Ferguson (AR) stated that ERISA should not stand in the way of state legislators tackling the issues states are experiencing with PBMs, and echoed Asm. Cooley's, Sen. Rapert's, and Rep. Oliverson's statements regarding further discussing ERISA.

Sen. Hackett stated that there has been a large movement recently towards self-funded plans which ERISA regulates. Sen. Hackett stated that rebates are a contractual arrangement, but no one knows the amount of the rebates and that causes many to speak out against them. Sen. Hackett asked how to increase transparency while maintaining that contractual relationship. Mr. Keepes stated that from a health plan perspective, they are faced with the decision of whether the rebates should be distributed at the point of sale at the pharmacy counter or put back into the health insurance premium to lower the premiums for an entire plan. Ms. Shrader agreed with Mr. Keepes and stated that 90% of all rebates go back to the client and it is up to the client to decide where to distribute them. The role of the PBM is to negotiate the very lowest price on drugs available, whether through rebates or through simply PhRMA lowering prices. Sen. Hackett asked if Ms. Shrader could state that no rebates are kept by the PBMs. Ms. Shrader repeated that 90% of all rebates go back to the client, but that does not mean that the PBMs keep 10% on every contract as it is a negotiated item in every contract.

Sen. Feldman asked Sen. Rapert if Arkansas has considered asking for an *en banc* re-hearing of the 8th Circuit case *PCMA v. Rutledge*. Sen. Feldman encouraged Arkansas to do so since the issues involved in the case are very important to many other states. Sen. Rapert stated that a decision has not been made yet. Ms. Shrader stated that *PCMA v. Rutledge* was a unanimous 3-0 decision and it was based on a prior 8th Circuit decision, *PCMA v. Gerhart*, which was also a unanimous 3-0 decision.

Rep. Matt Lehman (IN), NCOIL Treasurer, applauded Sen. Rapert for getting involved in the issues surrounding PBMs but stated that the real issue is the price of pharmaceutical drugs. Rep. Lehman stated that too many times states look to the federal government to solve problems but that is not the solution and the problems with the ACA is an example of that. Rep. Lehman stated that he looks forward to further discussing the Model but noted that pharmaceutical manufacturers and companies need to be part of all discussions going forward in order to hear from all sides to properly address all the issues

Sen. Rapert stated that he appreciated the discussions held today but clarified that, despite noting the issues with the Arkansas MAC statute, he has not agreed to any specific amendments to the Model yet. Sen. Rapert then referenced an op-ed written by Garth Reynold, Executive Director of the Illinois Pharmacists' Association, that notes how PBMs provide valuable services but that more than a third of the list price of brand medicines ends up going back to PBMs and other supply chain members, according to a recent study by the Berkeley Research Group.

The op-ed states that those savings rarely reach patients. Many insurance plans require patients to pay coinsurance on drugs, or a pre-determined percentage of the drug's cost. The problem, though, is that many beneficiaries' out-of-pocket spending is based on the drug's full list price, not the negotiated price secured by PBMs. As an example, a patient's heart disease medicine has a list price of $100. Her insurance requires her to pay 40 percent of that price, or $40. But the PBM negotiated a rebate of 30 percent on the list price, making the actual price of the medicine $70. The patient still pays $40, which means that she's paying 57 percent of the medicine's real price — not the 40 percent to which she agreed. Or consider a patient whose insurance plan requires him to pay $20 copays on all of his prescription pills, regardless of the pills' price. If the PBM negotiated a price that's less than $20, the patient still pays $20. The PBM simply keeps the savings for itself. With pricing strategies like this, it's no wonder why PBMs are joining forces with giant pharmacy chains; there's a lot to be said for the efficiency offered by an existing, giant customer base. Already, CVSHealth and Rite Aid act as their own PBMs.

Sen. Rapert stated that those examples are an echo of what is heard across the country. Sen. Rapert compared the issues before the Committee to asking owners of local hardware stores to sell a shovel for less than the cost of the shovel and then castigating the owner for not selling the shovel at that cost. Sen. Rapert stated that is simply not good policy. Sen. Rapert noted that many business and industries don't want the curtain to be lifted on certain business practices because such practices have made those businesses and industries into the powerhouses that they are today. Sen. Rapert then disagreed with some of PCMA's statements made in its comment letter such as: NCOIL propose model act puts safety & access to needed medications at risk; NCOIL proposed model act puts patient safety at risk; NCOIL model act ignores existing regulations; NCOIL proposed model act grants excessive rulemaking authority; and NCOIL proposed model act removes free market incentives.

Sen. Rapert stated that he supports free markets but does not support licenses to steal, and that he wants to see transparency, whether in this Model or a sperate drug pricing transparency model. When prescription drug costs account for 23 cents of every health insurance premium dollar, there is clearly a problem. Sen. Rapert stressed again that not all PBMs are bad actors. Sen. Rapert stated that he is starting to feel some consensus around certain issues and that one or two interim committee conference calls may be needed to further discusses some issues, but that NCOIL is perfectly positioned to provide a chassis to deliver to states for them to use to calm the waters in this arena.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:00 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES COMMITTEE
NCOIL SUMMER MEETING - SALT LAKE CITY, UTAH
JULY 13, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services Committee met at the Little America Hotel in Salt Lake City, Utah on Friday, July 13, 2018 at 9:00 a.m.

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

Other members of the Committee present were:

Rep. Sam Kito (AK)
Sen. Jason Rapert (AR)
Rep. David Livingston (AZ)
Sen. Travis Holdman (IN)
Rep. Matt Lehman (IN)
Rep. Joseph Fischer (KY)
Rep. Jim Gooch (KY)
Rep. Bart Rowland (KY)
Rep. Edmond Jordan (LA)
Rep. Joe Hoppe (MN)
Rep. Lois Delmore (ND)
Rep. George Keiser (ND)
Asw. Pamela Hunter (NY)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Deborah Ferguson (AR)
Rep. Paul Mosley (AZ)
Rep. Bryon Short (DE)
Rep. Richard Smith (GA)
Rep. Steve Riggs (KY)
Sen. Paul Utke (MN)
Asw. Maggie Carlton (NV)
Asw. Ellen Spiegel (NV)
Sen. Neil Breslin (NY)
Rep. Rodney Anderson (TX)
Rep. Joe Schmick (TX)

Also in attendance were:

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

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its March 3, 2018 meeting in Atlanta, GA.

CONTINUED DISCUSSION ON THE PRODUCER APPOINTMENT PROCESS

Chlora Lindley-Myers, Director of the Missouri Department of Insurance, stated that in Missouri, the producer appointment process was amended with the enactment of SB 193, which became effective in January 2003. Prior to that date, companies were required to notify the Director of any appointments or terminations and pay a $10 fee for each notification. As a result of SB 193, several changes were made to the producer law in an effort to reach uniformity, including the change from combined agent-broker, to a producer license.

In 2011, and again in 2015, there were legislative proposals that were submitted to reinstate the appointment process, but neither moved beyond internal review. The most recent 2015 proposal would have been revenue-neutral for the Department with no fees collected by the Department itself. SB 193, while removing the appointment termination fees in one part of the statute, raised the producer license fee to $100. The increased producer license fee did not make up for the financial losses as a result of the removal of the appointment and termination requirements and fees. With regard to whether Missouri is still able to protect consumers and track those who are fraudulent or abuse their privileges, there is room for improvement.

In the 2015 legislative proposal, the Department's Consumer Affairs and Market Regulation divisions jointly requested the reinstatement of the appointment laws to improve monitoring of the underwriting and sales activities at the agency level. It is more common for agents to represent multiple companies which makes ascertaining the extent of their illegal or possible fraudulent activities difficult if not impossible. Dir. Lindley-Myers stated that the Department has identified producers who have engaged in illegal activity, but the Department lacks the ability to fully identify other insurance companies or policyholders that might be affected.

Dir. Lindley-Myers stated that if the Department was able to reach out to other affected insurance companies, the Department would have the ability to work with those companies prior to an enforcement action to both determine the scope of the activity and to coordinate actions to lessen the impact on consumers in Missouri. Being able to take the agent's complaints and track patterns among specific producers to the company at the underwriter level would increase the Department's ability to identify companies with less stringent controls, poor training, and any other issues that might be there for a particular company.

That information would be invaluable to the market analysis process in determining which companies have indications of greater systemic problems that warrant an examination. This additional protection would keep the market more stabilized and provide greater protections for insurance consumers throughout Missouri. Dir. Lindley-Myers stated that the Department lost $2,750,000 by eliminating the appointment process, but by raising the license fee, the Department gained $2,860,000 due to more producers and that increased fee.

Ron Jackson of the American Insurance Association (AIA) stated that the producer appointment process is an issue of great importance to AIA's members and that said members are continuing to discuss the corresponding issue of revenue-neutrality. One possibility being discussed among AIA and its members is an assessment based upon the number of agents licensed in the state and producing for the companies licensed in the state. By way of example, if the 2018 revenue for the Missouri Department was $16.4 million and there were 100,000 agents in the state, then the agent fee would be $164, and that assessment could be assessed on the insurers by their premium volume in the state and that revenue would increase and decrease based upon the number of agents licensed in the state each year.

Mr. Jackson stated that with that type of assessment, there is an issue of retaliatory charges. To address that issue, one proposal might be to impose the assessment on domestic companies only. Mr. Jackson stated that AIA appreciates the opportunity to continue to discuss the issue of producer appointment process reform, including the accompanying issues of revenue-neutrality and Department enforcement.

John Fielding of the Council of Independent Agents and Brokers (CIAB) stated that CIAB does not believe the appointment process is necessary and urged the Committee to continue examining the issue. Mr. Fielding stated: a.) CIAB believes producer appointments are not

needed for consumer protection. The process may be a convenient way for regulators to get information but its anachronistic, unnecessary and costly. There are other ways to get that information that is cheaper and more efficient. Nine (9) states currently do not have the producer appointment process and the CIAB believes the consumers in those states are well-protected; b.) CIAB believes the appointment process imposes costly and timely regulatory burdens as the process differs from state to state; and c.) CIAB knows that states raise important revenue through producer appointments and terminations, but CIAB believes there are ways to make sure that any changes to the process are revenue-neutral. Mr. Fielding welcomed the Committee to use CIAB as a resource on this issue going forward.

Sen. Bob Hackett (OH), Chair of the Committee, asked Dir. Lindley-Myers to confirm that the Missouri reformed the producer appointment process in a revenue-neutral fashion. Dir. Lindley-Myers replied, yes, and noted that while the Department currently protects consumers very well, it could do so even better. Sen. Hackett stated that he believes this is issue is a perfect example of how a solution can be reached by collaboration among all interested parties.

UPDATE ON HEALTH SAVINGS ACCOUNTS DEVELOPMENTS

Dr. Bill West began by providing some brief background information. Dr. West is a board-certified OB/GYN and graduate of Jefferson Medical College. He founded First MSA (later First HSA) in 1999 as one of the first companies of its kind. First HSA was acquired by HealthEquity in 2011. Dr. West is Senior Vice President of Business Development for HealthEquity. Dr. West has been actively involved in the Consumer Directed Healthcare (CDH) industry. He is a member of the HSA Coalition, the AHIP HSA Council, the American Bankers Association (ABA) HSA Council and many other committees and councils. Dr. West noted that when he says “we” – he is referring to the ABA HSA Council, not Health Equity.

Dr. West stated that there are several public sector entities such as school systems, municipalities, counties, and states, that are looking to HSA’s as a solution to their problems. The question is – do HSA’s work? The ABA HSA Council is in the second year of a four-year study in which two school districts in Southcentral Pennsylvania went from a traditional co-pay plan to an HSA-only plan. The districts experienced a significant reduction in medical costs – an average of 25.7% reduction. After HSA contributions, the savings were 17.6% compared to prior utilization. Together, both districts saved over $3.8 million in the first two years (a total of 500 employees). Additionally, not only have the school districts done well, the employees have done well. The year-end average account balances have been: $1,406.70 (2015); $2,425.17 (2016); $3,422.88 (2017 – study not yet published). Dr. West stated that one of the districts just went back to their collective bargaining agreement early and resolved their healthcare issues very quickly – the district and unions agreed on keeping the HSA funding the same.

Dr. West stated that the ABA HSA Council has several legislative priorities, one being addressing chronic disease and HSA’s. People with chronic diseases are blowing through their deductible just on prescriptions alone and are unable to save for future healthcare expenses. Another legislative priority relates to working seniors. There are a lot of people who are 65 and older who continue to work and if they are in a co-pay or PPO plan and they enroll in Medicare, it is not a problem since there is coordination of benefits. However, if they are in an HSA-qualified plan and they enroll in Medicare, they are precluded from making any further contributions to their HSA account and from getting employer contributions in the HSA account.

The ABA HSA Council (Council) would also like to see increases to contributions to the OOP maximums to allow people to pay their entire OOP healthcare expenses with pre-tax dollars vs. post-tax dollars, not just an arbitrary number that was arrived at initially. Also, to provide some perspective, Dr. West stated that HSA's were enacted at the end of 2003 and the iPhone debuted in 2007. There have been 15 new models of the iPhone but no changes to HSA's. The initial HSA legislation was not prepared for the new developments we have seen in the healthcare system.

The Council would also like to see HSA's expanded into Medicaid, similar to what was done in Indiana with Healthy Indiana. Also, HSA's need to be protected from mandates or other issues that potentially could disallow or preclude HSA's from operating. For example, in Maryland, they provided coverage for male sterilization and because that was deemed to be non-preventive, it was deemed that there were no HSA-qualified plans in Maryland. That was subsequently correct via legislation in Maryland, but issues like that need to be monitored.

Dr. West stated that there have been over 30 bills introduced in Congress this session, and there was no action on any of them until the past two days. During the past two days, the House Ways and Means Committee marked-up and voted through 11 bills that work to improve HSA's. The aforementioned Council priorities were included in those bills, in addition to others. Dr. West closed by stating that there was bi-partisan support for those bills and that hopefully, they will be merged into one bill, passed through the House before the August recess, and presented to the Senate.

Rep. Steve Riggs (KY), NCOIL Immediate Past President, urged Dr. West to discuss with NCOIL CEO, Cmsr. Tom Considine, and representatives from the NAIC, about including HSA's as a topic of discussion during each organization's next trip to D.C.

Rep. Joe Schmick (WA) asked if there has been client satisfaction in the Council's four-year study. Dr. West stated that client satisfaction has been reported at over 95%. In the first three months when it was introduced, client satisfaction was below 5%, but as they utilized their HSA's, satisfaction grew. Rep. Schmick asked if he could be provided that information. Dr. West noted that the survey was conducted by the districts themselves and he will try and get that information to Rep. Schmick.

Sen. Hackett asked if flexible spending account reform was included in the bills that the House Ways and Means Committee voted on. Dr. West replied yes but stated that there is a caveat in a provision that says any amount over $500 that is rolled over into the next year will decrease the subsequent amount in the following year that you could deduct from your paycheck - so if the amount is $2,500 and you rolled over $700 you could only roll over $2,300 the next year.

Sen. Hackett asked if there have been any discussions about improving the ability to "dump" HSA's into IRA's and vice versa. Dr. West stated that, currently, you have a once-in-a-lifetime contribution out of your IRA into your HSA. Sen. Hackett asked if there have been any discussions about someone getting to retirement with a huge HSA and having the ability to roll it into their IRA. Dr. West stated that an HSA is actually better than an IRA because the HSA works exactly like the IRA in that if you take it out at age 65 or beyond as income, it's just taxable and there is no penalty, which is exactly what happens with an IRA; but if you use your HSA for qualified healthcare expenses, it's tax-free. Dr. West stated that the Federal government is reporting that the average couple retiring this year will have $260,000 in uncovered medical expenses during retirement. Accordingly, Dr. West stated that such couples

should use an HSA to pay for those healthcare expenses and other retirement accounts to pay for other expenses.

Asw. Maggie Carlton (NV) stated that in Nevada, they use HSA's and HRA's, and the problem with the reimbursement account is the "doughnut hole." Asw. Carlton asked what the utilization rates are and what are some of the outcomes in the Council's four-year study. In Nevada, they found that some folks were putting off doctor visits because they could not pay for them and ended up with more serious conditions. Dr. West stated that there is a decrease in utilization, but those changes in utilization are oftentimes at the prescription level. The Council looked for the scenario Asw. Carlton described and found that in year two, there was an increase in specialty drug usage. Dr. West also noted that there are several studies that offer conflicting conclusions about whether lower utilization is good or bad.

DISCUSSION ON RESOLUTION IN SUPPORT OF THE SMALL BUSINESS AUDIT CORRECTION ACT OF 2018

Sen. Jason Rapert (AR), NCOIL President, and sponsor of the Resolution in Support of the Small Business Audit Correction Act of 2018, began by stating that at last year's NCOIL Summer Meeting in Chicago, this Committee adopted without objection a Resolution in Support of an Exemption for Community Banks from Onerous and Unnecessary Regulations – sponsored by Sen. Travis Holdman (IN) – NCOIL Immediate Past President.

The reasoning behind that Resolution was that, despite their major role in the U.S. economy and their minimal role in the 2008 financial crisis, one of the most significant problems community banks faced was the sheer volume of banking regulations resulting from the enactment of Dodd-Frank. Many of those regulations were intended to stop activities that larger institutions conducted in the run-up to the financial crises – a fact that was reiterated yesterday by the President of the Utah Bankers Association during his remarks to the NCOIL Joint State-Federal Relations and International Insurance Issues Committee.

Such regulations require a degree of categorization, recordkeeping, and reporting that can be particularly onerous for smaller institutions such as community banks which do not have large compliance staffs; and, many community banks struggled with such unnecessary regulatory burdens. Sen. Rapert stated that he believes there are parallels between those issues and the issue that the Resolution before the Committee today seeks to address.

The Public Company Accounting Oversight Board (PCAOB), established by Congress in 2002 to oversee the audits of public companies in order to protect investors, was expanded by the Dodd-Frank Act in 2010 to include annual audits of all brokers and dealers – regardless of size – registered with the Securities and Exchange Commission. Currently, a three-person firm is held to the same standards as publicly traded firms. This has taken a financial toll on small firms in the investment and accounting industries around the U.S. This one-size-fits-all PCAOB audit requirement has inhibited the growth and success of small broker-dealer businesses with limited resources

Accordingly, 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. Sen. Rapert stated that it is important to note, as NCOIL is a bi-partisan organization, that H.R. 6021 and S.3004 have bi-partisan support in Congress: the House Sponsor is Rep. French Hill (R-AR) and the House Co-Sponsor is Rep.

Vicente Gonzalez (D-TX); the Senate Sponsor is Sen. Tom Cotton (R-AR) and the Senate Co-Sponsor is Sen. Doug Jones (D-AL). Sen. Rapert further stated that when he and other NCOIL legislators were in D.C. a few weeks ago for the NCOIL fly-in, he heard bi-partisan support for the bill from Members of Congress and their staff. Sen. Rapert further stated that over 400 small businesses in 49 of 50 states have supported this legislation and urged the Committee to support the Resolution.

Page Pierce, President of PSP Consulting, stated that she represents 3,400 small firms within the broker-dealer community in the investment industry, as well as untold small accounting firms across the country. Ms. Pierce noted that the number of small businesses that support this legislation has actually grown to over 800. Ms. Pierce stated that following the enactment of Sarbanes-Oxley and Dodd-Frank, irrespective of size, firms are required to hire a PCAOB auditor. Hiring such an auditor requires firms to follow PCAOB standards which are markedly different and significant more complex than American Institute of CPAs (AICPA) standards.

Ms. Pierce stated that there are 430,000 AICPA members. There are currently less than 438 PCAOB registered auditors and in 2012, there were 783. Accordingly, small businesses are requesting a return to the more appropriate AICPA standards. The issue with constriction of PCAOB auditors is one of supply and demand. We have the forces of the market coming into play when less than 450 PCAOB auditors are available to audit all public companies as well as the broker-dealers - you can imagine what their pricing strategy is. The broker-dealer community and the financial services industry consists of large companies, mid-size firms, and small businesses. As of January 2018, the small business community consisted of 3,400 firms – that is defined by FINRA as employing 150 representatives or less.

Less than 10 years ago, there were approximately 1,000 more small businesses in the industry than today. Ms. Pierce stated that she would like to prevent the next 1,000 small businesses from losing their livelihood and while the exemption from the PCAOB audit requirement is only one component of the trend of small-firm demise, it is an important one. If we can address and resolve this issue for small businesses, we can make a difference for small firms. There is a right fit and wrong fit – the PCAOB audit requirement is appropriate for public companies and broker-dealers which carry customer funds and securities, like JP Morgan and Morgan Stanley, because the investing public and markets are potentially at much greater risk from those companies.

Conversely, the PCAOB audit requirement does not make sense for privately held, non-custodial, small broker-dealers. At a time when small firms should be deploying their assets, human and financial, to the benefit and protection of their customers, statutes demand their capital for an audit that does not in any way protect those customers. It is worth noting that the PCAOB's mission is investor protection. The term investor as it relates to the PCAOB refers to individuals who invest in public company stock. The companies that will be eligible for the PCAOB audit exemption under the legislation are all non-public companies that by definition do not have public company investors. The eligible small, non-public companies contemplated in the Act do not carry customer funds or securities and are at all times subject to regulatory required monthly, quarterly and annual financial reporting obligations. Additionally, the users of such financial statements are regulators, not public company investors, because the small, non-public companies have none.

Ms. Pierce stated that small firms in the brokerage industry face disproportionate regulatory and audit costs and they are struggling to survive in every state. Approximately 10 small firms are going out of business per month which means small firm customers are losing their right to

choose local, loyal, sound advice from the people they trust. In surveys conducted within the small business community, the average pre-PCAOB audit fee was approximately $9,000 while the average post-PCAOB audit fee has increased every single year and is up to an average of over $18,000. Increased audit expenses have resulted in approximately $28 million being pulled away from customer-focused initiatives and instead spent on hiring a PCAOB auditor. Additionally, surveys conducted showed that pre-PCAOB, the average amount of man-hours spent preparing for an audit was 44, and post-PCAOB it was 84. Broker-dealers have a mere 60 days from their fiscal year-end to file their annual audited financial statements with regulators. The weekend overtime wages add millions to the annual audit cost.

Ms. Pierce closed by noting that even consumer advocacy organizations like Better Markets have taken a neutral approach on this legislation. Better Markets stated that the legislation poses no systemic risk to the markets, customers or investing public. Additionally, the official position of the SEC is that they do not oppose this legislation. Ms. Pierce urged the Committee to support the Resolution.

Upon a Motion made by Rep. Joseph Fischer (KY) and seconded by Rep. Steve Riggs (KY), the Resolution passed without objection by way of a voice vote.

ADJOURNMENT

There being no other business, the Committee adjourned at 10:15 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
NCOIL SUMMER MEETING - SALT LAKE CITY, UTAH
JULY 12, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the Little America Hotel in Salt Lake City, Utah on Thursday, July 12, 2018 at 11:45 a.m.

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

Other members of the Committee present were:

Sen. Jason Rapert (AR)
Rep. David Livingston (AZ)
Asm. Ken Cooley (CA)
Rep. Richard Smith (GA)
Rep. Matt Lehman (IN)
Rep. Joseph Fischer (KY)
Rep. Jim Gooch (KY)
Rep. Edmond Jordan (LA)
Sen. Dan "Blade" Morrish (LA)
Rep. Michael Webber (MI)
Rep. Joe Hoppe (MN)
Rep. Lois Delmore (ND)
Rep. George Keiser (ND)
Asw. Pamela Hunter (NY)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Paul Mosley (AZ)
Rep. Bryon Short (DE)
Rep. Martin Carbaugh (IN)
Sen. Brian Feldman (MD)
Sen. Paul Utke (MN)
Asw. Maggie Carlton (NV)
Asw. Ellen Spiegel (NV)
Sen. Neil Breslin (NY)
Sen. Jay Hottinger (OH)
Rep. Glen Mulready (OK)
Rep. Rodney Anderson (TX)
Rep. Tom Oliverson, M.D. (TX)
Rep. Joe Schmick (WA)

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 March 3, 2018 meeting in Atlanta, GA.

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

Francine Semaya, Esq., stated that this past March, the 5th Circuit Court of Appeals issued a 2-1 decision that vacated the DOL Fiduciary Rule. Essentially, the Court ruled that the DOL did not have the authority to adopt the Rule and found that the DOL had acted arbitrarily and capriciously. The DOL had 45 days from entry of the judgment to request that all the 5th Circuit judges re-hear the case (i.e. an en banc session). The

DOL also had an option to go to the U.S. Supreme Court for permission to appeal the 5th Circuit's decision, but the DOL did neither. California, New York, and Oregon had also filed motions to intervene in the 5th Circuit and asked for an en banc session. All motions were denied twice. Accordingly, last month, the Rule "died."

Ms. Semaya stated that while the current Administration let the Rule "die", the SEC, and a number of states, have worked to propose their own Fiduciary or best interest standard rules and laws. Additionally, the NAIC Annuity Suitability Working Group has been working on amending the NAIC Suitability in Annuity Transactions Model Regulation. Ms. Semaya also stated that many firms had taken steps necessary to be in compliance with the Rule so that advisors had to give conflict-free advice on retirement accounts thereby putting the client's needs ahead of any potential compensation. Both supporters and opponents of the Rule were widespread.

In April, the SEC released its proposed best interest rule for brokers which increased the SEC's requirements for conflict of interest for brokers, but it came very short of the more restrictive DOL Rule. Eleven (11) states have contacted the SEC asking it to make its proposal more like the DOL Rule. The SEC's proposal applies to both non-retirement and retirement accounts, unlike the DOL Rule which only applied to retirement accounts. There is a 90-day comment period on the SEC's proposal.

Ms. Semaya stated that Connecticut passed legislation that requires administrators of certain retirement plans to disclose conflicts of interest which went into effect on October 1, 2017. The law applies to any person that enters into a contract or agreement with a 403B plan not regulated under ERISA to provide services and reasonably expects to receive $1,000 or more in direct or indirect compensation. In Illinois, a bill is pending in the House titled "The Investment Advisors Disclosure Act." A bill was also introduced in the Maryland Senate that would have extended the fiduciary rules applicable to investment advisors to broker-dealers, agents, and financial advisors. On March 19, the Maryland Senate approved a financial reform bill titled the "Financial Consumer Protection Act of 2018" which included instructions to the Maryland Consumer Financial Protection Committee to study the outcome of Federal efforts on fiduciary duties and then determine whether or not Maryland should enact its own fiduciary law.

On February 7, Massachusetts proposed a regulation that would require investment advisors that are registered with the Massachusetts Securities Division to create a fee table for advisory clients. The fee table would be required to be updated annually and presented annually to their current advisory clients. Massachusetts also went after Scottrade in February for holding contests which was not only in violation of the DOL Rule, which was in partial effect at the time, but also in violation of Scottrade's internal rules. Such action prompted an interesting question: can states enforce a federal rule that has been incorporated into the internal policies of a company when the federal agency fails to do so?

Nevada was the first state to adopt something related to the DOL Rule back in 2017. The legislation is not applicable to insurance unless it is accompanied by investment advice. Regulations are starting to be promulgated to enforce that law. Two bills were introduced in New Jersey this past January – SB 735 would require financial advisors to disclose fiduciary status to investors. The bill makes a very clear distinction between non-fiduciary investment advisors and those subject to a fiduciary duty. Non-fiduciary advisors must advise clients orally and in writing that they do not have any duty to act in

the client's best interests. Fiduciary advisors would have to advise clients that they are subject to a fiduciary duty. Both types of advisors must give the proper disclosure, or they are subject to a $5,000 fine.

In New York, the initial proposal to amend its suitability regulation was issued on Dec. 27, 2017 and the comment period ended in February. In May, the NY DFS amended its proposal to require insurance companies to establish standards and procedures for recommendations to consumers for insurance products delivered or issued for delivery in NY. The updated proposal not only applies to standard life insurance and annuity contracts, but also in-force transactions. The proposal applies to all producers in the transaction who receive compensation regardless of the level of contact with the consumer. The proposal also prohibits stating or implying that a recommendation to enter into a sales transaction or in-force transaction is financial planning, comprehensive financial advice, investment management, or related services, unless such advisor has a certification or professional designation and is properly licensed.

Insurance companies will now be required to establish, maintain and audit a system of supervision to achieve compliance with the regulations. The best-interest standard will now be applicable to all sales of life insurance and annuity products. The proposal requires that the sales transaction be suitable, that there is a reasonable basis for believing the consumer has been reasonably informed of all features of the product whether favorable or unfavorable, and insurers must establish and maintain procedures designed to prevent financial exploitation. The comment period ended on June 15.

Ms. Semaya closed by stating that court rulings in CA, MO, SC and SD have imposed different types of fiduciary duties, and the next step is to see what the NAIC Annuity Suitability Working Group will do regarding amendments to its Model.

Dean Cameron, Director of the Idaho Department of Insurance, and Chair of the NAIC Annuity Suitability Working Group (Working Group), stated that it speaks volumes that he was chosen to Chair the Working Group as he has years of experience as a licensed agent selling annuities and life and health insurance. He has had the privilege of sitting down with folks to help them plan for their retirement and the NAIC recognizes that state regulators, as well as federal regulators, have an appropriate role in this marketplace. State regulators have the role of administration and enforcement of the standards of retirement plans and products within their jurisdiction. State insurance regulators are responsible for regulating the insurance companies and agents who sell products. The SEC and FINRA have the responsibility of joint jurisdiction with states over varia

Dir. Cameron noted that the current NAIC Annuity Suitability Model is doing a great job – 98% of the cases regulators see are handled through that Model. Unfortunately, the DOL and others staked out the moral high ground and labeled their efforts as acting in the consumer's "best interest." Dir. Cameron stated that, from his perspective, the majority of agents and carriers already act in the consumer's best interest. Because the DOL has staked out the moral high ground on "best interest," the NAIC has moved away from trying to define "best interest" and instead has focused on developing on a "standard of care" – how does the agent justify their recommendation to the consumer?

A lot of the discussion in the NAIC has been focused on what level of disclosure should be required. The DOL Rule required complete disclosure of commissions and there is almost a feeling that "commission" is a dirty word; but we all know that commissions are

what encourage agents to sit down with consumers and help them determine what products are available. The NAIC believes that if there are disclosures, it should be the same for commissions and fees and there should be an appropriate level of justification. There is a debate over whether the disclosure should be just how the agent is compensated, or how much they are compensated. Dir. Cameron noted that, as an agent, he never knew what the commission was when he recommended a product; his interest was doing right by the consumer because if he did so, the consumer would recommend him to friends and family. Most agents operate under that theory.

Dir. Cameron stated that another issue under debate is over the disclosure of non-cash compensation – does an agent have to disclose that he/she may qualify for a trip if they sell a certain amount of annuities? The problem is that most agents would not know until they are right on the cusp of qualifying, and most of the time that has no bearing on the product being recommended. Dir. Cameron stated that the NAIC understands that there is a retirement crisis in this country and it does not want to do anything that inhibits people from planning for their retirement. It is certainly not the NAIC's goal to mimic what the DOL was proposing. Rather, the NAIC's goal is to review the Model and to see if there are ways to collaborate and have consistency in the industry. Agents should be able to be informed as to what their requirements are in a straightforward manner, and carriers should have that ability as well. Dir. Cameron closed by stating that the NAIC welcomes NCOIL's input and collaboration on the Working Group's activities.

Rep. Matt Lehman (IN), NCOIL Treasurer, asked whether the NAIC sees the NY DFS developments as the start of perhaps seeing similar requirements in the P&C industry. Dir. Cameron replied no and stated that the NAIC has shut down such proposals before. Dir. Cameron also stated that the NAIC is a long way away from seeing any amendments to the Model being adopted given its longstanding methodical way of working, and that the NAIC certainly wants to avoid acquiescing the field to the DOL or SEC, as the NAIC firmly believes in state-based insurance regulation. Dir. Cameron stated that the NAIC is also concerned about having a patchwork of state laws on these issues.

Sen. Jason Rapert (AR), NCOIL President, asked Ms. Semaya and Dir. Cameron for the list of states that are pursuing laws or regulations similar to the DOL Rule. Ms. Semaya stated that New York's proposal is perhaps even more stringent than the DOL Rule, and referenced New Jersey, Maryland, Connecticut, Illinois, and Nevada. Dir. Cameron noted that despite passing legislation two years ago, Nevada has not been able to promulgate a rule on the legislation yet, and it is noteworthy that the legislation was brought forth by certain legislators, not the Nevada Dep't of Insurance. Dir. Cameron also noted that CA is pursuing legislation as well. Sen. Rapert noted that NCOIL passed a Resolution that he sponsored that opposed the DOL Rule in November 2016.

Sen. Rapert stated that he is interested in watching the aforementioned state activities because he still maintains his Series 7 license and having a number of different state requirements can be a compliance nightmare for advisors and companies. Sen. Rapert urged the Committee to monitor those activities and the NAIC's activities. Sen. Rapert closed by stating that many of these state activities, including the DOL Rule, are under the guise of helping the consumer but in reality, it disincentivizes agents from sitting down in the first place with those consumers.

Rep. Martin Carbaugh (IN) stated that he is an insurance agent and financial planner and it would be odd for everyone involved if certain products must be in the client's "best interest," while others have to be "suitable." What is in the "best interest" of a client can be very hard to determine, particularly when dealing with universal vs. whole life insurance distinctions. Rep. Carbaugh asked Dir. Cameron if there have been any discussions of statute of limitations in the NAIC's efforts.

Dir. Cameron stated that Rep. Carbaugh's example is a good illustration of why the NAIC is moving away from a "best interest" standard, and the current draft of the Model has a provision that precludes "looking back in hindsight." Dir. Cameron stated that the NAIC is moving towards a "standard of care" which focuses on the responsibility of the agent. The agent's responsibility is to disclose all pertinent information. If they recommend a particular product, they should document how they arrived at that recommendation; and they should document why the consumer chose the product. If an agent operates in that manner, they should be deemed to be acting in a certain standard of care or deemed to be acting in the best interest of the consumer. Dir. Cameron also stated that there is a debate about disclosing conflicts of interest, but noted that most consumers know that if they go to State Farm, they will most likely be buying State Farm products. If such requirements are imposed on agents, they must be reasonable.

Rep. Deborah Ferguson (AR), Chair of the Committee, asked Dir. Cameron when he believes the Working Group will be finished with its drafting efforts. Dir. Cameron stated that he believes the goal is to have a draft finished by the NAIC Fall Meeting.

Rep. Jim Gooch (KY) stated that is seeing a movement to vilify annuities and everyone needs to be sure moving forward that the very positive features of annuities are broadcasted appropriately. Dir. Cameron stated that he completely agrees with Rep. Gooch and that if the retirement crisis is to be addressed, it will be through consumers sitting down with advisors discussing available products, including annuities.

Rep. George Keiser (ND) stated that he was surprised to hear from Ms. Semaya and Dir. Cameron that such a high number of states were pursuing their own fiduciary laws or regulations. Given that there is so much concern and interest out there on these issues, Rep. Keiser asked if the NAIC has considered hiring an independent party to do an analysis on what the problems are in the marketplace, if any. Rep. Keiser stated that the NAIC needs to be sure that there really is a problem out there before developing a Model.

Dir. Cameron stated that Rep. Keiser's question is one that everyone at NAIC asked before starting efforts to amend the Model. The reality is that the Model, which a majority of states have passed, has done a phenomenal job. If anything, the NAIC has done a poor job of telling everyone how well the Model has performed. The difference in this specific situation is that the DOL's activities caused everyone to believe that the DOL Rule was going to be enacted. The NAIC was asked to do an informal study on these issues, and the NAIC asked states to report certain data. The NAIC learned that there were some instances where agents could be accused of acting in their interest, not necessarily in the consumer's interest. Accordingly, that led to proposed amendments to the Model. Dir. Cameron stated that if a third party is needed to conduct a study as Rep. Keiser suggested, he believes the NAIC would be willing to do it, but Dir. Cameron believes that is not necessary at this point in time.

PRESENTATION ON INDUSTRY TRENDS IN RETIREMENT PLANNING: SOLUTIONS TO HELP PLAN FOR THE FUTURE

John Mangan of the American Council of Life Insurers (ACLI) stated that the first step in addressing the retirement crisis in the country is to promote awareness and that ACLI would like to serve as a resource for NCOIL and its member-legislators. ACLI has a lot of resources and ideas to tap into. ACLI has a state fact-sheet that shows the impact of the retirement and life insurance industry in each state. The fact-sheet shows that in Utah in 2016, life insurers paid $3 billion in annuity related benefits to Utah citizens – second only to the social security administration. Most states have a similar number. People in Utah also have $300 billion worth of life insurance in force which in many cases serve as a source of retirement planning for spouses and families. That is something to consider when looking at policy – encouraging life insurance is a way of encouraging retirement security.

Mr. Mangan stated that on ACLI's website, you can access a new study called "Assessing American's Financial and Retirement Security" which outlines some of the good habits that create financial security which includes things such as creating a financial plan and having an emergency fund. One of the biggest obstacles to retirement planning is that only 1/3 of Americans have $500 or more in an emergency fund. The use of debt is also another major obstacle. The study also makes certain recommendations for state legislators to consider when developing retirement planning legislation.

Another ACLI initiative is called the Alliance for Lifetime Income which is a new group of large retirement and financial companies, many of which are ACLI members, who are trying to get Americans focused on lifetime income. Assuming you are able to save enough for retirement, it is important to make it last considering the increased life expectancy. That information can be viewed at www.allianceforlifetimeincome.org
Mr. Mangan further stated that ACLI also tracks all activity with state-run retirement plans. One promising approach is the Washington marketplace approach for small business - a way to connect small business to existing plans that are in the marketplace. Utah also recently passed an innovative approach – a $500 tax credit for any employer in the state that adopts a new retirement plan for its workers.

Steve Kline of the National Association of Insurance and Financial Advisors (NAIFA) stated that NAIFA believes that some of the sate-run retirement proposals that have been introduced that compete with the private sector plans and require employers to participate are not the answer to the retirement crisis. That is because there is already a vibrant and diverse private sector market that offers affordable options such as 401k's, 403b's, and various IRA's. If a retirement plan is not offered at work, employees have ready-access to low cost options through financial advisors and financial institutions.

When it comes to small businesses, financial advisors are ready willing and able to help them establish a retirement plan for their employees. As an example, one of NAIFA's members has a client in Ohio that is a small plumbing company with 2 owners, 6 employees, and no retirement plan. An advisor got them set up with a simple IRA and years later, the owners and employees have increased their contributions through consistent consultation with the financial advisor and the IRA is very healthy. Another example can be seen in Florida – a NAIFA member had a client who owned an AC installation and repair business with about 15 employees with no retirement plan. A

simple IRA plan was set up and years later, the IRA has approximately $1 million in assets. Mr. Kline noted that examples such as those also benefit the business since they are able to attract and retain employees.

Mr. Kline stated that whether a business or certain employee is blue-collar or whitecollar, a financial advisor can set up an appropriate plan. Mr. Kline provided examples of banks and civil engineering firms getting set up with a 401k that grew and worked very well for all involved. Mr. Kline also stated that advisors frequently help non-profit institutions such as local churches. Over time, with good management and consistent contributions, retirement plans can work for anyone. Mr. Kline noted that in all of the examples cited, the guidance and assistance of an advisor is almost as important as the plan itself. Contrarily, it is difficult to contact the right person, or anyone for that matter, when dealing with state-run retirement plans.

Mr. Kline also noted that NAIFA members frequently help independent contractors and that, for whatever reason, do not have retirement plans offered through their employment. Mr. Kline stated that a NAIFA member told him he has a nurse for a client that essentially works as a contactor through a staffing agency. She had no retirement plan and worked with an advisor who set her up with an IRA, invested in a low-cost mutual fund, and a tax-deferred variable annuity. She will be able to retire comfortably. Another example: a NAIFA member had an auto body repair shop employee for a client who made a decent income but had no retirement plan. His advisor set him up with a Roth IRA plus a tax-deferred variable annuity and he now has a healthy retirement nestegg.

Mr. Kline stressed that regardless of your income level or occupation, an advisor can help you plan for retirement. NAIFA members are committed to helping everyone with their retirement. Regarding state-run retirement plans, they seem to address the problems of availability of and access to retirement plans, but Mr. Kline stated that he believes those are not the real problems Americans are facing. Other problems are lack of saving due to a lack of financial education and competing financial needs. Mr. Kline stated that if a state does choose to address these issues, he believes the Washington approach is promising, but consumers are best served with plans offered by carriers combined with advice from an advisor.

Lance Schoening of Principal Financial (Principal) stated that Principal is an insurer and a global retirement asset manager. Among other things, Principal works closely with groups such ACLI and NAIFA to inform members of Congress on retirement policy. Mr. Schoening provided a cautionary tale of referring to certain studies when discussing whether there is a retirement crisis in America. A recent Wall Street Journal article stated that American retirees are in worse financial condition than the prior generation. When you look at the study that formed that opinion, the reporters relied on a government data set – the “current population survey” – which has been proven to underestimate retirement savings income by more than 50%. The U.S. Census Bureau published a survey last year that found the current population survey underestimated retirement savings income going back to 1990.

The WSJ article stated that retirement savings income was flat for the past two decades, but the U.S. Census Bureau actually found that median retiree incomes rose by more than 32% over inflation over the past two decades. At the same time, the Social Security Administration found that real median wages rose by only 11%. Nearly the same differential was shown in low and high-income retirees as well. That is a great

example of how policymakers have a moral obligation to ensure they are looking at and using all available data.

Mr. Schoening stated that regardless of whether you agree that there is a retirement crisis in America, nearly everyone can agree that there are significant challenges that need to be addressed. Mr. Schoening stated that a colleague recently told him that retirement planning is not a dinner-table conversation topic for Americans – that struck him as surprising. A recent survey from Morning Consult and Prudential stated that 80% of American workers rank retirement security as the top issue they want to hear from Congressional candidates this Fall.

Mr. Schoening stated that he recently read something in the reddit-sphere that is millennial-focused titled “FIRE” which stands for “financial independence – retiree early.” 359,000 millennials are signed up to that network to share ideas on how to live freely and save appropriately to retire early. Accordingly, retirement planning is an issue important to Americans no matter what age.

Congressional action on retirement planning hasn’t been taken since the Pension Protection Act in 2006. In that time, so much has been learned about American worker savings behaviors and what appropriate plan designs can do to affect retirement readiness. Chief among the measures introduced by Congress since late last year is the Retirement Enhancement and Savings Act (RESA). In 2016, RESA came out of the Senate Finance Committee unanimously. RESA was introduced in both Chambers this year with over 50 bi-partisan co-sponsors. RESA represents three main retirement policy objectives: a.) improve workplace retirement savings plan coverage of American workers; b.) increase savings rate adequacy; and c.) introduce and provide more lifetime income solutions to workers and defined contributions plans.

Mr. Schoening stated that the most widely reported statistic deals with coverage – about 50% of American workers have access to a work-site retirement savings plan. However, that is a cautionary statistic and should not be looked at in isolation as it is a point-intime measure and does not necessarily give an indication of a particular worker’s ability to access it over a career. The statistic signals a problem in terms of access but when you look at full-time private sector workers, about ¾ of them have access to a work-site savings plan and when they have access, about 80% of them participate. Accordingly, there is a solid foundation, but ways need to be explored to improve access, particularly with small employers. A Pew Charitable Trust survey stated that about 53% small to mid-size employers, those with 250 employees or less, sponsor a plan. A key objective is to close that gap.

A potential solution is something called an “open multiple employer plan.” RESA and other objectives would clear the way for such plans. Such plans allow a professional plan administrator fiduciary to design, maintain, and mange a plan and allow unrelated employers to adopt that plan. For small employers, it allows them to lessen the administrative burdens of managing plans, lessens the fiduciary responsibilities and liabilities, and allows small employers to band together to achieve a larger economy of scale. Strong, bi-partisan support exists for this concept.

Mr. Schoneing stated that increasing participation rates when a plan exists, and savings rate adequacy also need to be improved. Automatic plan provisions have been adopted by many large plans. T. Rowe Price just issued a report on their clientele block which is

generally large plan sponsors who widely use automatic plan provisions. The report showed the highest contribution rate in 10 years, an average deferral of 8.3%, and plans that used auto enrollment had participation rates 42% higher than plans that do not. Also, employee participation in auto-contribution increases was more than 5x higher in plans where it was an opt-out feature rather than an opt-in feature. That illustrates that participants want nudges from their employers, and participant surveys indicate that as well. However, employer surveys have opposite results so that gap needs to be closed. Congress can address that gap by incentivizing employers, particularly small employers, to adopt progressive auto-feature plan designs. For example, a plan design that autoenrolls employees at a 6% rate and increases that rate by 1% per year. Mr. Schoneing stated that those that follow that approach today report extremely low opt-out numbers.

ADJOURNMENT

There being no other business, the Committee adjourned at 1:00 p.m

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
NCOIL SUMMER MEETING - SALT LAKE CITY, UTAH
JULY 12, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at the Little America Hotel in Salt Lake City, Utah on Thursday, July 12, 2018 at 10:15 a.m.

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

Other members of the Committee present were:

Rep. David Santiago (FL)
Sen. Jason Rapert (AR)
Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Rep. Joseph Fischer (KY)
Rep. Bart Rowland (KY)
Rep. Edmond Jordan (LA)
Sen. Dan "Blade" Morrish (LA)
Rep. Michael Webber (MI)
Rep. Lois Delmore (ND)
Rep. George Keiser (ND)
Sen. Neil Breslin (NY)
Asw. Pamela Hunter (NY)
Sen. Bob Hackett (OH)
Sen. Jay Hottinger (OH)
Rep. Glen Mulready (OK)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Deborah Ferguson (AR)
Rep. David Livingston (AZ)
Rep. Bryon Short (DE)
Rep. Jim Gooch (KY)
Sen. Brian Feldman (MD)
Rep. Joe Hoppe (MN)
Sen. Paul Utke (MN)
Asw. Ellen Spiegel (NV)
Rep. Rodney Anderson (TX)
Rep. Joe Schmick (WA)

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 March 2, 2018 meeting in Atlanta, GA.

CONSIDERATION OF CONSUMER PROTECTION TOWING MODEL ACT

Rep. Matt Lehman (IN), NCOIL Treasurer, and sponsor of the Consumer Protection Towing Model Act, stated that at the NCOIL Spring Meeting in March, it was decided that a meeting was necessary among interested parties to ensure that a final version of the Model was ready for consideration at the Summer Meeting. Accordingly, on May 22, representatives from both the towing and insurance industries met to discuss and address some of the concerns from both industries. The version before the Committee

today is a result of that meeting and Rep. Lehman stated that he believes it represents a good and fair work product.

Rep. Lehman noted that there are three minor amendments to the Model that he would like to propose. First – in Section 6, Rep. Lehman proposed that the title be changed from “Private Property Towing” to “Commercial Private Property Towing” because the intent of the section is meant to apply to commercial properties that have parking lots, not for all private properties. We don’t want to bring someone’s home into the equation. Second – in Section 8A, after the last line, add: “If a state does not have a mechanism to provide the above requested information electronically, then the tow company will make all reasonable efforts to obtain the vehicle owner and lien holder information.” The reasoning for that amendment is that the Model requires towing companies to conduct data searches for the owner of the vehicle, but some states may not have that mechanism available. Third, in Section 11, change the title from “Certification Requirements” to “Tow Company Certificate Requirements.” The reasoning for that amendment is that “certification” within the towing industry refers to job related knowledge-based certification, such as the National Driver Certification Program, and that is not the intent of the section. Rep. Lehman urged the Committee to support the Model, as amended.

Erin Collins of the National Association of Mutual Insurance Companies (NAMIC) thanked Rep. Lehman and NCOIL staff for facilitating the interested parties meeting in May. The concerns that NAMIC had with the prior draft have been addressed. Accordingly, NAMIC supports the Model and urged the Committee to adopt it.

Upon a Motion made by Sen. Bob Hackett (OH) and seconded by Rep. Tom Oliverson, M.D. (TX), the Committee voted without objection to pass the Model, as amended, by way of a voice vote.

CONSIDERATION OF AMENDMENTS TO NCOIL MODEL STATE UNIFORM BUILDING CODE

Rep. Richard Smith (GA), Chair of the Committee, stated that Rep. Lewis Moore (OK), sponsor of the proposed amendments to the NCOIL Model State Uniform Building Code had informed him and others prior to the Committee that he is withdrawing said amendments.

UPDATE ON THE ALI RESTATEMENT OF THE LAW OF LIABILITY INSURANCE

Cmsr. Tom Considine, NCOIL CEO, stated that on May 2, 2018, the NCOIL Executive Committee held an interim meeting via conference call to discuss the ALI Liability Insurance Restatement (Restatement) before it was voted on at the ALI’s Annual Meeting later that month. Guest speakers participating on the call were: 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; and Laura Foggan – Partner – Crowell & Moring, LLP.

Cmsr. Considine stated that the ALI did make some positive changes to the Restatement before it was adopted at their Annual Meeting, but overall, there remain

several problematic provisions. A Restatement is supposed to re-state the law on a certain issue and, historically, all Restatements have been well-respected and objective in nature. However, this Restatement is not objective but rather a re-statement of what the ALI would like the law to be in the area of liability insurance. Notably, the Restatement started out as a "Principles Project" – which are aspirational in nature – but it somehow transformed into a Restatement.

Cmsr. Considine noted that prior to the NCOIL Spring Meeting in March, on behalf of NCOIL, he wrote a letter to each state's presiding jurist urging them to get involved and noting that the Restatement should not be utilized as a source for researching liability insurance law. Some jurists wrote back stating that they could not get involved since there was no "case or controversy" before them.

Cmsr. Considine stated that he believes the next step for NCOIL is for staff to compile a list of the provisions in the Restatement that are problematic, and then present to the P&C Committee either an omnibus Model Liability Insurance Law that accurately states the law on those provisions, or to present several "rifle shot" Models. Cmsr. Considine stated that he believes the better approach is the "rifle shot" approach, and that it is critically important to ensure that the Models are drafted in such a way as to make it clear that they are dealing with insurance topics, not court topics, because if the Models get presented to state Judiciary Committees, it will be very difficult for them to advance.

John Ashenfelter of State Farm thanked NCOIL for its involvement with the Restatement and stated that the ALI is apparently still considering some changes to the Restatement. Provisions of the Restatement that the ALI are still examining are: misrepresentation and rescission; insurer liability for the conduct of defense counsel; requiring judicial adjudication for withdrawal of defense; insurer recoupment of costs of the defense; duty to make reasonable settlement decisions; the Effect of a Reservation of Rights on Settlement Rights and Duties (notably – this issue has been dealt with in a different way in a separate Restatement); settlement without insurer consent; damages for insurer's breach of settlement duties; late notice under claims made and reported polices; and remedies.

Mr. Ashenfelter stated that the Tennessee legislature has acted in response to the Restatement which may be a good approach for other states to follow (TN SB 1862). There appears to be ample opportunity for NCOIL to step in and act in a way so as to affirm that state insurance legislators, as elected public policymakers, are those who are to make liability insurance law – not the ALI.

Rep. Smith asked Cmsr. Considine if any Model legislation would be prepared for the Committee to examine at the NCOIL Annual Meeting in December, and whether it would be in the form of an omnibus model or "rifle shot" models. Cmsr. Considine stated that the plan is to have a draft for the Committee to look at in December, and his recommendation is for the Committee to take the "rifle shot" approach.

Rep. Joseph Fischer (KY) asked if there is a list available of the provisions in the Restatement that identifies which are correct and incorrect restatements of the law. Mr. Ashenfelter stated that Laura Foggan is working on that list and can distribute it when finished.

Sen. Hackett asked what Tennessee did that was different than Ohio's approach which

passed a proposed bill providing that the Restatement "does not constitute the public policy of this state." Mr. Ashenfelter stated that he does not have the Tennessee bill in front of him, but he believes it walks a very careful line in acknowledging that the ALI gets it right in some areas but points out areas where the ALI mis-stated the law. Mr. Ashenfelter also noted that Restatements are very important pieces of work because courts look to them for guidance, and in this instance, some courts have already cited to the liability insurance restatement.

Rep. George Keiser (ND) stated that, in part, the problem is that it is not only the laws already enacted, but that when legislatures decide not to address a certain issue – that is also an exercise of the legislative prerogative. Rep. Keiser stated that represents a dilemma of sorts and asked how NCOIL can cover both sides in its response. Mr. Ashenfelter stated that is a great point and that could possibly be addressed by NCOIL adopting "rifle shot" models and states could examine them and determine whether or not to adopt them. Cmsr. Considine stated that an example of that approach is reflected in bad-faith legislation. More than two dozen states have considered that issue and decided not to adopt any legislation, but the ALI has taken a forward-leaning approach on that issue in the Restatement. Mr. Ashenfelter then clarified that the Tennessee approach (SB 1862) only dealt with the plain-meaning rule and accurately stated what the law is on that issue.

DISCUSSION ON THE ROLE OF INSURANCE IN PUBLIC-PRIVATE PARTNERSHIPS

Rep. Lehman stated that the issue of public-private partnerships (P3s) is quickly growing and it came to light in Indiana when a $325 million road project was defaulted on and there was a 25% bond requirement. That drove a discussion in the Indiana legislature about what is the proper percentage to require on P3s regarding bonding. Rep. Lehman stated that this issue is going to become part of a larger issue with the Trump Administration's infrastructure plans which P3s are going to be a part of.

Lynn Schubert, President of the Surety & Fidelity Association of America (Ass'n), agreed with Rep. Lehman's statement that P3s are going to be a big issue in state legislatures. The Ass'n wears three hats: a.) a licensed advisory organization to every state insurance department on issues of surety and fidelity; b.) statistical agent for sureties and fidelities; and c.) a trade ass'n whose members are global and regional insurance companies. Those Assn's members write over 97% of the premium volume for surety and fidelity in the U.S. The U.S. over the years has adopted a public policy of encouraging and requiring the use of surety bonds.

Ms. Schubert stated that a surety bond is an insurance policy but different from traditional insurance where you have two parties and the risk is shifted to one party. A surety bond is essentially a guarantee. By way of example, if Chairman Smith wants to hire Ms. Schubert to complete a construction project but is not sure if she can do it, he can ask an insurance company to "stand behind her" by issuing a surety bond which has two implications. The surety bond determines that the independent party believes she can perform the construction and if they are wrong, they must perform the construction project. There are different types of surety bonds but over 60% are issued for construction projects.

Ms. Schubert stated that over 100 years ago the Federal government decided that construction projects needed protection because people who are funding the projects

are taxpayers; and the people working on the projects should be able to have guaranteed payment since subcontractors have no recourse if the general contractor refuses to pay. Unlike being able to put a lien on someone's house, you can't put a lien on public property. Indiana is a very interesting example because the payment bond on that project was only 5% so there were subcontractors who didn't believe they had protection, so they stopped working.

Ms. Schubert stated that in the U.S. there is a public policy with the Federal government of 100% performance bonds which means whatever the contract price is must be bonded 100% with both a performance and payment bond. All states have similar laws called "Little Miller Acts" since the Federal statute is called "The Miller Act." Europe has much less stringent requirements.

Ms. Schubert stated that P3s are interesting and different from municipal bonds since entities are created specifically to invest in infrastructure projects. The first people to bid on those projects were European contractors and it was controversial that people called for European bonding policy to be accepted. Many states in enabling statutes have required 100% performance and payment bonds and Ms. Schubert stated that there is no reason to change that when someone else is just providing the financing. Ms. Schubert stated that a P3 is when someone else provides financing upfront and at the end of the day it is still "your" bridge/highway and "your" citizens who will come to you asking what happened if it is not complete – they don't care that a private entity is involved financing it. Accordingly, from a political and financing standpoint, it is still "your" project – the private entity is simply putting up the money upfront when there is a lack of public financing.

Ms. Schubert stated that many P3 enabling statutes either require 100% performance and payment bonds or they require conforming to other existing statutes which sets forth the public policy of that state. Ms. Schubert stated that is a good approach. Ms. Schubert stated that the Ass'n is a resource for anyone to reach out to determine what their state policy is. Ms. Schubert stated that recently, the push around the world has been to increase the protection so she would hate to see states decrease protections in P3 enabling statutes.

Ms. Schubert stated that if states are to permit alternative security for public works, they should only consider cash, municipal/government bonds, or a letter of credit for the same amount. Ms. Schubert stated that Pennsylvania used to have a law for its public works that required 100% performance and payment bonds. PA changed the law to still require 100% but to allow alternative security. A contractor wanted to do the incinerator project in Harrisburg. The contractor couldn't get bonds, so PA accepted a parental guarantee for 100%. The contractor ended up not completing the project and Harrisburg went bankrupt and the taxpayers of Harrisburg are still paying for it. There was even an indictment issued by a grand jury on Harrisburg public officials. At the end of the day, the grand jury's recommendation was to re-institute the law that required 100% performance and payment bonds.

Ms. Schubert stated that in Ontario, Canada, they did not have a requirement for performance or payment bonds and a study was conducted that provided great quotations such as: "non-bonded construction firms are 10 times more likely than bonded companies to suffer insolvency"; and "surety bonds could protect 25 times more Ontario economic activity than their premium cost." Ontario has since passed a law to

require 100% performance and payment bonds.

Ms. Schubert closed by stating that states will not restrict capacity, help local contractors get work, or save money by allowing discretion or looking for small penalty bonds. Subcontractors will increase their price and be cautious with their work if the projects aren't backed by 100% performance and payment bonds. The cost of a 100% performance and payment bond costs the same as a 50% or 30% performance and payment bond. That may sound crazy but it's true because they bond the whole contract, not the first or last 30% of the contract.

Rep. Lehman stated that years ago, pooling bond requirements (i.e. $1 million each to 10 contractors to meet a contractual $10 million bonding requirement) was common but many states have moved away from that practice. Rep. Lehman stated that he believes that has hurt smaller contractors and asked Ms. Schubert if she recommended going back to that practice. Ms. Schubert stated that it's not necessarily the fact that the smaller contractors can't get the bonding for the project, it's that the subcontractors can't meet the size of the project so what happens is that they need to enter into a joint venture and each party to the venture brings their bonding capacity to the table. Ms. Schubert also stated that states have pushed back on co-surety.

Sen. Dan "Blade" Morrish (LA), NCOIL Vice President, asked Ms. Schubert's thoughts on services bonds rather than construction bonds. Louisiana has a P3 with private hospitals to provide their safety net services for healthcare and asked if it is common to bond those services. Ms. Schubert stated that those bonds are available, although not as common as construction bonds, in addition to operational and maintenance bonds. In a P3 project, there is a financing phase which typically requires a surety bond to get to closing (or a letter of credit); a construction/design/build phase which is in the surety bond wheelhouse; and then the operation and maintenance phase which surety bonds are available for as well. The issue with the operation and maintenance phase with P3s is timing as many projects have a 30-year operation/maintenance period and it is difficult to predict what a contractor will do 30 years out.

Sen. Brian Feldman (MD) asked how complicated it gets with projects that cross state lines and asked how a national organization such as NCOIL can figure out ways to mitigate any of those complications. Ms. Schubert stated that many of those projects have specific enabling authority with specific requirements. Ms. Schubert also stated that the Ass'n is starting a new practice called The Model Contractor Development Program which teaches small construction contractors how to improve their company's operations and increase their bonding capacity.

Rep. Tom Oliverson, M.D. (TX) asked where the bond writers gets their financing from, and if the Ass'n has information lists each state's bonding requirements. Ms. Schubert stated that surety bonds are required to be written by licensed insurance companies which are regulated by state insurance departments. On the federal level, there is something called the Treasury List – for any surety bond written for any public entity, the list states a maximum number which a company may write a bond for. The Treasury List also allows co-surety and reinsurance to take a bond larger than that. So the beauty is that those bonds are written by companies that are regulated and have the reserves and capital to do so. Rep. Oliverson asked if there has ever been a situation where the insurance company defaults on its bonds. Ms. Schubert stated that there are instances where there are disputes as to whether the contractor has defaulted but no construction

project has ever fallen apart because the surety ran out of money. Ms. Schubert closed by stating that she is happy to provide the Committee with a list of all state bonding requirements.

Asm. Ken Cooley (CA), NCOIL Secretary, stated that as the size of these projects begins to grow rapidly, it is the obligation of policymakers to be aware of all of these issues stated today. Asm. Cooley stated that the role of companies is very important because they are in essence making judgments about an entity's ability to perform on very large transactions. Asm. Cooley stated that he believes in the function of sureties, but they can go insolvent and last month, a specialty surety company dealing with student loans in either North or South Dakota went belly up. Accordingly, it is important to analyze each and every aspect of these types of situations and projects.

RE-ADOPTION OF MODEL LAWS

Upon a Motion made by Rep. Keiser and seconded by Asm. Cooley, the Committee voted without objection by way of a voice vote to re-adopt for 5 years, per NCOIL bylaws, the Model Act Regarding Auto Airbag Fraud, the Model State Uniform Building Code, the Model Act Regarding Disclosure of Rental Vehicle Damage Waivers, the Model Anti-Runners Fraud Bill, the Property/Casualty Insurance Modernization Act, and the Property/Casualty Insurance Domestic Violence Model Act.

Rep. David Santiago (FL), Vice Chair of the Committee, offered amendments to the State Flood Disaster Mitigation and Relief Model Act (Relief Model) that is scheduled for re-adoption. Rep. Santiago stated that no one knows what will happen at the end of the month when the National Flood Insurance Program (NFIP) is set to expire but noted that everyone he met with during the NCOIL D.C. fly-in last month agreed that the NFIP is broken. Rep. Santiago offered proposed amendments to the Relief Model based on legislation Florida passed 4 years ago to allow the private flood insurance market to participate.

Rep. Santiago stated that the Florida legislation is working, and the reinsurance players immediately started diving into the market to find a way to find a marketplace for Florida's domestic carriers to start writing private flood. Rep. Santiago stated that he believes Florida currently has 12 domestic carriers that are writing private flood, and, in many cases, they have lowered the premiums for consumers and provided better coverage. For example, consumers can now get both replacement cost on dwelling and contents. Rep. Santiago stated that he believes the amendments can be a roadmap for the rest of the nation and can also send a signal to Congress that the states can act appropriately when it does not.

Lisa Miller, CEO of Lisa Miller & Associates, stated that Florida finally said, "enough is enough" and the legislation was a result of all interested parties sitting through painful but necessary negotiations to get the private flood insurance market involved to help consumers. FEMA was thankful for the legislation and the current FEMA Administrator, Brock Long, has said he is willing to help see the Florida legislation serve as the basis for a national Model law.

Ms. Miller stated that the proposed amendments are actually comprised of very simple concepts: prior approval of forms – to ensure that the forms meet or exceed NFIP coverage; flexible rates; authorized insurers must notify the [State entity for regulating

insurance] at least 30 days before writing flood insurance in the state and file a plan of operation and financial projections or revisions to such plan; ensuring the agent properly educates the consumer about the coverages available; and permitting the Insurance Commissioner to certify the validity of the product so that the banks are satisfied. Ms. Miller stated that she looks forward to working with the Committee and interested parties to see the amendments progress at the NCOIL Annual Meeting in December.

Paul Martin of NAMIC stated that if you look at the private flood insurance market as it existed in 2016, specifically the Herfindahl-Hirschman Index (HII), which is a measure of competitiveness and market concentration, only 1 state was rated as moderately competitive. In 2017, 20 states were rated as moderately competitive and 1 state, Alabama, was rated as competitive. In that 12-month period, the private flood insurance market grew 51%. The concern is introducing a Model law that would impede that organic growth. NAMIC looks forward to working with all interested parties to arrive at a workable solution that would continue that growth.

Rep. Santiago stated that he has heard that information before and it is fantastic, but there are challenges that remain and there is a need to address and create a common set of principles that allow the Federal government to get involved and embrace private flood insurance and allow more mortgages to be properly recognized by Fannie Mae and Freddie Mac. Mr. Martin stated that NAMIC agrees and understands that this is not just in insurance issue – it encompasses mortgages and insurance agents – but NAMIC just wants to be sure that NCOIL gets it right with this Model the first time. Ms. Miller stated that Florida revisits its flood insurance law every year and this is an evolving issue so expectations need to be managed.

Sen. Morrish asked if the NFIP still has rules that state if you leave NFIP you cannot come back. Ms. Miller replied yes, and that is still a major concern for insurance agents but when you look at the private market rates compared to the NFIP rates it makes the argument moot.

Upon a Motion made by Asm. Cooley and seconded by Rep. Oliverson, M.D., the Committee voted without objection to re-adopt the Relief Model until December by way of a voice vote so that Rep. Santiago can continue to develop his proposed amendments.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
NCOIL SUMMER MEETING – SALT LAKE CITY, UT
FRIDAY, JULY 13, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Little America Hotel in Salt Lake City, UT on Friday, July 13, 2018.

Asw. Maggie Carlton (NV), Vice Chair of the Committee, presided

Other Members of the Committee present were:

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Rep. Joseph Fischer (KY)
Rep. Steve Riggs (KY)
Rep. Bart Rowland (KY)
Rep. Edmond Jordan (LA)
Rep. Lois Delmore (ND)
Rep. George Keiser (ND)
Asw. Pamela Hunter (NY)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Sam Kito (AK)
Rep. Deborah Ferguson (AR)
Rep. David Livingston (AZ)
Rep. Bryon Short (DE)
Sen. Travis Holdman (IN)
Sen. Brian Feldman (MD)
Rep. Michael Webber (MI)
Sen. Bob Hackett (OH)
Rep. Glen Mulready (OK)
Rep. Joe Schmick (WA)
Rep. Jim Dunnigan (UT)

Also in attendance were:

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

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its March 2, 2018 meeting in Atlanta, GA.

DISCUSSION ON UTAH WORKERS' COMPENSATION INSURANCE MARKETPLACE

Dennis Lloyd, Senior Vice President and Chief Legal Counsel at WCF Mutual Insurance Company (WCF), stated that Utah has a healthy, low cost, and efficient workers' compensation marketplace. Utah has a healthy balance of business and labor interests that help Utah's public policymakers establish good public policy. Utah is a right-to-work state, has a healthy and diversified economy, and a low litigation rate in workers' compensation. Utah also has a low rate of fraud in workers' compensation claims. WCF has slightly over 50% of the insured market in Utah and there are just under 100 self-insured employers in Utah. Mr. Lloyd stated that WCF, as the dominant "player" in Utah, thinks that they are helpful in making the Utah

workers' compensation insurance marketplace efficient.

Mr. Lloyd then provided a history of WCF, noting that on July 1, 2017, WCF celebrated its 100th birthday. To provide perspective, 1917 was the start of the women's suffrage movement, and the start of U.S. involvement in World War I. In 1917, the name of the company was "The State Insurance Fund" (SIF) and was created by the State of Utah to operate as a mutual benefit group and it was given a $40,000 start-up loan. It operated in state government as a division within a department. By 1920, operating on its premium income and the interest earned on the same income, it was able to gain a market share of 25%. In 1922, SIF paid off the $40,000 loan by transferring bonds back to the state, and by 1936, SIF had 72% of the insured market in Utah.

However, Mr. Lloyd stated that, over time, SIF has garnered a reputation of paying all the claims that came through the door using manual processes such as card files and ledger books, and playing cards in the back room. SIF was not viewed as being robust or progressive. Fast forwarding to 1986, there were certain events that caught the eye of public policymakers, one of which was the failed thrift crisis. There were certain thrift organizations that had a relationship to the state in terms of state oversight and the allegation was made that the state could be liable for the failure of those thrifts and loans. After litigation and settlements, people began to ask whether there are other entities that could involve an allegation of state liability for their operations. The focus came upon SIF. In 1986, Mr. Lloyd stated that SIF was, by statute, named as the insurer of last resort. Additionally, in 1987, because of the concern over thrifts, the Utah Governor engaged in a formal organizational study that studied SIF and asked where it should be placed. The recommendation was that there should be an autonomous relationship between SIF and the state. That recommendation took on a life of its own in the public policy process and ultimately lead to WCF today.

Mr. Lloyd stated that in 1988, legislation was proposed to transform WCF from an agency in a department to a non-profit, quasi-public corporation. Under Utah law, a non-profit, quasi-public corporation is a type of corporate entity that is privately owned but has a public purpose. Utah law defined the private owners to be the policyholders and the public purpose to be the carrier of last resort. Others argued that the public purpose was the WCF's historical purpose of creating competition in the Utah workers' compensation marketplace. Then, Utah Insurance Commissioner Robert Wilcox took note of the corporate structure and stated that if WCF was going to be an insurance corporation, it will be regulated by the Insurance Department and would have to comply with the necessary requirements.

By 1993, WCF had adopted a business structure of wanting to operate more like an insurance business – card playing in the backroom had ended. WCF had engaged in new business practices such as fraud detection, utilization review, bill review, negotiating hospital contracts, and engaging in vocational rehabilitation to help injured workers. By 1998, WCF obtained tax-exempt status under section 501(c)27(b) of the Internal Revenue Code. The legislature took note of that and wanted to further distance itself from WCF. Accordingly, "of Utah" was struck from WCF's name so that it was named as it is today – WCF (Workers' Compensation Fund). There were refinements in the enabling legislation that occurred. WCF's success was reflected in its balance sheet and at one point in time, in 2003, a member of the AG's staff wrote a white paper that took the position that the surplus of the company belonged to Utah and argued that the legislature should have access to those funds. Gov. Leavitt at that time also ordered studies to be conducted of WCF, looking at its value as a state-asset. Those actions caught the attention of WCF's board of directors, and one board member recommended that WCF file a declaratory action, asking the court to rule on ownership of WCF's assets. In 2004, WCF

offered to settle the case with Utah for $50 million but no deal was reached. The very next day, the District Court issued a ruling in WCF's favor. The case, "WCF v. State," ended up being appealed to the Utah Supreme Court which ruled in WCF's favor. Many questioned the wisdom of the state in turning down WCF's $50 million settlement offer.

In 2016, Utah SB 63 was passed which allowed WCF policyholders to elect WCF board members, which meant that WCF no longer qualified for a federal income tax exemption. WCF later earned an "A" rating from A.M. Best and then in 2017, Utah SB 92 was passed which repealed WCF's enabling legislation and converted it into a mutual insurance corporation. Notably, throughout the entire legislative process of that bill, there was not a single opposition vote casted. Before the conversion process was finalized, the State auditor had to conduct an audit to ensure that no state assets were being taken by WCF.

Rep. Matt Lehman (IN), NCOIL Treasurer, asked if after WCF's conversion from a "pool" to a mutual insurance company, Utah has a pool/insurer of last resort. Mr. Lloyd stated that WCF has agreed to continue to serve as the insurer of last resort, and has notified Utah Insurance Commissioner Todd Kiser that if he ends up bidding out that role, WCF will competitively bid for it. Rep. Lehman asked a follow-up question of whether WCF is the sole carrier of last resort. Mr. Lloyd stated yes. Rep. Lehman then asked how that has impacted WCF's loss-ratio. Mr.

Lloyd stated that it has been WCF's policy to charge all employers, whether they are in the residual or voluntary market, a premium that is appropriate to their loss history. WCF works with NCCI and the Utah Insurance Department to file appropriate and adequate rates. Rep. Lehman stated it is an important issue because in Indiana, the residual market can charge a certain percentage above the voluntary market rate since those carriers are taking on more risk. Mr. Lloyd stated that WCF's approach to rating has been a tiered-rating system but none of the tiers are specifically designated as the residual market tier. Rates are set at what the underwriters and actuaries believe are appropriate. Rep. Lehman stated that he is interested in what NCCI has to say on Utah's approach because it sounds unique.

Rep. George Keiser (ND) asked if the reinsurance rate is different for the residual and voluntary markets. Mr. Lloyd stated that his understanding of WCF's reinsurance program is that WCF buys reinsurance for the entire company at rates that are in tiers, and there is a percentage of the loss that is self-insured before the reinsurance kicks in. None of the reinsurance purchase is specifically designated to go to the residual market. The reinsurance purchase is designated to go to WCF's loss-history as it proceeds through its tiers.

STATE OF THE LINE – AN UPDATE ON THE STATUS OF AND TRENDS IN THE WORKERS' COMPENSATION MARKETPLACE

Jeff Eddinger, FCAS, MAAA, Senior Division Executive – Regulatory Business Management of the National Council on Compensation Insurance (NCCI), began by stating that for the 2017 workers' compensation (WC) rate-filing cycle, 38 filings were made and there was only one rate-increase which was slight (LA). Seventeen states saw double-digit decreases, and 2016 data was extremely similar to 2017. Additionally, for the third year in a row, an underwriting profit was achieved. Mr. Eddinger stated that the underwriting profit is being driven by a low lossratio, and also noted that the loss-adjustment-expense (LAE) to loss ratio has slowly increased the last two years because of California's extremely high ratio. Mr. Eddinger stated that the investment gain on WC insurance transactions was reported as 12%, up from 10.8%, but below the long-term average of about 13%.

Mr. Eddinger then discussed WC premium drivers and noted Rep. Lehman's earlier question to Mr. Lloyd. Mr. Eddinger stated that while each state, Utah being one, is somewhat unique in how it handles a residual market, Utah's approach is somewhat similar in other states, and it is sometimes difficult to determine if there really is a residual market because some of the carriers write other business and write in other states. Mr. Eddinger noted that the data shows that combining state funds and private carriers, WC net written premium reached a high of $47.8 billion in 2005, and clearly took a hit during the 2008 recession, but since then it was grown back to $45 billion in 2017. Mr. Eddinger noted that there are some offsetting factors that are keeping the percentage of change in direct WC written premium flat right now. Employment and wages are up but the loss costs themselves are down by almost the same amount.

Mr. Eddinger then discussed WC loss drivers and stated that what's driving the rate decreases is a long-term, downward trend in claim frequency. Mr. Eddinger noted that some may question NCCI's data of the lowered claim frequency, but the Bureau of Labor Statistics' (BLS) data is extremely similar. Mr. Eddinger stated that there has been a decline in the amount of prescribed opioids in the WC system. In 2012, approximately 55% of WC claimants with a prescription were prescribed an opioid. By 2016, that figure decreased to about 45%.

Mr. Eddinger then discussed the residual market. The premium volume has remained relatively stable over the past 5 years, and the residual market share as a percentage of total premium has also remained stable for the past 5 years. Mr. Eddinger noted that, on average, when there is a residual market, the premium is about 40% higher than the voluntary market, which is necessary to account for the higher risk.

Mr. Eddinger then provided a summary of NCCI's 2017 data. On one hand: investment income remained below the long-term average; loss costs continued to decrease; lost-time claim frequency fell again; and net written premium for private carriers declined slightly. On the other hand: combined ratio improved to the lowest level in over half a century; payroll continued to increase; severity increases remained moderate; and residual Market remained stable and manageable.

Rep. Lehman stated that there has been a huge increase in loss-control for carriers, but they refuse to give any discounts because the rates are too low. Rep. Lehman asked Mr. Eddinger where he sees rates trending in the future given that dynamic. Mr. Eddinger stated that NCCI thinks the rates are where they need to be given the data available and cannot speak for the carriers. Mr. Eddinger also noted that insurance carriers, like other companies, are looking to make a profit, and they have also realized that the least expensive claim is the one that doesn't happen, and employers are increasing workplace safety.

Rep. Lehman then asked if monopolistic states such as Ohio and North Dakota are seeing rate decreases. Mr. Eddinger stated that there is very little data available from monopolistic states. Rep. Keiser stated that there has been an emphasis on workplace safety and therefore a decrease in workplace accidents. Rep. Keiser asked how much in the recent data can be attributed to the legislation that many states have passed relative to cost-drivers. Mr. Eddinger stated that overall, the impact of state reforms is a very small piece of the data, and that he is confident that monopolistic states have similar data.

Asw. Maggie Carlton (NV), Vice Chair of the Committee, stated that in Nevada, construction used to be a large part of the economy but that has changed. Construction WC claims are expensive, so she asked if a decrease in construction jobs factored into the lower overall claims frequency. Mr. Eddinger stated that those types of shifts do have impacts, however, only huge

events like the great recession tend to show up in the data.

RE-ADOPTION OF MODEL LAWS

Upon a Motion made by Rep. Keiser and seconded by Rep. Lehman, the Committee voted without objection by way of a voice vote to re-adopt for five (5) years, per NCOIL bylaws: the Model Act on Workers' Compensation Coverage for Volunteer Firefighters; the Construction Industry Workers' Compensation Coverage Act; and the Model Act Regarding Workers' Compensation Insurance Coverage in Professional Employer Organization (PEO) Relationships.

Upon a Motion made by Asm. Ken Cooley (CA), NCOIL Secretary, and seconded by Rep. Keiser, the Committee voted without objection by way of a voice voce to re-adopt the Model Act on Workers' Compensation Repackaged Pharmaceutical Reimbursement Rates until the NCOIL 2018 Annual Meeting in December since proposed amendments to the Model are in the process of being developed and considered.

ADJOURNMENT

There being no further business, the Committee adjourned at 3:45 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
SALT LAKE CITY, UT
JULY 15, 2018

The National Council of Insurance Legislators (NCOIL) Business Planning and Executive Committee met at the Little America Hotel on Sunday, July 15 at 9:00 a.m.

NCOIL President, Sen. Jason Rapert, AR, Chair of the Committee presided.

MEMBERS OF THE COMMITTEE PRESENT:

Sen. Dan "Blade" Morrish, Vice President
Rep. Matt Lehman, Treasurer
Asm. Ken Cooley, Secretary
Rep. Sam Kito, AK
Rep. Deborah Ferguson, AR
Rep. Martin Carbaugh, IN
Rep. Joe Fischer, KY
Rep. Richard Smith, GA
Rep. Lois Delmore, ND
Rep. George Keiser, ND
Sen. Bob Hackett, OH
Rep. Tom Oliverson, TX

OTHER LEGISLATORS PRESENT:

Rep. Jim Gooch, KY
Sen. Paul Utke, MN

ALSO PRESENT:

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

MINUTES

A motion was made and seconded to approve the minutes of the March 4th Executive Committee and June 2nd Executive Committee Interim Call.
meeting. The motion carried on a voice vote.

FUTURE LOCATIONS

Cmsr. Considine stated that recommendations for the 2020 Summer Meeting were being held back because of the dates of the national political conventions. Frankly, NCOIL needs to go to a big city in presidential years like NY metro area or Boston, however, we should also go to Ohio in the near future.

Sen. Rapert stated that every location has its own draw and attractions. During the CIP meeting, participants could see the skyline of lower Manhattan and amazed at how beautiful is was from the Hyatt. It was basically the vista in a postcard of NYC. He continued that Rep. Riggs and he

took the ferry and went to WTC museum and there is a lot of draw. Obviously, Boston and Ohio are good as well and we should make an effort to get there.

Rep. Keiser stated it has been a long time since NCOIL has been to NYC and we should expect some attrition due to all of the attractions.

Rep. Ferguson stated that everyone she spoke to had a great time in NJ during CIP meeting.

Cmsr. Considine stated that the CIP meeting was in a traditional conference room and this meeting will have a view of the NYC skyline.

Sen Rapert stated that CIP stakeholders want to have it there in Jersey City again.

Rep. Riggs echoed Sen. Rapert's point for Jersey City for CIP and that many of the industry and participants love that location and can visit the company headquarters while visiting. He believes we should go there but make a commitment to Ohio for a future summer meeting.

Former President Mike Stinizano stated the last time NCOIL came to Ohio was in 1992 in Columbus, which coincided with the 500th anniversary of Columbus' voyage to the new world.

Sen. Rapert said it's very easy to get to NYC from the Jersey City Hyatt, about 90 seconds by ferry.

Rep. Lehman made a motion to have the 2020 Summer Meeting in NJ, pending the dates of the national political conventions. Rep. Riggs seconded, and the motion carried on a voice vote.

Sen. Rapert asked the staff to research specific dates and locations for 2021 in Ohio.

Cmsr. Considine stated that the Spring 2021 in Denver, Colorado. March 18 - 21 in Denver. We will look at Ohio.

RECRUITMENT OF NEW MEMBER STATES

Sen. Rapert talked about new state and participation with the IEC. And having them assist to recruit new member states. The IEC is sending a letter out to potential new members from Sen. Rapert. He noted that at 34, NCOIL has the most contributing states it has ever had.

ADMINISTRATION

Commissioner Considine noted that there were 277 registrants for the Summer Meeting, 51 legislators and participants from 34 states. 6 legislators participated via ILF scholarship. 5 Commissioners participated, and 14 insurance departments were present.

Paul Penna gave the 2018 mid-year unaudited financial report through June 30, 2018 that showed $509,327.38 in revenue and $412,195.27 in expenses for a net operating revenue of $97,132.11

2017 audited financials show revenue of $999,339.50 and expenses of $858,196 for excess of $141,142.81 and net operating assets of $449,498.

CONSENT CALENDAR

Sen. Rapert asked if any member had an item to take off the consent calendar. No member did so and Asm. Cooley made a motion to accept and Rep. Carbaugh seconded. Carried on a voice vote

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

Asm. Cooley stated that after discussions with his colleagues there were amendments at the dais and apologized for the delay. He stated that he wished for the revised model to be considered at the Annual Meeting in Oklahoma City. He reiterated the purpose is to ensure that legislators understand how the authority that is given to the Executive Branch is utilized

Sen. Rapert stated that it would be held for now and legislators should look for it in their packets for the Annual Meeting in Oklahoma City.

OTHER SESSIONS

Sen Rapert noted the Griffith Foundation Legislator Luncheon, “Drones and Insurance: Changes and Challenges in the Regulatory Environment”, Dr. Kathleen McCullough, Florida State University was interesting and well attended. And the Institutes Griffith Foundation Fundamentals of Insurance Programs were well attended and insightful for the new legislators.

Frank Tomasello of the Griffith Foundation reiterated the opportunity to do more webinars and options to learn more, such as NCOIL & Griffith cohosting a quarterly webinar. Staff will follow up.

Sen. Rapert noted that Utah Attorney General Sean Reyes did a great job during the luncheon and the message from Gov. Herbert was well received. He also noted that the General Sessions - Innovation General Session – Navigating the Future of Autonomous Vehicles: A Tech and Insurance Update; Health General Session – Breaking Down Silos: Innovative Solutions to Address the Opioid Epidemic; and Property & Casualty General Session – Arrive Alive: Legislative and Industry Trends to Stop Distracted Driving were informative and timely. Lastly, The Institutes Griffith Foundation Fundamentals of Insurance Programs were held during the meetings and were informative for legislators new to insurance public policy.

OTHER BUSINESS

Sen. Rapert thanked Rep. Dunnigan for all his work hosting us in SLC and noted is the Utah House Commerce & Labor Chair and Utah is a contributing state that, per NCOIL bylaws he is automatically added member of the Executive Committee.

He also thanked the staff as well as Sen. Morrish for his willingness to take on the NCOIL Vice Presidency. He is capable, experienced and will do a great job.

ADJOURNMENT

There being no further business, the committee adjourned at 9:39.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUDGET COMMITTEE
SALT LAKE CITY, UT
JULY 12, 2018

The National Council of Insurance Legislators (NCOIL) Business Planning and Budget Committee met at the Little America Hotel on Thursday, July 12 at 5:00 p.m.

NCOIL Treasurer, Rep. Matt Lehman, IN, Chair of the Committee presided.

MEMBERS OF THE COMMITTEE PRESENT:

Vice Chair: Rep. Lois Delmore (ND)
Sen. Jason Rapert (AR)
Sen. Dan "Blade" Morrish (LA)
Rep. Steve Riggs (KY)
Sen. Neil Breslin (NY)

ALSO PRESENT:

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

Rep. Lehman called the meeting to order at 5:11 p.m. He stated that NCOIL was continuing positive growth as evident by the budget before them. He stated that this was the beginning of the review and it would be adopted at the Annual Meeting in Oklahoma City. He asked Paul Penna to go over the specifics.

Penna stated the 2019 Proposed Budget before them had total revenue of $1,132,000 and total expenses of 1,037,524.10 for an excess of $94,475.10. The document shows the 2018 adopted budget has revenue of $1,032,500 with expenses of $924,470 with an excess of $108,030. It also shows the 2017 actual amount including revenue of $999,339.50 and $858,196.69 for an excess of $141,142.81. There is $116,300 in other spending and expenses that do not affect the 2017 bottom line.

Penna went through the five changes to the budget including;

1. Accounting for 2019 Spring Meeting registration opening in 2018 with its own category.
2. Potential reduction of IEC grant from $100,000 to $80,000
3. Elimination of exhibit space since it is a CIP benefit.
4. Creation of a future location deposit
5. Increase in travel budget

Rep. Lehman reiterated that the travel amount was because of the 50th anniversary and asked if there were any questions and reminded committee members that final adoption would take place at the Annual Meeting in Oklahoma City.

There being no other business, the committee adjourned at 5:17 p.m.